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LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET SALISBURY, NC 28147

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F 000	INITIAL COMMENTS A complaint survey was conducted from 4/25/23 through 4/28/23. Event ID# RJXQ11. The following intake was investigated NC00201065 and resulted in immmediate jeopardy. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. 1 of the 1 complaint allegation resulted in deficiency. 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: Based on observations, record review and staff,	F 600	Past noncompliance: no plan of	

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

Electronically Signed | 05/15/2023

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resident, Nurse Practitioner, and Law Enforcement Detective interviews the facility failed to protect Resident #1 right to be free from sexual abuse by Resident #2, who was his roommate. Resident #1 was severely cognitively impaired and did not have the capacity to consent to sexual activity. Resident #2 had intact cognition. On 3/30/23 Resident #2 was observed by two Nurse Aides (NA #1 and NA #2) at Resident #1's bedside. Resident #1's brief was opened, and Resident #2 was rubbing Resident #1's penis with his hand. Using the reasonable person concept, all residents would expect to be free from sexual abuse in their home and could experience anger, anxiety, fear, and depression. This was for 1 of 3 residents reviewed for resident abuse.

Findings included:

Resident #1 was admitted to the facility on 5/31/2016 with a diagnosis of cerebral palsy, epilepsy, and major depressive disorder and developmental delay.

A quarterly Minimum Data Set (MDS) assessment dated 1/12/23 showed Resident #1 was severely cognitively impaired, had unclear speech (slurred or mumbled words) and usually understood others. The MDS showed that Resident #1 required extensive assistance from one to two staff members for activities of daily living (ADL). Resident #1 was assessed as being always incontinent of bowel and bladder.

Resident #1's care plan revised on 1/30/23 revealed a focus area which stated, Resident #1 has impaired cognition function with impaired thought processes related to disease process of

correction required.

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cerebral palsy and being developmentally delayed. Interventions included: Ask yes/no questions in order to determine needs, approach resident from the front in a calm an unhurried manner, identify yourself at each interaction, face me when speaking and make eye contact, reduce distractions with communication by turning off the television, radio, resident understands simple, directive sentences. provide the resident with necessary cues and stop and return if agitated.

Resident #2 was admitted to the facility on 11/28/2019 with a diagnosis of Type II diabetes, history of falling, and major depressive disorder.

A comprehensive Minimum Data Set assessment dated 3/4/23 coded Resident #2 as being cognitively intact and needing extensive assistance with the support of 2 persons in the areas of transfer and extensive assistance with the support of one person for dressing, toilet use and personal hygiene. Resident #2 used a wheelchair for mobility and was coded as not steady, only able to stabilize with staff assistance for surface-to-surface transfers. Resident #2 was assessed to not display any behaviors such as physical or verbal symptoms directed towards others.

A review of a facility reported incident dated 3/30/23 revealed staff witnessed Resident #2 masturbating. Resident #1 while Resident #1 was lying in bed.

A review of the facility investigation dated April 6, 2023, read in part; Resident #1 and Resident #2 were roommates. Two Nurse Aides reported they saw Resident #2 hands down Resident #1 pants as they were walking by his room and had his

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hands around Resident #1's penis. The Nurse Aides immediately stopped the action and Resident #2 was separated from Resident #1 immediately and Resident #2 was put on one-to-one care. A room move was completed, and Resident #2 was moved into a room with alert and oriented resident while still being on one-to-one care. Resident #1 was assessed and did not present any frightened or withdrawn behaviors and had no change in his normal daily activities. Resident #1's responsible party was notified. The local police department was notified and has forwarded the investigation to the detective section of the police department, and it was an on-going investigation. Adult protective services were notified ... ...in conclusion, based on interviews and witness statements, our facility has decided to substantiate the allegation of sexual abuse.

