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F 000	INITIAL COMMENTS A complaint survey was conducted on 06/20/23 through 06/28/23. The facility was notified on 07/12/23 of additional Immediate Jeopardy identified after management quality review. Therefore, the exit date was changed to 07/12/23. The following intakes were investigated: NC00198878, NC00199134, NC00200667, NC00200744, NC00200929, NC00201337, NC00201966, NC00202380, NC00203068, NC00203167, NC00203752. Intake NC00203167 and NC00203752 resulted in immediate jeopardy. 3 of the 20 complaint investigations resulted in a deficiency, F600 and F607. Immediate jeopardy was identified at: CFR 483.10 at F580 at scope and severity of J. CFR 483.12 at F600 at scope and severity J. CFR 483.12 at F607 at scope and severity of J. Tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/16/23 and was removed on 06/23/23. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		8/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/03/2023

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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physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff and Physician interviews the facility failed to notify the Medical Director when a resident (Resident #9) experienced an acute change in condition on 06/13/23 as described by Nurse Aide (NA) #3 as restless, pale in color, struggling to breathe, and a change in urinary continence and as described by NA #4 as restless and up and down all night for 1 of 1 resident reviewed for notification of change. A few hours later Resident #9 was found slumped over in his wheelchair in cardiac arrest. Resident #9 expired in the facility on 06/13/23.

Immediate jeopardy began on 06/13/23 when Resident #9 experienced an acute change in condition and Nurse #2 failed to notify the physician. Immediate jeopardy was removed on 06/23/23 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D (no actual harm with more than minimal harm that is not immediate jeopardy) to ensuring monitoring systems are in place and the completion of staff education.

The finding included:

Resident #9 was readmitted to the facility on 04/05/23 with diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, atrial fibrillation and heart failure.

The quarterly Minimum Data Set (MDS)

F 580

F580 Notify of Changes

1. Resident #9 no longer resides at this facility.

2. Current residents with acute changes in condition have the potential to be affected by this deficient practice.

3. DON and ADON have completed education for all licensed staff including full-time, part-time, PRN and agency staff on the importance of notifying the resident□s physician when the resident presents a change in condition, including when a resident presents different than known baseline, lethargic, restless or short of breath. Education was also provided on the use of the on-call MD system for after hours and on weekends. DON or designee will review the 24 hour report during clinical meetings to identify residents who may have had a change in condition. Licensed staff that have not received the education will be required to have education prior to the next shift worked. Newly hired licensed staff will receive education in orientation.

4. DON or designee will audit 5 resident records 5 times per week for 4 weeks, then 5 resident records for 3 times per week for 4 weeks, then 5 resident records 2 times per week for 4 weeks to look for signs of change of condition and ensure

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F 580	Continued From page 3 assessment dated 04/10/23 revealed Resident #9 was cognitively intact. A review of Resident #9's medical record revealed the following medication and treatment orders: *04/06/23 Ventolin HFA (Albuterol) Inhalation Aerosol Solution 108 micrograms (mcg) (90 Base) 2 puffs inhale orally four times a day for wheezing/dyspnea, give with spacer. A review of Resident #9's progress note dated 06/13/23 at 5:07 AM revealed, Resident #9 was up and down from his bed to his wheelchair and vice versa most of the night. He was constantly complaining of pain to bilateral lower extremities but would not take any physician ordered pain meds. His bilateral lower extremities were draining serous sanguineous, both blood and the liquid part of blood (serum), fluid in moderate amounts. Resident #9 had previously cut off his Unna boots (medicated dressings/wraps applied to his legs used to control swelling) and refused to allow staff to replace them. He was non-compliant with all meds and care. Would not allow staff to assist with any care at this time. Will continue to offer pain med and or treatment to bilateral lower extremities. The note was written by Nurse #2. A review of Resident #9's progress note dated 06/13/23 at 5:59 AM revealed, Ventolin HFA Inhalation Aerosol Solution 108 mcg (90 Base) 2 puffs inhale orally four times a day for Wheezing/Dyspnea give with spacer inhaler. Refused med. The note was written by Nurse #2. A review of Resident #9's Medication Administration Record for 06/2023 indicated	F 580	changes are reported to the physician and any orders if needed are put in place. 5. The Director of Nursing will bring these audits to the Quality Assurance Committee meeting monthly for three consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. 6. Date of completion August 3, 2023.	

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Resident #9 refused his Ventolin Inhaler on 06/13/23 for 6:00 AM.

A review of Resident #9's progress note dated 06/13/23 at 6:40 AM revealed, the nurse was called to room via staff, and upon arrival Resident #9 was noted to be slumped over in his wheelchair, non-responsive to verbal stimuli, blue in color with no respirations. Resident #9 was placed on floor and Cardiopulmonary Resuscitation (CPR)was initiated. 911 was called. CPR continued until 911 arrived. Pronounced deceased at 7:00 AM. MD was notified. The note was written by Nurse #2.

On 06/20/23 at 9:10 PM during an interview with Nurse #2 the Nurse confirmed that she took care of Resident #9 about 3 nights a week and on the night of 06/12/23 until the morning of 06/13/23. The Nurse reported the Resident was alert and oriented and was non-compliant with his medications mainly his heart medications and the medicated dressing to his legs. She explained that his legs were edematous and had draining sores and he would cut the medicated dressings off after the nurses applied them. The Nurse explained that Resident #9 acted no different that night of 06/12/23 to 06/13/23 as he did on any other night, she had taken care of him. She stated he was restless in that he was up and down from his bed to the chair and at one time they found him lying in the floor but that was not anything unusual about him either because he would often put himself on the floor. She stated the Resident complained of pain in his legs but refused to take pain medication for the pain. Nurse #2 continued to explain that around 4:00 AM she found the Resident using the telephone on the wall in the hall saying he wanted to call

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911. She stated she took the phone from him and off the wall because he called 911 all the time and that was no change in his behavior. The Nurse reported if she thought he warranted being sent to the hospital she would have called 911 herself. Nurse explained that she last spoke with Resident #9 between 6:00 AM to 6:20 AM when he was sitting in his wheelchair in the hallway, and she gave him his Ventolin inhaler which was due at 6:00 AM. Nurse #2 continued to explain that during shift change she was giving report to the oncoming nurse when nurse aides yelled for the nurses to come down to Resident #9's room where they found him sitting in his wheelchair at the foot of his roommate's bed. He was slumped over and nonresponsive. The Nurse continued to explain that she and the Nurse Educator initiated CPR with the Nurse Educator starting the chest compressions first. Nurse #2 stated someone had called 911 and when the EMS arrived, the Nurse Educator had already stopped CPR due to Resident #9 not responding to the CPR. The Nurse again confirmed that she had not called the on-call provider services or the physician regarding a change in condition for Resident #9 because she did not think he had experienced any change in condition. The Nurse stated if she thought Resident #9 experienced a change in condition, she would have called EMS herself.

Resident #9 expired in the facility on 06/13/23.

An interview was conducted with NA #4 on 06/21/23 at 4:25 PM. The NA stated he routinely worked with Resident #9 about 2-3 nights a week and had taken care of the Resident the Saturday and Sunday night prior to the morning of Monday 06/13/23. The NA explained that Resident #9 was not his usual self throughout the shift in that he

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F 580	Continued From page 6 was restless, he was going from his chair then back to his bed like he was restless. He continued to explain that earlier in the night he found Resident #9 lying on the floor and went to get Nurse #2 and NA #3 to help him get the Resident out of the floor and back into his chair where he always stayed. He reported he had never known of the Resident to lie in the floor before. The NA explained that the Nurse asked the Resident if he was in pain and the Resident denied being in pain and wanted to stay in the floor where he said was more comfortable for him. After some encouragement the Resident agreed to get into his wheelchair. The NA stated he and NA #3 left the room to continue their rounds. Then later in the night Resident #9 turned his call light on and when the NA answered it the Resident wanted him to call an ambulance for him but did not say why he wanted the ambulance. The NA stated Resident #9 had never asked him to call an ambulance before that night and he went and got Nurse #2 for the Resident before the NA left the room to continue his rounds. The NA stated that he did not know what transpired between Resident #9 and Nurse #2 after he left the room, but the NA knew the Nurse did not call an ambulance for Resident #9 before he left off shift because the Resident was still at the facility. The NA continued to explain that after he got home that morning someone from the facility called and asked him if Resident #9 had asked him to call an ambulance and he told the person that he did, and the NA reported to Nurse #2 that the Resident wanted an ambulance called but did not say why. The NA stated he had never known of Resident #9 requesting an ambulance or calling for an ambulance himself nor did he observe the Resident trying to use the hall phone to call an	F 580		

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F 580	Continued From page 7 ambulance himself. During an interview with NA #3 on 06/21/23 at 4:59 PM the NA reported that she was one of the two NAs that took care of Resident #9 on a routine basis but the night of 06/12/23 to 06/13/23 NA #4 was the Resident's aide and he helped with his care. NA #3 explained that earlier in the night NA #4 found him lying on the floor and came and got her and Nurse #2 to get Resident #9 up out of the floor. The Resident stated he wanted to stay in the floor, but they put him back into his chair and NA #3 left the room to continue her rounds. NA #3 continued to explain that around 4:30 AM she noticed Resident #9 trying to call 911 using the phone on the wall in the hallway. When the NA asked him what he was doing the Resident told her that he was having trouble breathing and wanted to go to the hospital. The NA stated Resident #9 seemed to be struggling to breathe and was pale, so she immediately went to Nurse #2 who was at the nurses' desk and told her that Resident #9 was trying to call 911 using the hall phone and he stated he was having trouble breathing and was pale. The NA stated the Nurse asked her why she didn't just take the phone from Resident #9 and the NA told the Nurse because he didn't look right and wanted to go to the hospital. The NA reported Nurse #2 went to Resident #9 who was still trying to call 911 from the hall phone and took the phone from the Resident and told him that he was asking to go to the hospital but he won't take his medications here so what was the hospital going to do for him then proceeded to remove the phone from the wall. Resident #9 sat back down in his wheelchair still looking pale and struggling to breath. NA #3 stated Nurse #2 walked back to the nurses' desk and did not come back to the	F 580		

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hall until she started her med pass around 5:45 AM to 6:00 AM. The NA stated she knew Resident #9 was not his usual self that night because he would normally do what he wanted to like go smoke when he wanted then to go to his room, and he was normally continent but that night he was incontinent and had to be changed. The NA stated she was certain she reported his change in behavior to Nurse #2 because she and NA #4 discussed how Resident #9 was acting different that night.

During an interview with the Director of Nursing (DON) on 06/21/23 at 1:15 PM the DON explained that after the morning meeting on 06/13/23 NA #5 informed her that third shift NA #3 reported that Resident #9 had fallen during the shift and had tried to call 911 himself by using the phone in the hall but Nurse #2 took the phone from him and did not assess him for a change in condition. She continued to explain that they found the Resident slumped over in his wheelchair and CPR was initiated but the Resident expired. The DON stated that based on the information she was given and the fact that there was no incident report about Resident #9's fall she reported the situation to the Administrator and an investigation was started because they felt Nurse #2 should have assessed the Resident's change in condition and notified the Medical Director for further orders.

On 06/21/23 at 10:45 AM during an interview with the Administrator he reported that when he learned of the situation with Resident #9 on the morning of 06/13/23 he immediately started an investigation of the situation and found that the Resident was complaining of pain and had even requested to go to the emergency room and tried

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to call 911 himself until Nurse #2 took the phone from him and from the wall so that he couldn't call 911 himself. The Nurse should have assessed the Resident and called the Medical Director and the Nurse on Duty to report the Resident's change in condition, but she didn't and ultimately Resident #9 coded and expired. The Administrator stated he felt the Nurse was negligent in not assessing the Resident's change in condition and notifying the physician to obtain further guidance in the situation.

An interview conducted with the resident's Physician on 06/20/23 at 2:20 PM revealed he was not surprised when he was notified that Resident #9 had expired because of his history of refusing his medications and treatments that were necessary to prevent swelling and fluid overload which were related to his significant heart failure. While reviewing Resident #9's death certificate the MD explained that the Resident went into biventricular dysrhythmia (arrhythmias that cause the heart to beat too fast, which prevents oxygen rich blood from circulating to the brain and body and may result in cardiac arrest) heart failure related to his coronary heart disease. He continued to explain that Resident #9's heart was beating so fast that even if he was in the emergency room there was a slight chance of survival but regardless, the MD indicated a medical provider should have been notified of Resident #9's change in condition status so that he could be evaluated and treated accordingly.

On 06/22/23 at 2:30 PM the Administrator was notified of Immediate Jeopardy at F 580.

The facility provided a Credible Allegation of Immediate Jeopardy Removal on 06/23/23.

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On 6/13/23 at approximately 4:30 am Nurse Aide #3 identified Resident #9 as restless, pale in color, struggling to breathe, and a change in urinary continence. Nurse Aide #4 described Resident #9 as being restless and up and down all night long requesting to go to the hospital. There was no notification made to the MD regarding the change in condition for Resident #9. At approximately 6:40 am CNA #5 and CNA #6 started their round and discovered resident to be slumped over in wheelchair. At that time, they called for help. The Nurse Practice Educator responded. Upon assessment the Nurse Practice Educator determined resident was not breathing and did not have a pulse. Resident was placed on the floor by the Nurse Practice Educator, CNA #5, and CNA #6. Chest compressions were started by the Nurse Practice Educator after confirming resident was a full code. Resident #9 expired in the facility.

On 6/22/23 the Nurse managers reviewed residents who have change of condition during the last 30 days using the 24-hour report. The 24-hour report was reviewed for indicators of a change such as not at baseline, not normal for resident, lethargic, shortness of breath, new onset pain, etc. Any opportunities identified during this audit will be corrected by the Nurse Managers by 6/22/23.

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:

The Director of Nursing and Assistant Director of Nursing educated Licensed Nurses regarding the

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requirements for notification of the Physician following a change of condition. The Director of Nursing and Assistant Director of Nursing educated Nursing Assistants on identifying a change in resident condition and reporting to the Licensed Nurse immediately. Verbal education was given on a change of condition is noting when a resident presents different than known baseline, lethargic, restless or short of breath. Furthermore, education was provided on how to use the on-call MD system after hours and on weekends. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. It will be the responsibility of the Director of Nursing to ensure this is completed. Education will be completed by 6/22/22.

Effective 6/22/2023 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/23/2023

On 06/28/23 the facility's Credible Allegation for removal of Immediate Jeopardy on 06/23/23 was validated by verifying the nurse managers reviewed the 24-hour report sheets to identify residents that had any change in condition within the last 30 days and followed up on the changes by 06/22/23. The nurse managers also educated the licensed nurses on the requirements for notifying the providers in the changes in conditions. Nurse aides were educated on identifying a resident's change in condition to be anything different from the resident's baseline and should be reported immediately to the licensed

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F 580	Continued From page 12 nurse. The Director of Nursing will be responsible to ensure no staff, facility or agency will work before being educated on the new procedure. The facility's removal date of 06/23/23 was validated.	F 580		
F 600 SS=K	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, resident, staff, and Psychiatric Nurse Practitioner interviews the facility failed to protect a resident's right to be free from abuse or mistreatment when Resident #11's arms were pinned between Nurse Aide (NA) #10 and the resident during incontinence care when Resident #11 became combative. On 02/16/23 during incontinence care Resident #11 became combative with staff and attempted to pinch, scratch, and bite the staff. When Resident #11 was turned on her side facing NA #10, NA #10 pinned Resident #11's arms and hands between the NA and Resident to	F 600	F600 Free from Abuse and Neglect 1. Resident #11 and Resident #1 continue to reside in the facility, Resident #2 no longer resides at the facility. Resident #1 and Resident #11 have not presented with any signs of mental anguish or psychosocial harm related to the reportable incidents. Resident #9 no longer resides at the facility. 2. Current residents that encounter a resident to resident incident have the	8/3/23

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prevent Resident #11 from pinching and scratching the staff and so they could finish the incontinence care. Resident #11 was noted to have bruises to bilateral hands and lower arms. This was for 1 of 1 resident reviewed for resident to staff abuse. The facility also failed to protect a female resident (Resident #1) from sexual abuse from a male resident (Resident #2) on 03/19/23 when Resident #2 entered Resident #1's room and touched her breast and vaginal area (outside of her clothes). NA #1 asked Resident #2 to stop touching Resident #1 and then left Resident #1 alone and unsupervised with Resident #2 while she went to report the sexual abuse to Nurse #1. Nurse #1 failed to notify the Administrator of the sexual abuse. Then on 03/20/23 Resident #2 again entered Resident #1's room and tried to touch and kiss her. Resident #1 did not want Resident #2 touching or kissing her. This affected 1 of 3 residents reviewed for resident-to-resident abuse. The facility further failed to prevent a resident (Resident #9) from being neglected on 06/13/23 when he experienced an acute change in condition. NA #3 described the change in condition as restless, pale in color, struggling to breathe, and a change in urinary continence. NA #4 described the change as restless and up and down all night. Resident #9 requested and attempted to call Emergency Medical Services (EMS) and Nurse #2 removed the phone from Resident #9 and took it off the wall. Nurse #2 neglected to call or seek medical assistance for 1 of 1 resident reviewed for neglect (Resident #9). Resident #9 was found slumped over in his wheelchair in cardiac arrest. Resident #9 expired in the facility on 06/13/23.

Immediate jeopardy began on 02/16/23 when Resident #11's arms were pinned down by NA

F 600

potential to be affected by unreported altercations and unreported allegations of abuse. Current residents with acute changes in condition have the potential to be affected by this deficient practice.

3. DON and ADON have completed education for staff members on abuse, including the various types of abuse (verbal, physical, mental, sexual, neglect, involuntary seclusion, exploitation, misappropriation, resident to resident and mistreatment). Education was also provided on changes of behavior/mood that can indicate abuse and that residents presenting with these behaviors/mood changes should be monitored and the change reported to their supervisor. Staff that have not received the education will be required to have education prior to the next shift worked. Newly hired staff will receive the preceding education during orientation.

4. DON or designee will conduct skin checks on residents with BIMS 11 and lower on 5 residents 5 times per week for 4 weeks , then 5 residents 3 times per week for 4 weeks, then 5 residents 2 times per week for 4 weeks to look for signs of abuse. Administrator or designee will conduct interviews with residents with a BIMS 12 and higher on 5 residents 5 times per week for 4 weeks, then 5 residents 3 times per week, then 5 residents 2 times per week to ask residents if they have experienced abuse or neglect. Allegations of abuse or

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F 600	Continued From page 14 #10 during incontinent care. Immediate jeopardy was removed on 06/23/23 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity E (no actual harm with more than minimal harm that is not immediate jeopardy to ensuring monitoring systems are in place and the completion of staff education. The findings included: 1. Resident #11 was admitted to the facility on 11/21/22 with diagnoses that included cerebral vascular accident, diabetes mellitus and dementia. A review of Resident #11's care plan initiated 12/07/22 revealed the Resident required assistance with her activities of daily living (ADL) related to left hemiparesis and mood symptoms. The goal indicated her needs would be anticipated and met through encouraging her to participate in the activity to her fullest capacity, provide the amount of assistance required to complete the task and promptly answering call light. Further review of the Resident's care plan dated 12/07/22 revealed Resident #11 exhibited verbal/manipulative behaviors by making false accusations about staff, continuously ringing call light for attention and conversation, periods of refusing care and being combative with staff, behaviors of pinching her arms causing abrasions and skin tears and will call staff names and hit staff while providing care. The goal that the Resident will seek care giver support when feeling frustrated would be attained by encouraging her to be changed and if refused report to nurse and return to provide care later,	F 600	neglect will be investigated immediately. 5. Administrator will bring the audit results to the Quality Assurance Committee meeting monthly for three consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. 6. Date of completion August 3, 2023.	

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explain the procedure for care task before starting and allowing the Resident to express her feelings.

A review of Resident #11's skin assessment dated 02/04/23 revealed there were no skin issues documented.

The quarterly Minimum Data Set (MDS) assessment dated 02/16/23 indicated that Resident #11 was severely cognitively impaired and had no behaviors during the assessment reference period.