A review of an undated signed statement from Nurse Aide #1 read; "I saw on the morning of 3/30/23, at (name of nursing home) me and another CNA was taking the trash out that morning, was at the end of the 300 hall, walked by 315, which is Resident #1 and Resident #2's room. Saw Resident #2 by Resident #1's bedside, cover was pulled down, Resident #1's gown was pulled up, diaper was undone, Resident #2 had his hand on Resident #1's private area, using an up and down motion on his privates, we asked at that time Resident #2 what are you doing he jumped and moved his wheelchair to his side of the room, then we asked Resident #1 what was he doing to you, he had a scared look on his face, also asked Resident #1 why his diaper was open, Resident #2 responded he likes it that way, me and the other CNA reported this to the nurse as soon as it happened, Resident #2 was removed

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from Resident #1 and replaced in another room."

An interview was completed with NA #1 on 4/25/23 at 1:32 PM. NA #1 witnessed the incident on 3/30/23 between Resident #1 and Resident #2. NA #1 stated that she had been with NA #2 to take out the trash on 3/30/23 before her shift was ending at 7:00 AM and observed Resident #2 in his wheelchair leaning over Resident #1's bed and had his hand on Resident #1's penis and his hand was going up and down. NA #1 asked Resident #2 what he had been doing and why Resident #1's brief was undone. Resident #2 told NA #1 that Resident #1 liked it that way and wheeled back to his side of the room immediately. NA #1 reported Resident #1 did have an erection. NA #1 stated that to her knowledge, Resident #1 had never undone his brief or tried to take it off. NA #1 stated Resident #1 had a confused look on his face when they (NA #1 and NA #2) entered the room and reported after the sexual encounter Resident #1 seemed a little down and had his head was down looking sad. NA #1 reported there was no evidence this happened before. NA #1 stated she was shocked by the sexual encounter between Resident #1 and Resident #2. NA #1 reported sometimes the door would be closed but staff would open it as Resident #1 had a seizure disorder and staff liked to have the door open in case Resident #1 would have a seizure. NA #1 stated sometimes Resident #2 would try and help Resident #1 by pulling the covers over him but never had witnessed anything that would cause concern. NA #1 reported that Resident #1 would refuse ADL care and really had to get to know the staff before allowing the NA to assist. NA #1 stated Resident #2 required transfer assistance by staff and used a stand up to lift transfer

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method so he would not be able to go over to Resident #1's bed independently unless he was up in his wheelchair. NA #1 reported that since the incident Resident #1 seems happy and will wave and smile when NA #1 walked by.

A review of an undated signed statement from Nurse Aide #2 read; "On Thursday March 30, 2023 around 6:30 AM I (name) and another CNA were walking down the 300 hallway to attempt to take the trash out upon doing so walking up towards room #315, which the door was opened, me and CNA observed Resident #2 with his right hand moving up and down very fast while holding Resident #1's penis in his hand. The brief was torn open. Resident #1 was asked by myself what was he doing. Resident #1 stated he wasn't doing anything but then stated that Resident #1 asked Resident #2 to change his brief. Resident #2 then tried to hurry up and fix the brief and stated Resident #1 no longer wanted to be changed. I, myself had just left room 315 before this occurred after getting Resident #2 up, I proceeded to try and do cares for bed A which Resident #1 refused to be cleaned up. Resident #1 had a very distraught look on his face."

An interview was completed with NA #2 on 4/25/23 at 3:14 PM. NA #2 stated she had witnessed the incident on 3/30/23 between Resident #1 and Resident #2. NA #2 stated that on 3/30/23 she and NA #1 had been taking the garbage out around 6:40 AM and walked by Resident #1 & Resident #2's room and observed Resident #2 had his right hand on Resident #1's penis. NA #2 stated Resident #1's penis was erect, and Resident #1 was just lying in his bed with a distraught look on his face. NA #2 stated we (NA #1 & NA#2) asked Resident #2 what he

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was doing, and he said to NA #1 and NA #2 Resident #1 asked Resident #2 to change him. NA #2 reported she told Resident #2 that Resident #1 could not talk and would not be able to verbalize he needed to be changed. NA #2 reported Resident #2 tried to cover Resident #1 back up and replied, "Yes, he did ask me to change him" and wheeled back over to his side of room. NA #2 stated "Resident #1 could be difficult (refusing care) about his personal hygiene and would not signal anyone to change him." NA #2 reported Resident #1 was willing to have her (NA#2) complete his ADL, but when she first started working with him, he would not let her. NA #2 reported Resident #1 needed to get to know a person first before he would allow them to provide care. NA#2 confirmed she was assigned to Resident #1 and Resident #2 on 3/29/23 from 11:00 PM to 7:00 AM and Resident #2 was the last resident she had gotten up out of bed during her shift around 6:00-6:30 AM. NA#2 had not witnessed any sexual encounter previously with Resident #1 and Resident #2 and was surprised when she witnessed it. NA #2 stated that she had reported the sexual encounter to the Nurse on duty.

An interview was completed with NA #3 on 4/25/23 at 2:07 PM who stated she had worked on 3/30/23 and at 7:05 AM provided care ADL care for Resident #1 which included changing his brief. NA #3 reported Resident #1 was happy to see NA #3 and appeared no different than previous days she had cared for him. NA #3 explained Resident #1 had not refused his care on the morning of 3/30/23 and had always been cooperative when NA #3 would provide his care but knew Resident #1 would refuse care from other NAs. NA #3 explained she had not

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witnessed any type of sexual inappropriateness between Resident #1 and Resident #2 and was surprised to learn of the sexual encounter.

A risk assessment note written by the Director of Nursing dated 3/30/23 read in part; staff separated roommate from resident, 1:1 Initiated with roommate and roommate moved to a room with an alert and oriented roommate. Resident (Resident #1) assessed by nursing staff, no complaints of pain or visible injury noted. No acute distress noted. Incontinent care provided by staff.

An interview was completed with the Director of Nursing (DON) on 4/25/23 at 4:20 PM who stated the report to her was two staff were walking down the hallway and observed "inappropriate movement" of Resident #2 on Resident #1's private area. The DON explained they quickly got Resident #2 away from Resident #1 and had Resident #2 with 1:1 care. Resident #2 was moved to a room with a resident who was alert and oriented as it was believed it could reduce the risks of sexual abuse to reoccur as the resident could verbalize and understand if something bad like an unwanted sexual encounter would occur. DON reported that when she arrived at the facility on 3/30/23 she saw Resident #1 approximately between 8:00 AM and 8:30 AM and he appeared fine and was not scared. The DON reported that Resident #2 and Resident #1 had been roommates for over a year, and they gotten along good, and Resident #2 would look out for Resident #1 and would try to help Resident #1 by offering to shave him, however the staff did not let that occur. The DON stated that the facility had maintained 1:1 care with Resident #2 every shift and the Social

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Worker (SW) completed daily rounds on both Resident #1 and Resident #2 to ensure Resident #1 did not have any psychosocial (changes in how a person would think, their feelings, moods, or ways of coping) effects from the incident. DON stated that once Resident #2 could not go back to his old room with Resident #1 he wanted to go to a different facility where he had a friend. The DON reported that full body audits were completed on all residents that were not alert and oriented and interviews with residents that were alert and oriented revealed no concerns related to sexual abuse.

An interview was completed with Resident #1 on 4/25/23 at 1:00 PM who was sitting in his chair next to his bed with numerous toys in front of him. Resident #1 was receptive to conversation by shaking his head, smiling and grunting but was unable to answer any specific questions regarding the incident with Resident #2 nor did he change his facial expressions when asked about the incident. Resident #1 appeared happy and was pointing to his walls which were adorned with cartoon characters.

An undated signed statement from Resident #2 was reviewed. It read; "I Resident #2, was trying to help Resident #1 change his brief because I saw that his brief was soiled. When I asked him if he wanted me to change it, he nodded his head showing that he did. When the CNAs (certified nursing assistants) walked in, they saw what I was doing. I know that I should not have touched him or tried to change his brief, I knew that it was wrong from the beginning, but I wanted to help him. I would never do anything to hurt him. I care about Resident #1." The statement was signed by Resident #2.