Review of the Initial Allegation Report for resident abuse dated 02/16/23 revealed the Administrator was notified during the morning meeting that Resident #11 had new discolorations to her right and left arms. Nurse Aide (NA) #9 was listed as the accused individual. The report was signed by the Administrator.

A review of the Investigation Report for resident abuse dated 02/20/23 revealed the accused individual was NA #9 with NA #10 and NA #11 witnessing the incident. The report summary read the Administrator interviewed staff and statements indicated that 3 staff members, NA #9, NA #10 and NA #11, were attending to Resident #11 while the Resident was attempting to hit, bite and scratch the staff while they were attempting to change her. NA #9 indicated that she did not hold the Resident's hands or arms during her interaction with the Resident. NA #10 indicated that she did hold the Resident's hands together so that the staff could finish changing the Resident without being injured. All the staff's statements were consistent indicating that Resident #11 was being combative with staff and

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swinging her bed remote. The incident resulted in physical injury of discolorations to the Resident's left and right forearms. The incident was substantiated. The summary of the investigation found that staff did hold down the Resident's arms to keep her from hitting and scratching them.

During an observation and interview with Resident #11 on 06/20/23 at 10:10 AM the Resident was alert and talkative while lying in bed, well-groomed and without body odors. The Resident held the bed remote in her right hand which was resting next to her on the bed as was the call light and her cell phone. Resident #11 explained that she vaguely remembered the incident when two girls, she could not remember who they were, held her hands down and caused bruises on her hands but could not remember when it was or any details about it. She stated she thought it was just a big misunderstanding. There were no bruises or skin tears noted on the Resident's arms or hands.

During an interview with NA #9 on 06/20/23 at 9:40 PM the NA explained that during that night in question she was asked to assist NA #11 with Resident #11 because the Resident can be combative so they must have 2 staff members to go into the Resident's room to render care. The NA stated Resident #11 "was soiled from top to bottom and desperately needed to be changed" and she agreed to let them change her. When NA #11 started to pull her covers down Resident #11 picked up her bed remote and hit NA #11 on her hand which made a "loud thud." She stated they stopped and called Nurse #7 into the Resident's room and the Nurse tried to talk her into letting the NAs change her, but the Resident still refused

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F 600	Continued From page 17 care. They ended up not being able to provide care. The NA stated, later the Resident reported that staff hit her, even though the Resident #11 already had bruising on her left hand that was verified by Nurse #7. An interview was conducted with NA #10 on 06/20/23 at 7:52 PM revealed the NA assisted NA #11 who was assigned to Resident 11 during the night of 02/15/23 to 02/16/23, when the Resident refused to be changed for hours and was soaked and soiled with urine and stool. NA #10 stated that by the time Resident #11 allowed them to change her she required a full bed change along with her soiled brief and gown. The NA explained that when they were halfway finished with the task Resident #11 started pinching, scratching, and attempting to bite them. When they rolled Resident #11 onto her side facing NA #10, NA #10 indicated that she had to pin Resident #11's arms between their (Resident #11 and NA #10) bodies so they could finish care and prevent her from scratching. The NA was insistent that she did not touch the Resident's hands that if the Resident was bruised then the bruising was present before they went into her room to provide care. The NA stated that she positioned Resident #11 the way that she had been taught by the Nurse Educator when the staff had to care for combative residents. On 06/22/23 at 8:15 AM during an interview with NA #11 the NA explained that she was assigned to Resident #11 on 02/15/23 and that they attempted to change Resident #11 multiple times during the 12-hour shift, and multiple times she refused. She stated by the early morning you could literally smell the strong urine and bowel movement odor in the hallway and when she did	F 600		

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allow them to change her the Resident required a brief change complete with her gown and bed sheets. NA #11 reported that Nurse #7 came into the Resident's room and asked the Resident not to pick at a sore on her hand because she had it bleeding but the Resident continued to pick at the sore. NA #11 explained NA #10 assisted her with the Resident's incontinence care and halfway through the process the Resident began to scratch, pinch and attempted to bite them while swinging the bed remote at them. She continued to explain when they turned the Resident towards NA #10 the NA had to lay the Resident's arms down and lean over her to prevent the Resident from scratching them and to finish changing her, but NA #10 never held the Resident's hands down. The NA stated she did not notice any bruising on Resident #11's hands or arms because if she had, she would have reported it.

An interview was conducted with Nurse #7 on 06/20/23 at 8:40 PM who explained that she worked with Resident #11 often during the evening shifts and was on duty on 02/15/23 to the morning of 02/16/23. The Nurse reported that Resident #11 already had bruises to her arms and hands before that evening shift because the Resident had pulled a band aid off her left arm earlier in the shift and was picking at the skin tear and had it bleeding with blood on her bed and I asked her several times that night not to pick at the skin tear that she was making it worse, but she continued to pick at the skin tear. She stated the Resident had bruise's on her arms as well, but she did not report the bruising, nor did she document the bruising because she always had bruising. That night Resident #11 had refused to be changed multiple times but at one point she agreed to be changed so all three NAs went in

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there to change her because they did not allow one aide to provide care for Resident #11 because of her behaviors.

During an interview with Nurse #6 on 06/20/23 at 8:56 PM the Nurse confirmed she was on duty the night of 02/15/23 to 02/16/23 and assisted Nurse #7 in attending to Resident #11. Nurse #6 stated she did not remember or know about any bruising on Resident #11, but she knew that Nurse #7 had walked in on the Resident picking at a sore on her arm and had it bleeding. The Nurse reported that Resident #11 had refused care multiple times even after calling out for it several times that night. She stated she had instructed the NAs not to go into the Resident's room by themselves to provide care because of Resident #11's combative behaviors and false accusations toward the staff and she felt that was best for everyone's protection. Nurse #6 stated that she was not aware of any accusations made by Resident #11 against any of the NAs that worked that night until she came back on duty and learned that NA #10 was suspended because she crossed the Resident's arms in order to roll her over to provide care and NA #9 and Nurse #7 were in the room at the time.

An interview was conducted with the Unit Manager (UM) on 06/20/23 at 1:50 PM who explained that she did not know any details about an incident with Resident #11 and NAs #9, #10 and #11 on the night of 02/15/23 to 02/16/23 except that she was asked by the Administrator on 02/16/23 to complete a skin assessment on Resident #11 that showed bruising on one of her hands, but she couldn't remember which hand. The UM stated Resident #11 told her that they held her hands down to change her but did not

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explain who they were.

During an interview with NA #7 on 06/20/23 at 2:25 PM the NA explained that on the morning of 02/16/23 she overheard some aides talking about how Resident #11 had hit NA #9 with her bed remote and they took it from her. She stated when she went to see the Resident right after she overheard the conversation, the Resident had bruising on both hands, near her elbow and a skin tear which had steri strips on her hand that had dried blood on it that looked like it had already been tended to it. The NA stated the bruising was not there the Tuesday prior because she dried her hair, and it wasn't there.

On 06/20/23 at 8:00PM during an interview with the Activity Assistant she explained that she visited Resident #11 on the morning of 02/16/23 and noticed the bruising and skin tears on the Resident's arms and hands. She stated the Resident told her that they held her hands down when they were changing her last night. The Activity Assistant continued to explain that she asked the NA (don't remember who it was) on the hall what happened, the NA told her that Resident #11 was trying to hit and bite the NAs on the night shift while they were changing her and they had to hold her hands down, with their hands flat on top of her hands to prevent the Resident from being combative while they changed her.

An interview was conducted with the Nurse Educator on 06/20/23 at 9:00 PM who explained that she only educated the staff after the events that occurred, and she had educated the staff not to provide care for Resident #11 alone, always have at least 2 staff when providing her care because of the Resident's potential to be

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combative.

During an interview with the former Director of Nursing (DON) on 06/22/23 at 2:55 PM the DON reported he was the acting DON from January through most of February 2023. The DON explained that he remembered Resident #11 in that she frequently accused the staff of being abusive to her and they were afraid to go into her room to provide care for her, so I had them go in with at least 2 people and to document the care provided. The Resident liked to use her call light and bed remote as a "lasso" and swing at them, threatening to hit them.

An interview was conducted with the Administrator on 06/21/23 at 10:45 AM who explained that the staff (he could not remember who) informed him in the morning meeting on 02/16/23 that Resident #11 had bruise's on her arms and to his knowledge there had been no reports of bruising reported on the Resident before that day. The Administrator stated the Nurse Educator informed him that she had taught the staff to cross the residents' arms in front of them in order to make turning and repositioning easier for the residents but not intending to hurt them. The Administrator continued to explain that he interviewed Resident #11 on 02/16/23 and did not see any bruising nor did he document it in his statement that he did or did not observe any bruising. He stated the Resident reported to him that a large aide, NA #9 held her hands down during care which caused the bruising on her hands and NA #11 was present at the time. He reported that they collected written statements from the NAs involved which were NA #9 who denied holding the Resident's hands down, NA #10 who admitted to holding the Resident's hands

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down and NA #11 who denied holding the Resident's hands down.

The Administrator was notified of the immediate jeopardy on 07/12/23 at 4:49 PM.

The facility provide the following IJ removal plan:

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

At approximately 9:00 am on 2/16/2023 the Administrator was notified that Resident #11 had new discolorations to her right and left arms. The Administrator and Infection Preventionist entered the room to interview Resident #11 to gather information on the new discolorations to her arms. Resident #11 stated that a large black woman held her down last night causing the discolorations. The Administrator asked what led up to the event, Resident #11 stated she could not recall. The Administrator asked when the event occurred, Resident #11 stated last night. The Administrator asked Resident #11 to describe the event, Resident #11 stated "it happened during the time the nursing aides attempted to change me" and the nurse aide put her hands together. Resident #11 then stated it was a large nurse aide who held her down. Facility staff interviewed the staff working the hall from the previous night shift, interviews indicate that Resident #11 was combative with staff who attempted to change her clothing and bedding that were soiled. The Administrator collected written statements from the NAs that were involved in the allegation. NA #11 was present during the care and denied holding the residents' hands down. NA #9 denied holding the residents'

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hands down while providing care. NA #10 stated the resident was combative while providing care and she held the residents' hands together to avoid being injured.