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A telephone interview was completed on 4/26/23 at 12:57 PM with Resident #2. The DON at the facility he had transferred to was present during the phone call to assist Resident #2 with any difficulties with the phone. Resident #2 stated the only thing that happened on 3/30/23 was that Resident #1 wanted help to change his diaper. Resident #2 was asked how he knew that, and Resident #2 stated he pointed to his middle part. Resident #2 stated then Resident #1 asked him to stop and repeated he was trying to change Resident #2's wet diaper. Resident #2 was asked if he had his hands on Resident #1's penis and he replied No. Resident #2 stated that two staff asked him what he was doing, and he (Resident #2) had stopped changing Resident #1. Resident #2 stated he had never changed Resident #1's diaper before.

An interview was completed with Nurse #1 on 4/25/23 at 3:01 PM and she stated she had never witnessed any sexual abuse between Resident #1 and Resident #2, and she was surprised to learn of the incident. Nurse #1 explained Resident #2 spent time knitting in his room or would like to roam the hallways talking to other people. Nurse #1 reported when Resident #1 was in a different room (3/30/23 to 4/4/23 unable to recall exact date of conversation) Resident #2 was adamant about going back to his room with Resident #1 and stated to Nurse #1 if he could not go back to his room he wanted to move to a different facility. Nurse #1 reported that Resident #1 had been more friendly and interacted more with Nurse #1 since the incident and seemed happier and had not refused his medications.

A telephone interview was completed with

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Resident #1's responsible party (RP) on 4/25/23 at 7:00 PM. The RP explained that she went to see Resident #1 on 3/31/23 and Resident #1 was in good spirits and appeared to be his usual self. RP had never known Resident #1 to have any sort of sexual encounter like what happened on 3/30/23 and was certain he did not understand what was being done to him. RP said that she was aware of Resident #1 refusing care and first had to get to know his NA before he would cooperate. RP had small conversations with Resident #2 when she would visit Resident #1 and had no concerns with Resident #2.

A review of a Nurse Practitioner progress note dated 4/3/23 at 4:00 PM read in part; The DON and Social Worker (SW) asked me to see patient (Resident #1) regarding an incident that occurred with another patient (Resident #2) involving a sexual encounter. Staff states that this patient can't consent to any sexual encounters due to cerebral palsy. DON stated police were notified of the incident as well as State and other protocols were followed. Patient was asked about the encounter, but he makes incomprehensible sounds at baseline. A physical exam was attempted, but the patient refused holding his pants tightly. An exam attempt will be tried again later this week. The Nurse Practitioner noted Resident #1 seemed withdrawn during interaction.

An interview was completed with the Nurse Practitioner (NP) on 4/26/23 at 11:28 AM. NP saw Resident #1 for an examination on 4/3/23 and he would not allow the NP to pull his pants down to do an examination of his peri area. The NP explained Resident #1 had communicated by gestures of arms and facial expressions that he

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did not want the NP to touch him. NP was able to listen to his heart and lungs. NP explained that was the first time on 4/3/23 she had met Resident #1. NP saw Resident # 1 on 4/26/23 at 11:15 AM and reported Resident #1 was very cooperative, and she was able to examine Resident #1's peri area. NP stated there were no bruises and no redness to his peri area. NP confirmed if Resident #1 was bruised, bruises could be observed up to 6-8 weeks after an injury. NP reported she did not have any other concerns for Resident #1.

An interview was completed with the Administrator on 4/25/23 at 10:43 AM who stated Resident #2 and Resident #1 had been roommates for 18 months. The Administrator stated Resident #2 had always been kind to Resident #1 and did not believe this sexual incident had happened previously. Resident #1 never showed any kind of behavior towards Resident #2. The Administrator believed that Resident #2 did not think he had done anything wrong. The Administrator stated "Resident #2 was asked if he touched Resident #1 and Resident #2 replied no, he did not and then admitted yes, he did touch him. Resident #2 was then asked did you touch his brief and Resident #2 stated "no, well yes, I did touch his brief", Resident #2 was asked did you touch his penis, Resident #2 replied no, well yes I did touch his penis" The Administrator asked Resident #2 why he did it, and Resident #2 told the Administrator that Resident #1's brief was soiled and Resident #2 was going to help change him. The Administrator stated that Resident #2 was separated from Resident #1 in another room with an alert and oriented male resident and Resident #2 did not like the new room and wanted to go