On 3/19/23 Nurse Aide #1 entered Resident #1 room and witnessed Resident #2 touching Resident #1 breast and vagina through her clothing. Nurse Aide #1 asked Resident #2 to stop touching Resident #1 and he did immediately. Nurse Aide #1 went and reported to Nurse #1. Resident #1 reported that Resident #2 entered Resident #1's room again on 3/20/23 and tried to touch and kiss her. Resident #1 was sent to the Emergency Department on 3/21/23 for evaluation and returned to the facility. Resident #1 was seen and will continue to be seen by psych services.
Resident #2 no longer resides in the facility. All residents have the potential to be involved in resident-to-resident abuse but residents with cognitive impairment, dependent transfer statuses and such are more vulnerable to such situations.

On 6/21/23 the Social Worker and Administrator conducted interviews with alert and oriented residents having a BIMs of 12 or greater to ensure there were no other reportable incidents. On 6/21/23 the Director of Nursing, Assistant Director of Nursing and Unit Manager completed skin assessments on residents that are not alert and oriented. There were no concerns identified.

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:

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F 600	Continued From page 24 Initial education was completed on 3/22/23 with staff regarding identifying abuse. On 6/21/23 the Director of Nursing and Assistant Director of Nursing educated current staff in all departments on Abuse. Education included verbal abuse, sexual abuse, physical abuse, mental abuse, neglect, involuntary seclusion, exploitation, misappropriation of resident property, resident to resident abuse and mistreatment. Staff were educated on identifying any changes in behavior or patterns that may be indicative of resident-to-resident abuse. Staff in all departments were educated that if they identify changes in behavior, they should monitor the resident while reporting the concern to their supervisor and additional monitoring will be put into place. The staff and residents with Bims of 12 and greater were informed by the Director of Nursing, Assistant Director of Nursing or the Regional Nurse Consultant on 6/22/23 in one-to-one verbal communication that abuse of any type would not be tolerated in this facility. For the residents with a BIMs of 11 or less the RP was contacted with the same education. The Director of Nursing and Administrator will ensure that staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. In the event abuse is witnessed the staff member should stay with the resident providing protection from the abuse. Furthermore, staff were educated to remain with the resident when they are alleging abuse on someone present. The Director of Nursing will provide education to newly hired staff, including agency during orientation. Education was given in a verbal and/or written format and the staff were asked to give feedback to confirm understanding of the education.	F 600		

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Education was given in verbal format with written key points to include types of abuse provided.

Effective 6/21/2023, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/23/2023

Validation of the immediate jeopardy removal plan was conducted in the facility on 06/28/23. The interviews with alert and oriented residents were reviewed with no additional concerns noted. The skin assessment of non-alert and oriented residents were reviewed with no additional concerns noted. The initial education from 03/21/23 was reviewed along with the education completed on 06/21/23 along with staff signature sheets to verify completion and understanding of the education. The education included the different types of abuse, how to stop the abuse, how/when to report abuse or suspected abuse, and the importance of immediately notifying the Administrator of any suspected or witnessed abuse. The abuse education was verified to be included in the new hire orientation information for any newly hired staff. Interviews with staff across all departments in the facility revealed they were able to verbalize the abuse policy and procedure. They were able to verbalize the education points of stopping the abuse and immediately protecting the residents and reporting the suspected or witnessed abuse to the facility Administrator. The facility's IJ removal date of 06/23/23 was validated.

2. Resident #1 was admitted to the facility on 01/18/23.

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Review of the significant change Minimum Data Set (MDS) dated 03/13/23 revealed that Resident #1 had clear speech and was able to make her needs known and was able to understand others. Resident #1 was moderately cognitively impaired and required limited to extensive assistance with activities of daily living.

Resident #2 was admitted to the facility on 04/01/21 with diagnoses that included anxiety, major depressive disorder, vascular dementia, and others.

Review of a care plan for Resident #2 initiated on 08/06/21 read Resident #2 tends to exhibit sexually inappropriate behavior towards staff members. The goal read, Resident #2 will verbalize an increased understanding and demonstration of control of sexually inappropriate behaviors. The interventions included: monitor medications for potential contribution to sexually inappropriate behaviors, monitor laboratory test results and report abnormal results to physician, evaluate need for behavioral health consult, when sexually inappropriate behaviors occur, approach Resident #2 in a calm, unhurried manner, reassure as necessary, if Resident #2 becomes combative or resistive postpone care/activity and allow time for him to regain composure, provide privacy as needed, allow time for expression of feelings, divert Resident #2 by giving alternate objects or activities, listen and try to calm resident, and remove Resident #2 from environment.

Review of the quarterly Minimum Data Set (MDS) assessment dated 03/10/23 revealed that Resident #2 was moderately cognitively impaired,

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had no delirium, no behaviors, rejection of care, or wandering during the assessment reference period. Resident #2 required limited to extensive assistance with activities of daily living and used a wheelchair for mobility.

Review of a facility incident report dated 03/21/23 read, Resident #1 reported that Resident #2 came into her room and started holding her hand and kissing her hand, then proceeded to touch her breast on top of her clothing and under her clothing, then tried to touch her vaginal area. Resident #1 stated that she asked Resident #2 to stop, and he did. Resident #1 was not sure of the exact date and time the incident occurred. Resident #1 was assessed for injuries, and none were noted. An investigation was initiated. Resident #2 was placed on one-on-one supervision. Resident #1 was sent to the Emergency Department (ED) for evaluation. The report was completed by the Director of Nursing (DON).

Resident #2 was discharged home from the facility on 03/29/23.

Review of the facility's schedule for 03/19/23 revealed that Nurse Aide (NA) #1 was caring for Resident #1 and Nurse #1 was on the unit where Resident #1 resided.

An observation and interview were conducted with Resident #1 on 06/20/23 at 10:23 AM. Resident #1 was resting in bed and was well groomed. She stated that she recalled the incident with Resident #2. She stated she did not know the date or time but stated she was in her room but could not recall if she was in bed or in her wheelchair and Resident #2 came in her

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room and "touched me on my breast and tried to touch my vagina but I pushed his hand away." She explained that he touched her on top of her clothes, but she did not like to talk about it and stated she tried to block it from her memory because she did not like to think about what had happened to her. Resident #1 explained her spouse had recently passed away and she did not want another man touching her. She added that Resident #2 had never made an inappropriate gesture or passes toward her before but again she did not wish to talk about the incident anymore.

Nurse Aide (NA) #1 was interviewed via phone on 06/20/23 at 2:33 PM who confirmed that she was caring for Resident #1 on 03/19/23. She stated that evening Resident #1 was in her wheelchair in her room and Resident #2 who had been outside smoking entered Resident #1's room in his wheelchair. NA #1 stated that when she entered Resident #1's room, they were both in their wheelchair's facing each other and Resident #1 stated to her, "please tell him to remove his hand from my twat", NA #1 stated that Resident #2's hand was on top of Resident #1's clothes in her vaginal area. NA #1 stated she very sternly asked Resident #2 to stop touching Resident #1 and he did. NA #1 stated that she then left the room with Resident #1 and Resident #2 still in their wheelchairs alone facing each other to go and alert Nurse #1 of what had occurred. As NA #1 was returning to Resident #1's room she passed Resident #2 in the hallway in his wheelchair returning to his room on the same unit. NA #1 stated that both Resident #1 and Resident #2 were alert and oriented and aware of what was going on, and Resident #1 was very clear that she did not want Resident #2 touching her, she

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further explained Resident #1 was not sad or tearful but appeared like her usual self. NA #1 stated that at the end of her shift she had reported what had occurred to NA #7 and followed up with Nurse #1 about if she had documented what had occurred. NA #1 stated that Nurse #1 stated she had not documented anything regarding the incident because she felt it was consensual. NA #1 stated that she did not think anything about leaving Resident #1 and Resident #2 in the room together while she went to report to Nurse #1 because "he instantly removed his hand from her when I asked him to." She added that she assumed Nurse #1 had taken care of what she needed to regarding the incident.

Attempts to speak to Nurse #1 were made on 06/20/23 at 11:12 AM and were unsuccessful.

A statement provided by Nurse #1 dated 03/22/23 at 5:00 AM read on Sunday night 03/19/23 during medication pass, staff reported to this writer of witnessing Resident #2 in Resident #1's room and had his hand in Resident #1's brief while both residents were sitting in wheelchairs in the room. This Nurse asked Resident #1 about the incident, and she replied, "so this is my p***y, and I can do what I want." Resident #1 used other foul language and reported to this writer that the incident was consensual between the two parties involved.

NA #7 was interviewed via phone on 06/20/23 at 3:20 PM who confirmed that she cared for Resident #1 on 03/20/23 during the day shift. She stated that during report that morning NA #1 had told her about the incident that had occurred between Resident #1 and Resident #2 during the

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night. She reported that Resident #2 touched Resident #1 on the outside of her pants in her vaginal area and touched her breast and that she had reported the incident to Nurse #1. NA #7 stated that Resident #1 did not mention anything to her about the incident with Resident #2 during that shift and was her usual self. NA #7 stated that Resident #2 never had sexual behaviors toward other residents that she was aware of, but he did at times grab staff inappropriately.

NA #5 was interviewed on 06/20/23 at 2:07 PM and confirmed that she was caring for Resident #1 on 03/21/23. She stated that Resident #1 had turned her call light on and requested to get out of bed, she stated that she and NA #6 were going to assist Resident #1 with getting up. During the transfer NA #5 stated that Resident #1 had tears in her eyes and told her that Resident #2 had his hands down Resident #1's pants and had touched her breasts. NA #5 stated she left the room while NA #6 stayed with Resident #1 and went and told Nurse #4 what Resident #1 had reported. NA #5 was certain that Resident #1 was "sad and had tears in her eyes" when she told her what had happened, and it was very clear that Resident #1 did not want Resident #2 touching her. NA #5 stated that after they reported to Nurse #4, she, reported to the DON and Administrator, and they immediately began an investigation. She added that she had not seen Resident #2 touch another resident inappropriately, but he did have a foul mouth and would grab staff inappropriately from time to time. NA #5 stated that Resident #2 stayed in the building for a bit after this incident, but he was on one-to-one supervision until he discharged home.

NA #6 was interviewed on 06/20/23 at 1:04 PM

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who confirmed that she was caring for Resident #1 on 03/21/23 during the day shift. She stated that Resident #1 had requested to get out of bed and she and NA #5 were assisting with the transfer. During the transfer Resident #1 stated that Resident #2 had touched her in places that he should not be touching her and Resident #1 was very clear she did not want Resident #2 touching her at all. NA #6 stated that Resident #1 stated that Resident #2 had touched her inside her pants and her breast area, and that NA #1 had gotten Resident #1 to stop and reported it to Nurse #1. NA #6 stated that when Resident #1 told her and NA #5 what had happened, they immediately reported it to Nurse #4 who told the DON and Administrator and they began an investigation. NA #6 stated she did not recall Resident #1 being tearful or sad, but she was very clear she did not want Resident #2 touching her. NA #6 stated that Resident #2 stayed in the building for a few weeks and was on one-to-one supervision until he discharged home.

Nurse #4 was interviewed via phone on 06/20/23 at 11:52 AM who confirmed that she was caring for Resident #1 on 03/21/23. She stated she had gotten report that morning from a nurse she could not recall but stated that there was nothing in report about the incident with Resident #1 and Resident #2. She stated that Resident #1 had requested to get out of bed by NA #5 and NA #6 and during the transfer Resident #1 was not acting like her usual self, she was very upset and not joking with them like she normally did. Resident #1 reported that Resident #2 had stuck his hands down her pants and touched her breast and NA #5 and #6 immediately came and reported to Nurse #4. Nurse #4 confirmed that she went and reported to the DON who asked

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that Resident #1 be sent to the ED for evaluation which she was and returned with no new orders. Nurse #4 explained that she had worked at the facility since January 2023 but was not familiar with Resident #2 or his history but the time she had worked with Resident #2 this type of inappropriate behavior was not his normal.

Review of an ED note dated 03/21/23 read in part, patient presents to the emergency room after being referred from the nursing home of potential sexual assault. The patient states that a patient came into the room and touched her on the breast and vagina. There was never any sexual act performed. It is impossible to know how many days ago this was but probably between 3 and 5. Vaginal exam was not performed because we are unsure how many days ago this has been and by history the patient states there was no touching her with his penis or penetration. The ED disposition read, discharge, patient was brought to the emergency room for evaluation of sexual assault. This occurred somewhere between 3 to 5 days ago. It consisted of a man touching her breast and vagina. Patient states that he never touched her with his penis, nor did he have penetration into her vagina. There is no reason this late in to perform a vaginal exam since there was no penetration according to the patient. Even if there had been penetration there were too many days that have past to have an exam be pertinent.

The Social Worker (SW) was interviewed on 06/20/23 at 4:30 PM who stated that she was alerted of the incident between Resident #1 and Resident #2 on 03/21/23 and she had gone down to interview Resident #1. The SW stated that Resident #1 was not tearful she was "almost

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angry and upset." She recounted the events that Resident #2 had come into her room and touched her on her breast and vaginal area and that she did not want him touching her at all. The SW stated that following the interview she had interviewed the other alert and oriented residents on the unit to see if any other incidents had occurred and none were reported, and she continued to check on Resident #1 daily for a while after the event.

The Psychiatric Nurse Practitioner was interviewed on 06/21/23 and confirmed that he had seen and evaluated Resident #2 while he was in the facility. He stated that Resident #2 had vascular dementia along with depression but was alert and oriented and knew what was going on, knew how he was feeling. The Nurse Practitioner stated he became aware of the incident between Resident #1 and Resident #2 and saw Resident #2 who denied the incident had occurred. He further stated that Resident #2 had a history of behaviors including being sexually inappropriate to staff, but to his knowledge this was the only incident that had occurred with another resident while Resident #2 was in the facility.

The DON was interviewed on 06/20/23 at 4:03 PM who stated that on 03/21/23 Nurse #4 had made her and the Administrator aware of the reports from Resident #1 who stated that Resident #2 had touched her inappropriately. She stated that she had gone and done a head-to-toe assessment of Resident #1 and only Resident #1 and then had Nurse #4 send her to the ED for evaluation. The DON stated that Resident #1 stated Resident #2 had touched her breasts on top of her clothes and tried to touch her vaginal area and she stopped him. The event occurred

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on 03/19/23 but was not reported to her until 03/21/23 at which time the investigation was initiated. All staff that were involved were interviewed as well as the residents, Resident #2 was placed on one-to-one supervision until he discharged home a few weeks after the incident. The DON indicated that Resident #2 was alert and oriented and aware of what he was doing. She stated that she had reviewed Nurse #1's statement indicating that the incident was consensual, but she never got that response from Resident #1 and Nurse #1 was ultimately terminated from the facility. The DON stated that NA #1 should not have left Resident #1 and Resident #2 alone together in the room, she should have immediately stopped the abuse and removed Resident #2 from the room then alerted Nurse #1.

The Administrator was interviewed on 06/20/23 at 4:59 PM who stated that he was notified of the incident between Resident #1 and Resident #2 on 03/21/23 and he immediately made sure the residents were separated and began his investigation. He stated Resident #2 was placed on one-on-one supervision and they began interviewing the staff that worked from 03/19/23 through 03/21/23 to find out what had occurred and what was reported. The Administrator confirmed that he had interviewed Resident #1 on 03/21/23 and she reported that Resident #2 came in her and room and touched her on breast and vaginal area and she did not like that. Then Resident #1 reported that on 03/20/23 Resident #2 had again entered her room and tried to touch and kiss on her and she reported feeling "unsafe" in the facility. The Administrator stated he notified local law enforcement and Resident #1 was sent to the ED for evaluation and returned. During the

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conversation the Administrator stated that Resident #1 was very clear this was not consensual, and she did not want Resident #2 touching her. The Administrator stated that once he became aware of the incident, he immediately began his investigation and educated the staff on immediately protecting the resident who had been abused.

The Administrator was notified of the immediate jeopardy on 06/21/23 at 8:41 AM.

The facility provided the following IJ removal plan:

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

At approximately 9:00 am on 2/16/2023 the Administrator was notified that Resident #11 had new discolorations to her right and left arms. The Administrator and Infection Preventionist entered the room to interview Resident #11 to gather information on the new discolorations to her arms. Resident #11 stated that a large black woman held her down last night causing the discolorations. The Administrator asked what led up to the event, Resident #11 stated she could not recall. The Administrator asked when the event occurred, Resident #11 stated last night. The Administrator asked Resident #11 to describe the event, Resident #11 stated "it happened during the time the nursing aides attempted to change me" and the nurse aide put her hands together. Resident #11 then stated it was a large nurse aide who held her down. Facility staff interviewed the staff working the hall from the previous night shift, interviews indicate that Resident #11 was combative with staff who

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attempted to change her clothing and bedding that were soiled. The Administrator collected written statements from the NAs that were involved in the allegation. NA #11 was present during the care and denied holding the residents' hands down. NA #9 denied holding the residents' hands down while providing care. NA #10 stated the resident was combative while providing care and she held the residents' hands together to avoid being injured.

On 3/19/23 Nurse Aide #1 entered Resident #1 room and witnessed Resident #2 touching Resident #1 breast and vagina through her clothing. Nurse Aide #1 asked Resident #2 to stop touching Resident #1 and he did immediately. Nurse Aide #1 went and reported to Nurse #1. Resident #1 reported that Resident #2 entered Resident #1's room again on 3/20/23 and tried to touch and kiss her. Resident #1 was sent to the Emergency Department on 3/21/23 for evaluation and returned to the facility. Resident #1 was seen and will continue to be seen by psych services.

Resident #2 no longer resides in the facility. All residents have the potential to be involved in resident-to-resident abuse but residents with cognitive impairment, dependent transfer statuses and such are more vulnerable to such situations.

On 6/21/23 the Social Worker and Administrator conducted interviews with alert and oriented residents having a Brief Interview for Mental Status (BIMS) of 12 or greater to ensure there were no other reportable incidents. On 6/21/23 the Director of Nursing, Assistant Director of Nursing and Unit Manager completed skin

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F 600	Continued From page 37 assessments on residents that are not alert and oriented. There were no concerns identified. 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: Initial education was completed on 3/22/23 with staff regarding identifying abuse. On 6/21/23 the Director of Nursing and Assistant Director of Nursing educated current staff in all departments on Abuse. Education included verbal abuse, sexual abuse, physical abuse, mental abuse, neglect, involuntary seclusion, exploitation, misappropriation of resident property, resident to resident abuse and mistreatment. Staff were educated on identifying any changes in behavior or patterns that may be indicative of resident-to-resident abuse. Staff in all departments were educated that if they identify changes in behavior, they should monitor the resident while reporting the concern to their supervisor and additional monitoring will be put into place. The staff and residents with Bims of 12 and greater were informed by the Director of Nursing, Assistant Director of Nursing or the Regional Nurse Consultant on 6/22/23 in one-to-one verbal communication that abuse of any type would not be tolerated in this facility. For the residents with a BIMs of 11 or less the RP was contacted with the same education. The Director of Nursing and Administrator will ensure that staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. In the event abuse is witnessed the staff member should stay with the resident providing protection from the abuse. Furthermore, staff were	F 600		

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educated to remain with the resident when they are alleging abuse on someone present. The Director of Nursing will provide education to newly hired staff, including agency during orientation. Education was given in a verbal and/or written format and the staff were asked to give feedback to confirm understanding of the education. Education was given in verbal format with written key points to include types of abuse provided.

Effective 6/21/2023, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/23/2023

Validation of the immediate jeopardy removal plan was conducted in the facility on 06/28/23. The interviews with alert and oriented residents were reviewed with no additional concerns noted. The skin assessment of non-alert and oriented residents were reviewed with no additional concerns noted. The initial education from 03/21/23 was reviewed along with the education completed on 06/21/23 along with staff signature sheets to verify completion and understanding of the education. The education included the different types of abuse, how to stop the abuse, how/when to report abuse or suspected abuse, and the importance of immediately notifying the Administrator of any suspected or witnessed abuse. The abuse education was verified to be included in the new hire orientation information for any newly hired staff. Interviews with staff across all departments in the facility revealed they were able to verbalize the abuse policy and procedure. They were able to verbalize the education points of stopping the abuse and

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immediately protecting the residents and reporting the suspected or witnessed abuse to the facility Administrator. The facility's IJ removal date of 06/23/23 was validated.