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back with Resident #1, the Administrator told Resident #2 he could not. The Administrator stated he offered Resident #2 a different room and Resident #2 stated if he could not go back to being roommates with Resident #1, he wanted to go to another facility. The Administrator had reported that when Law Enforcement came to the facility to take a report on 3/30/23 they had referred the case to the detective due to the nature of the sexual encounter. The Administrator reported the Detective visited the facility the week of April 3, 2023, and interviewed Resident #1 and the NAs who witnessed the incident. The Administrator indicated Resident #2 had been discharged at the time of the Detective's visit.

An interview was completed on 4/26/23 at 9:00 AM at the local law enforcement agency with the detective assigned to the case for Resident #1 and #2. The Detective stated he had interviewed Resident #2 at his new facility (date unknown) and stated during the interview with Resident #2 he felt Resident #2 was trying to use his age, being in a nursing home as a method to minimize his sexual behavior and told the Detective he (Resident #2) had not done anything wrong. The Detective stated Resident #2 never admitted to doing anything wrong to Resident #1 and reported he (Resident #2) was changing Resident #1's diaper. The Detective stated that he did inform Resident #2 he could go to jail and stated Resident #2 appeared a little more nervous when hearing this but never admitted to any wrongdoing. The Detective reported he was waiting for medical information from the facility Resident #2 is at and once that is received, he will present the case to the District Attorney regarding pressing any charges. The Detective reported he attempted to interview Resident #1

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the week of April 4th (no specific date given) at Resident #1's facility but due to his impaired cognition he was not able to answer any questions the detective asked.

The Administrator was notified of the Immediate Jeopardy on 4/26/23 at 5:12 P.M.

The facility provided the following corrective action plan with a compliance date of 4/5/23:
Corrective action for resident involved:

On March 30, 2023, at approximately 8:00am, two certified nursing assistants reported to charge nurse that they witnessed Resident #2 with his hand in Resident #1's brief around his penis as they were walking past room 315 to take out trash. Nurse aide #1 immediately removed resident#1's roommate, Resident #2, from room and notified charge nurse and remained with resident #2, who was cognitively intact, while nurse aide #2 stayed with resident#1. On 3/30/2023, upon notification by phone of incident, the Director of Nursing drove to the facility to meet with Resident #1, who was severely cognitively impaired, with a diagnosis of Cerebral Palsy and was assessed by the Director of Nursing for any injury on the resident's body as a result of the alleged abuse and incontinent care was provided for resident #1. The assessment revealed that resident #1 had no obvious bruising or redness on his body or genitals. On 3/30/2023, the Director of Nurses notified Resident #1's responsible party and the Medical Director of the alleged abuse. On 3/30/2023, once determined that there was suspected abuse the Administrator notified police and Adult Protective Services and submitted initial allegation report to State Survey Agency. On

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3/30/2023, the Administrator and Director of Nursing interviewed resident #2 regarding alleged abuse. Resident stated he was attempting to change resident #1's brief. Immediately following the incident, resident #2 was transferred to room 306B and placed on 1:1 supervision in which he remained until his discharge on 4/4/2023. On 3/30/2023, the Director of Nursing and Administrator interviewed each of the two nurse aides separately to get details of the alleged abuse. During the interviews, each nurse aide also completed a reenactment of the event. On 4/5/2023, the Administrator concluded alleged abuse and based on investigation findings substantiated alleged abuse of resident #1. On 4/6/2023, the Administrator submitted an investigation report to the State Survey Agency with findings.

Corrective action for potentially impacted residents:

On 3/30/2023, the Director of Nursing identified residents that were potentially impacted by this practice by completing head to toe body audits on all residents with a BIMS below 13 on all current residents. The results included: 47 of 47 residents had no areas of concern identified related to skin integrity or potential injuries. On 4/3/2023, all current residents with a BIMS of 13 or above were interviewed by the Administrator and were asked if they had any concerns related to sexual abuse or been approached by anyone about having sex or been touched inappropriately. The results included: 34 of 34 residents denied any alleged abuse occurred. On 3/31/2023, the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to abuse. The results

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included: There were no grievances or Resident Council Minutes that included any abuse. On 3/31/2023, the Administrator audited resident#2 chart to assure that sex offender registry was reviewed as part of the new admission process. The results included: sex offender registry checked prior to resident admitting to facility and resident #2 was not on the sex offender registry. On 4/3/2023, the Director of Nursing (DON) interviewed all full-time, part-time, and PRN (as needed) direct care staff including agency (licensed nurses, certified nursing assistants, and medication aides) to determine if staff had observed any sexual abuse or inappropriate touching of residents by anyone including resident #2. The findings of the audit were: No staff were aware of any other incidents involving sexual abuse or inappropriate touching.

On 3/30/2023, after gathering more details, the Quality Assurance Committee convened to discuss the alleged abuse incident and the status of the investigation. On 4/4/2023, there was an additional Quality Assurance meeting attended by the Director of Nursing, Administrator, Interdisciplinary Team and the Quality Assurance Consultant to review the Abuse policy and status of the investigation. There were no additional findings at that time.

Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 3/30/2023 the Director of Nursing/Staff Development Coordinator began in-service of all full-time, part-time, and PRN (as needed) staff, administration, housekeeping, dietary, nursing, therapy and maintenance (including agency) on

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the abuse prohibition/reporting policy. This training will include all current staff including the agency. This training included: Abuse Types, reporting abuse allegations immediately to nurse/DON/Administrator, what to do if abuse observed or suspected, assuring resident safety, zero tolerance of retaliation of reporting allegations of abuse, addressing challenging behaviors and catastrophic reactions, along with notification of local law enforcement, Adult Protective Services, and State Survey Agency. Staff were also asked if they were aware of any abuse occurring to any resident in the facility and what to do if observed or suspected. No staff were aware of any other abuse occurring in the facility.

The Director of Nursing will ensure that any of the above-identified staff (all staff including agency) who do not complete the in-service training by 4/3/2023 will not be allowed to work until the training is completed. This training will be included in the new hire orientation for any newly hired staff.

On 4/3/2023, the Administrator completed re-education related to resident's rights policy with all current residents with BIMS of 13 or higher and provided a copy of policy to residents.
How the facility plans to monitor its performance to make sure that solutions are sustained:

Beginning the week of 4/3/2023, The Administrator or designee will monitor the abuse process to ensure residents are free from abuse and any abuse identified reported and addressed according to facility policy using the QA Tool for Abuse. The Administrator or designee will interview 3 staff members to monitor if staff know

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the procedure for reporting alleged abuse and when and who to report to. Also, the Administrator or designee will interview 5 residents related to Abuse and how and when to report allegations of abuse. As a part of the interviews, the Administrator or designee will include questions pertaining to whether the interviewed staff observed or were they aware of any abuse. The monitoring will be completed weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and an ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Therapy Director, Health Information Manager, and the Dietary Manager.

The facilities corrective action plan with a compliance date of 4/5/23 was validated during the on-site review of 4/25/23 through 4/27/23 by the following: A review of completed audit logs was reviewed which included interviews with residents who were alert and oriented regarding if they (residents) had been approached by anyone relating to having a sexual encounter; audit logs related to body checks for any injuries which were conducted on residents who were not alert and oriented. An audit of staff abuse interview questions was reviewed regarding if staff had witnessed any sexual abuse, inappropriate touching to a resident in the facility, if so, did they provide safety to the resident, if yes, did the resident display any emotional response and if

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F 600	Continued From page 18 abuse was observed who it would get reported to. A review was completed of the resident rights training and review of the in-service sign-in sheet for alert and oriented residents. Audit logs that included the educational information provided to staff during the in-service and a review of in-service staff sign-in logs was reviewed. Randomly selected staff on all shifts were interviewed to verify if they have received training on sexual abuse as well as an interview with the staff educator who verified a follow-up training related to the sexual abuse incident on 3/30/23 had been planned. A review of the Quality Assurance Monitoring tool - Recognizing and Reporting Abuse/Neglect which began on 4/4/23 which included ongoing interviews with 3 staff weekly and 5 residents related to abuse allegations and reporting abuse verified the monitoring was being completed. Additional interviews with the Corporate Quality Assurance Nurse Consultant, the Administrator, Director of Nursing and the former Social Worker related to the monitoring plan were completed during the on-site review.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		5/2/23