3. Resident #9 was initially admitted to the facility on 08/24/22 and readmitted to the facility on 04/05/23 with diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and atrial fibrillation.

Resident #9's care plan initiated 08/25/22 revealed the Resident was at risk for respiratory complications related to chronic obstructive pulmonary disease and congestive heart failure. The goal was that Resident #9 would have no signs or symptoms of respiratory distress that would be attained by utilizing the following interventions: obtaining labs as ordered and reporting to the physician as indicated, during apnea (temporary cessation of breathing) observe the Resident's color and report to physician as indicated, observe for dyspnea (difficult or labored breathing) use of accessory muscles which indicates respiratory distress, observe respiratory status and changes in mental changes as well, medicate as ordered and monitor for side effects, monitor and record lung sounds, monitor and report oxygen saturation levels, and oxygen as ordered via nasal cannula. The Resident's care plan also indicated he refused medications and treatments and refused care related to activities of daily living. The interventions included educating the Resident on the importance of taking his medications and treatments and reporting to the physician when the Resident refused.

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The quarterly Minimum Data Set (MDS) assessment dated 04/10/23 revealed Resident #9 was cognitively intact and was independent with his activities of daily living. The MDS also indicated the Resident was always continent of bladder and bowel. There was no refusal of care during the assessment reference period.

A review of Resident #9's medical record revealed the following medication and treatment orders:
*11/25/25 Carvedilol (antihypertensive) 25 milligrams (mg) tablet by mouth twice a day.
*04/25/23 Diltiazem (for heart rate control) 90 mg capsule by mouth every 12 hours.
*08/25/22 Lisinopril (antihypertensive) 40 mg tablet by mouth one time a day.
*08/24/22 Furosemide (diuretic) 40 mg tablet by mouth every 24 hours as needed for congestive heart failure. Give with Potassium Chloride 20 milliequivalents (meq) if needed.
*08/25/22 Spironolactone (antihypertensive/diuretic) 50 mg tablet by mouth one time a day.
*04/06/23 Ventolin HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puffs inhale orally four times a day for wheezing/dyspnea, give with spacer.
*05/26/23 Apply Unna boots (medicated dressings/wraps used to reduce swelling) to bilateral legs once a day on Monday, Wednesday, and Friday.

A review of Resident #9's progress noted dated 06/13/23 at 5:07 AM revealed, the Resident was up and down from the bed to the wheelchair and vice versa most of the night. Constantly complaining of pain to bilateral lower extremities but would not take any ordered pain medicine.

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Bilateral lower extremities draining serous sanguineous (bloody) fluid in moderate amounts. He previously cut off Unna boots and refused to allow staff to replace them. Non-compliant with all meds and care. Unable to allow staff to assist with any care currently. Will continue to offer pain medication and or treatment to bilateral lower extremities. The note was written by Nurse #2.

A review of Resident #9's progress note dated 06/13/23 at 5:59 AM revealed, Ventolin HFA Inhalation Aerosol Solution 108 micrograms (mcg) (90 Base) 2 puffs inhale orally four times a day for Wheezing/Dyspnea give with spacer inhaler. Refused medication. The note was written by Nurse #2.

A review of Resident #9's Medication Administration Record for 06/2023 indicated Resident #9 refused his Ventolin Inhaler on 06/13/23 at 6:00 AM.

A review of Resident #9's progress note dated 06/13/23 at 6:40 AM revealed, called to room via staff, upon arrival Resident noted to be slumped over in wheelchair, non-responsive to verbal stimuli, blue in color with no respirations. Placed on floor and initiated Cardiopulmonary Resuscitation (CPR). 911 called. CPR continued until 911 arrived. Pronounced at 7:00 AM. MD notified. The note was written by Nurse #2.

On 06/20/23 at 9:10 PM during an interview with Nurse #2 she confirmed that she took care of Resident #9 about 3 nights a week and on the night of 06/12/23 until the morning of 06/13/23. The Nurse reported the Resident was alert and oriented and was non-compliant with his medications, mainly his heart medications and

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F 600	Continued From page 42 the medicated dressing to his legs. She explained that the Resident's legs were edematous and had draining sores and he would cut the medicated dressings off after the nurses applied them. The Nurse explained that Resident #9 acted no different on the night of 06/12/23 to 06/13/23 than he did on any other night that she had taken care of him. She stated the Resident was restless in that he was up and down from his bed to the chair and at one time they found him lying in the floor, but that was not anything unusual for him because he would often put himself on the floor. She stated the Resident complained of pain in his legs but refused to take pain medication for the pain. Nurse #2 continued to explain that around 4:00 AM she found the Resident using the telephone on the wall in the hallway saying he wanted to call 911. She stated she took the phone from the Resident and removed the phone from the wall because he called 911 all the time. The Nurse reported if she thought he warranted being sent to the hospital she would have called 911 herself. She reported she attempted to obtain the Resident's vital signs, but he refused. The Nurse explained that she last spoke with Resident #9 between 6:00 AM to 6:20 AM when he was sitting in his wheelchair in the hallway, and she gave him his Ventolin inhaler which was due at 6:00 AM. Nurse #2 continued to explain that during shift change she was giving report to the oncoming nurse when nurse aides yelled for the nurses to come down to Resident #9's room where they found him sitting in his wheelchair at the foot of his roommate's bed. He was slumped over and nonresponsive. The Nurse continued to explain that she and the Nurse Educator initiated CPR with the Nurse Educator starting the chest compressions first. Nurse #2 stated someone had called 911 and when the EMS arrived, the	F 600		

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Nurse Educator had already stopped CPR due to Resident #9 not responding to the CPR. The Nurse again insisted that if she thought Resident #9's condition had changed in a way that warranted being sent to the hospital she would have called 911 herself.

A review of Resident #9's progress note dated 06/13/23 at 7:18 AM revealed, attempted CPR at 6:42 AM, Resident remained without pulse or respirations when assessed, mottled in appearance, warm to touch but cooling. Notified on call physician services, Director of Nursing (DON), and Resident Representative (RR). The note was written by the Nurse Educator.

An interview was conducted with the Nurse Educator on 06/20/23 at 9:00 PM. The Nurse explained that on the early morning of 06/13/23 she was standing at the nurses' desk when two Nurse Aides (NA) #5 and #6 began yelling for the nurses to go down to Resident #9's room because they needed some help. She stated when she and Nurse #2 arrived at the Resident's room, he was slumped over in his wheelchair sitting at the foot of his roommate's bed. The Nurse reported she and Nurse Aide #5 and #6 transferred the Resident to the floor and she initiated CPR by providing chest compressions after it was determined that the Resident was a full code, while Nurse #2 assembled the oxygen supplies.

Resident #9 expired on 06/13/23 in the facility.

An interview was conducted with NA #4 on 06/21/23 at 4:25 PM. The NA stated he routinely worked with Resident #9 about 2-3 nights a week and had taken care of the Resident the Saturday

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F 600	Continued From page 44 and Sunday night prior to the morning of Monday 06/13/23. The NA explained that Resident #9 was not his usual self throughout the shift in that he was restless, he was going from his chair then back to his bed like he was restless. He continued to explain that earlier in the night he found Resident #9 lying on the floor and went to get Nurse #2 and NA #3 to help him get the Resident out of the floor and back into his chair where he always stayed. The NA reported he had never known of the Resident preferring to lie in the floor before. The NA explained that the Nurse asked the Resident if he was in pain and the Resident denied being in pain and wanted to stay in the floor where he said was more comfortable for him. After some encouragement the Resident agreed to get into his wheelchair. The NA stated he and NA #3 left the room to continue thier rounds. Then later in the night Resident #9 turned his call light on and wanted him to call an ambulance for him but did not say why he wanted the ambulance. The NA stated Resident #9 had never asked him to call an ambulance before that night and he went and got Nurse #2 for the Resident and when the Nurse went to Resident's room the NA left the room to continue his rounds. The NA stated that he did not know what transpired between Resident #9 and Nurse #2 after he left the room, but the NA knew the Nurse did not call an ambulance for Resident #9 before he left off shift. The NA continued to explain that after he got home that morning someone from the facility called and asked him if Resident #9 had asked him to call an ambulance and he told the person that he did, and the NA reported to Nurse #2 that the Resident wanted an ambulance called but did not say why. The NA stated he had never observed Resident #9 using the facility phone to call 911 and had never asked him to call	F 600		

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F 600	Continued From page 45 911 for him in the past. During an interview with NA #3 on 06/21/23 at 4:59 PM the NA reported that she was one of the two NAs that took care of Resident #9 on a routine basis but the night of 06/12/23 to the morning of 06/13/23 NA #4 was the Resident's aide and she helped with his care. NA #3 explained that earlier in the night NA #4 found him lying on the floor and came and got her and Nurse #2 to help get the Resident up out of the floor. The Resident stated he wanted to stay in the floor, but they put him back into his chair and NA #3 left the room to continue her rounds. NA #3 continued to explain that around 4:30 AM she noticed Resident #9 trying to call 911 using the phone on the wall in the hallway. When the NA asked him what he was doing the Resident told her that he was having trouble breathing and wanted to go to the hospital. The NA stated Resident #9 seemed to be struggling to breathe and was pale, so she immediately went to Nurse #2 who was at the nurses' desk and told her that Resident #9 was trying to call 911 using the hallway phone and he stated he was having trouble breathing and was pale. The NA stated the Nurse asked her why she didn't just take the phone from Resident #9 and the NA told the Nurse because he didn't look right and wanted to go to the hospital. The NA reported Nurse #2 went to Resident #9 who was still trying to call 911 from the hall phone and took the phone from the Resident and told him that he was asking to go to the hospital but he won't take his medications here so what was the hospital going to do for him then proceeded to remove the phone from the wall. Resident #9 sat back down in his wheelchair still looking pale and struggling to breath. NA #3 stated Nurse #2 walked back to	F 600		

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the nurses' desk and did not come back to the hall until she started her med pass around 5:45 AM to 6:00 AM. The NA stated she knew Resident #9 was not his usual self that night because he would normally do what he wanted to do like go back and forth from his room to smoke and he was normally continent but that night he was incontinent and had to be changed. The NA stated she was certain she reported his change in behavior to Nurse #2 because she and NA #4 discussed how Resident #9 was acting different that night.

During an interview with Nurse #3 on 06/21/23 at 10:15 AM the Nurse reported she took care of Resident #9 during day shift several days a week. The Nurse explained that the Resident was alert and oriented and performed his own activities of daily living. The Nurse continued to explain that Resident #9 refused his medications and medicated Unna boots that were used to control the swelling in his lower extremities. She stated that on May 17th, 2023, the swelling in his trunk, scrotum and legs was so bad that his skin looked leathery, and he agreed to go to the hospital because he was pretty much miserable and that was the only time he had asked to be sent to the hospital. She did not recall Resident #9 ever calling 911.

An interview was conducted with NA #1 who was Resident #9's full time NA on third shift. The NA explained the Resident was alert and oriented and could voice his wants and needs. He was continent by using his urinal and would go to the bathroom himself when needed. Resident #9 had his own routine of sitting in his wheelchair most of the time and sometimes would get in his hard back chair, but he rarely laid in his bed because

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he said he couldn't breathe when he got into his bed. She stated he was a smoker and smoked throughout the night. The NA continued to explain that she had never known of Resident #9 using the hall phone and he had never asked her to call 911 for him. The NA stated the Resident would complain of pain in his legs but would refuse pain medication when it was offered to him.

During an interview with the Director of Nursing (DON) on 06/21/23 at 1:15 PM the DON explained that after the morning meeting on 06/13/23 NA #5 informed her that third shift NA #3 reported that Resident #9 had fallen during the shift and had tried to call 911 himself by using the phone in the hall but Nurse #2 took the phone from him and did not assess him for a change in condition. She continued to explain that they found the Resident slumped over in his wheelchair and CPR was initiated but the Resident expired. The DON stated that based on the information she was given and the fact that there was no incident report about Resident #9's fall she reported the situation to the Administrator and an investigation was started because they felt Nurse #2 should have assessed the Resident's change in condition and notified the Medical Director for further orders. The DON stated the facility determined Nurse #2 was neglectful.

An interview conducted with the Adult Protective Services (APS) Social Worker (SW) on 06/20/23 at 9:50 AM revealed she was concerned about Resident #9 who resided at the facility and expired the morning of 06/13/23. The SW explained that she received a reportable death notification from the facility Administrator who reported a nurse was being investigated for negligence related to his death.

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On 06/21/23 at 10:45 AM during an interview with the Administrator he reported that when he learned of the situation with Resident #9 on the morning of 06/13/23 he immediately started an investigation of the situation and found that the Resident was complaining of pain and had even requested to go to the emergency room and tried to call 911 himself until Nurse #2 took the phone from him and from the wall so that he couldn't call 911 himself. The Nurse should have assessed the Resident and called the Physician and the Nurse on Duty and reported the Resident's change in condition, but she didn't and ultimately Resident #9 coded and expired. The Administrator stated he felt the Nurse was negligent in not assessing the Resident's change in condition and seeking medical guidance in the situation.

An interview conducted with the Medical Director (MD) on 06/20/23 at 2:20 PM revealed he was not surprised when he was notified that Resident #9 had expired because of his history of refusing his medications and treatments that were necessary to prevent swelling and fluid overload which were related to his significant heart failure. The MD explained that he had recently counseled the Resident on the importance of taking his medications especially his medication (diltiazem) of which the Resident thought was poison. While reviewing Resident #9's death certificate the MD explained that the Resident went into biventricular dysrhythmia (arrhythmias that cause the heart to beat too fast, which prevents oxygen rich blood from circulating to the brain and body and may result in cardiac arrest) heart failure related to his coronary heart disease. He continued to explain that Resident #9's heart was beating so fast that

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F 600	Continued From page 49 even if he was in the emergency room there was a slight chance of survival but nevertheless, he should have been sent to the emergency department for further evaluation. The Administrator was notified of Immediate Jeopardy at F 600 Neglect on 06/22/23 at 2:30 PM. The facility provided a Credible Allegation of Immediate Jeopardy removal on 06/23/23. Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: On 6/13/23 at approximately 4:30 am Nurse Aide #3 identified Resident #9 as restless, pale in color, struggling to breathe, and a change in urinary continence. Nurse Aide #4 described Resident #9 as being restless and up and down all night long requesting to go to the hospital. Nurse #2 was made aware of the changes and did not assess Resident #9 herself, took the phone away from the resident and did not call 911. At approximately 6:40 am CNA #5 and CNA #6 started their round and discovered resident to be slumped over in wheelchair. At that time, they called for help. The Nurse Practice Educator responded. Upon assessment the Nurse Practice Educator determined resident was not breathing and did not have a pulse. Resident was placed on the floor by the Nurse Practice Educator, CNA #5, and CNA #6. Chest compressions were started by the Nurse Practice Educator after confirming resident was a full code. Resident #9 expired in the facility. Nurse #2 was suspended on 6/13/23 pending	F 600		

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investigation and the contract agency was notified on 6/21/23 of her termination.

Current residents residing in the facility have the potential to be affected by the deficient practice.

On 6/22/23 the Director of Nursing or Assistant Director of Nursing interviewed residents with a BIMs of 12 or greater to identify if they had experienced any change in condition. Residents with a BIMs of 11 or less had an assessment by the Director of Nursing or Assistant Director of Nursing for any changes not at baseline, not normal for resident, lethargic, shortness of breath, new onset pain, etc. There were no issues identified with this audit.

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:

On 6/22/2023 the Director of Nursing educated licensed nurses on identifying changes in condition or assessing for changes when reported to them on a resident with an acute change of condition. The nurse will complete an assessment of the resident and then call the physician, nurse practitioner, or medical director, provide them the information, and obtain orders for the treatment of the resident. In the event the charge nurse is not available to report to, another nurse in the facility is to be notified as well as the Director of Nursing. On 6/22/23 Director of Nursing or Administrator educated current staff including clinical and all ancillary departments on the definition of neglect: "Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that

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are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Education included that residents should be allowed to call 911 at their will. On 6/23/23 the Director of Nursing and Assistant Director of Nursing provided nurse aides education on how to identify a change of condition in noting when a resident presents different than known baseline, lethargic, restless, or short of breath. Education was provided both verbally and in written format and the staff members were asked to repeat understanding of what they were being educated on. Staff members were reminded by the Administrator or the Director of Nursing that neglect would not be tolerated in the facility and that residents needs to be addressed and met. Any staff member, including agency, will be unable to work until the education has been completed. The Director of Nursing is responsible for ensuring education is provided prior to working. The Director of Nursing will provide the education to new hires during orientation.

Effective 6/22/2023/2022 the Administrator will be ultimately responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/23/2023

On 06/28/23 the facility's Credible Allegation for the removal of Immediate Jeopardy on 06/23/23 was validated by the facility providing proof that the facility had interviewed residents with a BIMs score of 12 or higher to identify if they had a change in condition that had not been assessed. The facility also assessed residents with a BIMs score of 11 or below to identify if they had a change in their baseline conditions. There were

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F 600	Continued From page 52 no issues identified with the assessments. Through multiple interviews with the facility staff the facility was able to verify that the administration had provided education on identifying changes in conditions on the residents which included completing assessments on the changes and notifying the providers for further orders when necessary. The facility Administrator and Director of Nursing educated all facility staff about the definition of neglect. The education included the residents should be allowed to call 911 at their will. The facility administration provided educated to the nurse aides and gave written information as well as expected return demonstration on neglect and changes in condition. The facility staff were reminded that neglect would not be tolerated in the facility and the residents' needs came first. The facility's IJ removal date of 06/23/23 was validated.	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		8/3/23

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F 607	Continued From page 53 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to identify abuse, protect all residents from abuse, and report abuse to the state agency and local law enforcement and complete a thorough investigation that included staff interviews of bruising that was reported to have occurred during incontinence care for 1 of 3 residents (Resident #11) reviewed for abuse. On 02/16/23 Nurse Aide (NA) #10 pinned Resident #11's arms between their bodies when Resident #11 became combative during incontinent care. After the care Resident #11 was noted to have bruising to her bilateral lower arms. At the conclusion of the investigation the facility substantiated abuse but allowed NA #10 to return to work to care for other residents in the facility. The facility further failed to protect Resident #1 on 03/19/23 when Resident #2 entered Resident #1's room and touched her on her breast and vaginal area, the incident was witnessed by NA #1 who asked Resident #2 to stop touching Resident #1 then left Resident #1 and Resident #2 alone and unsupervised in the room while she went to report the sexual abuse to	F 607	F607 Develop/Implement Abuse/Neglect Policies 1. Resident #11 and Resident #1 continue to reside in the facility, Resident #2 no longer resides at the facility. Resident #1 and Resident #11 have not presented with any signs of mental anguish or psychosocial harm related to the reportable incidents. Resident #9 no longer resides at the center. 1. Current residents have the potential to be affected by this deficient practice. 2. DON and ADON have completed education for staff members on abuse, including the various types of abuse (verbal, physical, mental, sexual, neglect, involuntary seclusion, exploitation, misappropriation, resident to resident and mistreatment). Education was also provided on changes of behavior/mood that can indicate abuse and that residents	

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Nurse #1. Nurse #1 failed to report the sexual abuse to the Administrator on 03/19/23 which allowed a second incident of sexual abuse on 3/20/23 to occur. On 03/21/23 Resident #1 reported the sexual abuse that occurred on 03/19/23 to NA #5 and NA #6 who then reported the sexual abuse to the Director of Nursing (DON) and Administrator. The facility failed to thoroughly investigate the allegation of abuse to ensure all residents were assessed for sexual abuse. This affected 1 of 3 residents reviewed for resident-to-resident abuse (Resident #1).