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F 609	Continued From page 19 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to report an allegation of sexual abuse to the State Agency, Law Enforcement and Adult Protective Services within two hours of becoming aware of the allegation for 1 of 2 abuse allegation reports reviewed for reporting alleged violations. (Resident #1). The findings included: Review of the facility policy revised on 9/2022 titled "Abuse Prohibition"," read in part: Definitions: e. Crime is defined by law of the applicable political subdivision where the facility is located. Examples of commonly accepted crimes include ...., sexual abuse ..... f. Criminal sexual abuse: serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct Serious bodily injury includes sexual intercourse with a resident by	F 609	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. □ F609 Reporting of Alleged Violations Corrective action for resident(s) affected by the alleged deficient practice. On March 30, 2023, two certified nursing assistants reported to charge nurse that	

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F 609	Continued From page 20 force or incapacitation or through threats of harm to the resident or other sexual act involving a child. M. Sexual Abuse - is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault. This is any non-consensual sexual conduct of any type. Covered Individuals Annual Abuse Reporting Guidelines: The timeframe requirements for reporting reasonable suspicion of crimes: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the Covered Individual must report the suspicion immediately, but not later than 2 hours after forming the suspicion. A review of an undated signed statement from Nurse Aide #2 read in part; "On Thursday March 30, 2023 around 6:30 AM I (name) and another CNA (certified nursing assistant) were walking down the 300 hallway to attempt to take the trash out upon doing so walking up towards (Resident #1 and Resident #2's room), which the door was opened, me and CNA observed Resident #2 with his right hand moving up and down very fast while holding Resident #1's penis in his hand." An interview was completed with NA #2 on 4/25/23 at 3:14 PM who had witnessed the incident on 3/30/23 approximately 6:40 AM between Resident #1 and Resident #2. NA #2 stated that she had reported the incident to Nurse #2 who had worked the 11:00 PM -7:00 AM shift on 3/29/23. An interview was completed with the Support Nurse (Nurse #3) who stated that she had received a text message from Nurse #2 around 6:40 AM however Nurse #3 explained she had been sleeping and normally would not work on Thursdays (3/30/23). Nurse #3 stated she	F 609	they witnessed Resident #2 with his hand in Resident #1□s brief around his penis as they were walking past room 315 to take out trash. Nurse aide #1 immediately removed resident#1□s roommate, Resident #2, from room and notified charge nurse and remained with resident #2, who was cognitively intact, while nurse aide #2 stayed with resident#1. On 3/30/2023, upon notification by phone of incident, the Director of Nursing drove to the facility to meet with Resident #1, who was severely cognitively impaired, with a diagnosis of Cerebral Palsy and was assessed by the Director of Nursing for any injury on the resident□s body as a result of the alleged abuse and incontinent care was provided for resident #1. The assessment revealed that resident #1 had no obvious bruising or redness on his body or genitals. On 3/30/2023, the Director of Nurses notified Resident #1□s responsible party and the Medical Director of the alleged abuse. On 3/30/2023, once interviews were completed with staff, assessment of Resident #1 and incontinent care for Resident #1 was complete, which took more than two hours, it was determined that there was suspected abuse the Administrator notified police and Adult Protective Services and submitted initial allegation report to State Survey Agency at 11:30am. On 3/30/2023, the Administrator and Director of Nursing interviewed resident #2 regarding alleged abuse. Resident stated he was attempting to change resident #1□s brief. Immediately following incident, resident #2 was transferred to	

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F 609	Continued From page 21 immediately contacted DON via phone at approximately 7:45 AM. An interview was completed with the Director of Nursing on 4/27/23 at 3:15 PM who stated that she learned of the incident from her support nurse (Nurse #3) who called her on the phone 7:30 - 7:50 AM. The DON explained that she was in her vehicle on her way to work and arrived at work around 8:00 AM and met with the Administrator when she arrived. A review of a Complaint Intake and Health Care Investigations Initial Allegation Report dated 3/30/23, revealed the Time the Facility Became Aware of Incident was documented as 11:30 AM. The date reported to Law Enforcement was 3/30/23 and the time was documented as 12:00 PM. The Allegation details read: Staff witnessed Resident #2 masturbating Resident #1 while Resident #1 was lying in bed. An email received from the Administrator dated 4/28/23 revealed that Adult Protective Services was notified at 11:45 AM on 3/30/23. An interview was conducted with the Administrator on 4/26/23 at 12:41 PM who was asked why the initial allegation report dated 3/30/23 indicated the facility learned of the incident at 11:30 AM documented on the report. The Administrator stated, "As the Abuse Coordinator I found out at 11:30 AM."	F 609	room 306B and placed on 1:1 supervision in which he remained until his discharge on 4/4/2023. On 3/30/2023, the Director of Nursing and Administrator interviewed each of the two nurse aides separately to get details of the alleged abuse. During the interviews, each nurse aide also completed a reenactment of the event. On 4/5/2023, the Administrator concluded alleged abuse and based on investigation findings substantiated alleged abuse of resident #1. On 4/6/2023, the Administrator submitted investigation report to State Survey Agency with findings. Corrective action for residents with the potential to be affected by the deficient practice On 5/1/2023, the Administrator and Director of Nursing was educated by the Regional Nurse Consultant on regulatory reporting time of two hours for abuse to state agencies. The Administrator and Director of Nursing was also educated on assigning a backup person for reporting abuse to the state agencies. On 5/1/2023, the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to reporting allegations of abuse per facility policy. The results included: There were no grievances or Resident Council Minutes that included any abuse. Additionally, the Administrator reviewed all investigation reports submitted to State Survey Agencies for the past 30 days to ensure allegations of	

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abuse submitted per facility policy. The findings included: No other residents affected by alleged deficient practice and reports submitted per facility policy.

Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 4/30/2023 the Director of Nursing/Staff Development Coordinator began in-service of all full-time, part-time, and PRN (as needed) staff, administration, housekeeping, dietary, nursing, therapy and maintenance (including agency) on the abuse prohibition/reporting policy. This training will include all current staff including agency. This training included: Abuse Types, reporting abuse allegations immediately to nurse/DON/Administrator, what to do if abuse observed or suspected, assuring resident safety, zero tolerance of retaliation of reporting allegations of abuse, along with notification of local law enforcement, Adult Protective Services, and State Survey Agency. Staff were also asked if they were aware of any abuse occurring to any resident in the facility and what to do if observed or suspected. No staff were aware of any other abuse occurring in facility. The Director of Nursing will ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 5/1/2023 will not be allowed to work until the training is completed. This training will be included in new hire orientation for any newly hired staff. The new process to be put in place for reporting alleged violations

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to the state agencies is that the Administrator will report abuse with-in two hours of the incident occurring. If the Administrator is not available to report violations to state agencies, the Director or Nursing will be the backup to the Administrator for reporting violations to the state agencies. If the Director of Nursing is not available to report violations to the state agencies, the Staff Development Coordinator will be the backup to the Director of Nursing for reporting violations to the state agencies.

Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Beginning the week of 5/8/2023, the Administrator or designee will monitor the abuse process to ensure residents are free from abuse and any abuse identified reported and addressed according to facility policy using the QA Tool for Recognizing and Reporting Abuse. The Administrator or designee will interview 5 staff members to monitor if staff know the procedure for reporting alleged abuse and when and who to report to. Also, the Regional Nurse Consultant will review allegation reports submitted to State Survey Agencies to ensure reports are submitted per the regulatory requirement, which is within two hours of the incident occurring. The monitoring will be completed weekly for 4 weeks and then monthly for 2 months or until resolved.

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LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 24	F 609	Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Therapy Director, Health Information Manager, and the Dietary Manager. Date of Compliance: 5/2/2023	