Immediate jeopardy began on 02/16/23 when the facility failed to identify, thoroughly investigate, report, and protect all residents from abuse after an allegation of staff to resident abuse. Immediate jeopardy was removed on 06/23/23 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity E (no actual harm with potential for harm) to ensure monitoring systems are in place and the completion of staff education.

The finding included:

A review of the facility's policy titled "Abuse Prohibition" revised 10/24/22 revealed: Centers prohibit abuse, mistreatment, misappropriation of property, exploitation and neglect. The Center will implement an abuse prohibition program through the following: investigation of incidences and allegations. 7. Immediately upon receiving information concerning a report of suspected or alleged abuse the administrator will perform the following: 7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on:

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presenting with these behaviors/mood changes should be monitored and the change reported to their supervisor. In addition, education was provided that the alleged perpetrator and victim should be separated with the perpetrator being monitored. Initial reports should be filed with Law Enforcement, Adult protective Services and the North Carolina Department of Health and Human Services within the allotted time limits. A complete investigation will be conducted within the five-day requirement set by Federal Regulations. Staff that have not received the education will be required to have education prior to the next shift worked. New staff will receive the preceding education in orientation.

3. Chief Nursing Officer or designee will review all reportable events involving abuse or neglect to ensure all reports are filed within the allowed time limits set by Federal Regulations, that all investigations are completed within allowable time limits and that all allegations of abuse or neglect are thoroughly investigated.

4. Chief Nursing Officer or designee will bring findings from the review of files to the Quality Assurance Committee meeting monthly for three consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.

5. Date of completion August 3, 2023.

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7.7.1 whether abuse occurred and to what extent; 7.7.2 clinical examination of injuries; 7.7.3 causative factors. 7.8 The investigation will be thoroughly documented in Risk Management Portal. Ensure that documentation of witnessed interviews is included.

Further review of the facility's policy read: a. A review of the facility's policy titled "Abuse Prohibition" revised 10/24/22 revealed: Centers prohibit abuse, mistreatment, misappropriation of property, exploitation, and neglect. 7. Immediately upon receiving information concerning a report of suspected or alleged abuse the administrator will perform the following: 7.2 report allegations to state and local authorities involving abuse (verbal, mental, physical, and sexual) no later than 2 hours after the allegation is made.

1. Resident #11 was admitted to the facility on 11/21/22 with diagnoses that included cerebral vascular accident, diabetes mellitus and dementia.

A review of the Initial Allegation Report dated 02/16/23 indicated the facility became aware of the abuse incident of new discolorations on Resident #11's right and left arms at 9:00 AM on 02/16/23. The Report indicated local law enforcement was notified on 02/16/23 at 3:00 PM.

A review of the facility Investigation Report dated 02/20/23 for Resident #11 abuse that occurred on 2/16/23 revealed the accused individual was Nurse Aide (NA) #9 with NA #10 and NA #11 witnessing the incident. The report summary read the Administrator interviewed staff and statements indicated that 3 staff members, NA #9, NA #10, and NA #11, were attending to

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Resident #11 and the Resident was attempting to hit, bite and scratch the staff while they were attempting to change her. NA #9 indicated that she did not hold the Resident's hands or arms during her interaction with Resident #11. NA #10 indicated that she did hold Resident #11's hands together so that the staff could finish changing the Resident without being injured. All the staff's statements were consistent indicating that Resident #11 was being combative with staff and swinging her bed remote. The incident resulted in physical injury of discolorations to the Resident 11's left and right forearms. The summary of the investigation found that NA #10 did hold down Resident 11's arms to keep her from hitting and scratching the staff and the incident was substantiated but NA #10 continued to work and provide care to the other residents.

During an observation and interview with Resident #11 on 06/20/23 at 10:10 AM the Resident was alert and talkative while lying in bed. Resident #11 explained that she vaguely remembered the incident when two girls, she could not remember who they were, held her hands down and caused bruises on her hands but could not remember when it was or any details about it. She stated she thought it was just a big misunderstanding.

During an interview with NA #9 on 06/20/23 at 9:40 PM the NA explained that she was still worked at the facility and worked a few nights a week. She continued to explain that on 2/16/23 she was asked to assist NA #11 with Resident #11 because the Resident could be combative so they must have 2 staff members to go into the Resident's room to provide care. NA #9 stated Resident #11 was soiled from top to bottom and

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needed to be changed and she agreed to let them change her. When NA #11 started to pull the Resident's sheet down Resident #11 picked up her bed remote and hit NA #11 on her hand which made a loud thud. She stated they stopped and called Nurse #7 into the Resident's room and the Nurse tried to talk the Resident into letting the NAs change her, but the Resident still refused care. They ended up not being able to provide care. The NA stated, later Resident #11 told other staff members (she could not recall who) that they hit her, but the Resident already had a bruise on her left hand. When NA #9 was asked if she was interviewed by anyone about the situation the NA stated that she had not been interviewed about the incident, but Nurse #6 asked her to write a statement about the events of 2/15/23 before she left the facility on 02/16/23.

An interview conducted with NA #10 on 06/20/23 at 7:52 PM revealed she assisted NA #11 who was assigned to Resident #11 during the night of 02/15/23 to 02/16/23. NA #10 stated that by the time Resident #11 agreed to allow them to change her she required a full bed change along with her soiled brief and gown. NA #10 explained when they were halfway finished with providing care, Resident #11 started pinching and scratching them so when they rolled the Resident over to facing her, she crossed the Resident arms and extended them downward between her body and the Resident's body to prevent the Resident from scratching and biting. NA #10 was insistent that she did not touch Resident 11's hands and if the Resident was bruised then the bruising was present before they went into her room to provide care. NA #10 was asked if she was interviewed by anyone from the facility about the incident and she indicated, no one had

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spoken with her about the events of the night of 2/16/23 with Resident #11 or she would have demonstrated to them how she crossed the Resident's arms. She stated she was only asked by Nurse #6 to write a statement about the night of 2/16/23 before she left that morning. NA #10 reported she was suspended pending investigation then was allowed to go back to work but has not been assigned to Resident #11. The NA stated the last night she worked at the facility was Friday 06/16/23.

On 06/22/23 at 8:15 AM during an interview with NA #11 she explained she still worked at the facility and the last night she worked was 06/21/23. The NA stated she was assigned to Resident #11 on 02/16/23 and that they attempted to change Resident #11 multiple times during the 12-hour shift, and multiple times she refused. She stated by the early morning you could literally smell the strong urine and fecal odor in the hallway and when the Resident did allow them to change her, Resident #11 required a brief change including her gown and bed sheets. NA #11 explained NA #10 assisted her with Resident 11's incontinence care and halfway during the process the Resident began to scratch, pinch and attempted to bite them while swinging the bed remote at them. She continued to explain when they turned Resident #11 toward NA #10 the NA had to lay the Resident's arms down and lean over her to prevent the Resident from scratching them and to finish changing her, but NA #10 never held the Resident's hands down. NA #11 stated she did not notice any bruising on Resident #11's hands or arms because if she had, she would have reported it. The NA stated no one from administration had interviewed her about the situation but she did write a statement

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as requested by Nurse #6 for her protection because it was common for Resident #11 to accuse the staff of doing things that they did not do.

An interview was conducted with Nurse #7 on 06/20/23 at 8:40 PM who explained that she worked with Resident #11 often during the evening shifts and was on duty the night of 02/15/23 to the morning of 02/16/23. The Nurse reported that Resident #11 already had bruising to her arms and hands before that evening shift because the Resident had pulled a band aid off her left arm earlier in the shift and was picking at the skin tear and had it bleeding with blood on her bed and I asked her several times that night not to pick at the skin tear that she was making it worse, but she continued to pick at the skin tear. She stated the Resident had bruising on her arms as well, but she did not report the bruising because she always had bruising. The Nurse explained that night Resident #11 had refused to be changed multiple times but at one point she agreed to be changed so all three NAs went in there to change her mainly because they did not allow one aide to provide care for Resident #11 because of her behaviors. The Nurse stated she did not know anything about Resident #11's accusations toward the nurse aides during that shift until she came back to work her next scheduled shift and learned that NA #10 had been "let off" for several days. The Nurse stated no one from administration interviewed her about the nights events or she would have told them how Resident #11 acted and that the bruising on the Resident's arms and the skin tear was there when she started her shift the evening of 02/15/23.

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During an interview with Nurse #6 on 06/20/23 at 8:56 PM the Nurse confirmed she was on duty the night of 02/15/23 to 02/16/23 and assisted Nurse #7 in attending to Resident #11. Nurse #6 stated she did not remember or know about any bruising on Resident #11, but she knew that Nurse #7 had walked in on the Resident picking at a sore on her arm and had it bleeding. The Nurse reported that Resident #11 had refused care multiple times even after calling out to be changed several times that night. Nurse #6 stated she had instructed the NAs not to go into the Resident's room by themselves to provide care because of Resident #11's combative behaviors and false accusations toward the staff and she felt that was best for everyone's protection. Nurse #6 stated that she was not aware of any accusations made by Resident #11 against any of the NAs that worked that night until she came back on duty and learned that NA #10 was suspended because she crossed the Resident's arms in order to roll her over to provide care and NA #9 and Nurse #7 were in the room at the time. The Nurse stated she had the staff write statements about the night's events and gave them to the Nurse Educator but was never interviewed by administration about the events or she would have explained what happened during the shift.

An interview was conducted with the Unit Manager (UM) on 06/20/23 at 1:50 PM who explained that she did not know any details about an incident with Resident #11 and NAs #9, #10 and #11 on the night of 02/15/23 to 02/16/23 except that she was asked by the Administrator on 02/16/23 to complete a skin assessment on Resident #11 that showed bruising on one of her hands, but she couldn't remember which hand.

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The UM stated Resident #11 told her that they held her hands down to change her but did not explain who they were. The UM explained that she did not report what Resident #11 told her about how the bruising occurred because the Administrator was already aware of the bruising and had interviewed the Resident during her presence. The UM stated she was not asked to investigate the incident, nor did she interview any staff about the incident because that was not her job to do so.

An interview was conducted with the Nurse Educator on 06/20/23 at 9:00 PM who explained that she was no longer employed at the facility but stated she only educated the staff after the incidents of abuse had occurred. The Nurse continued to explain that she educated the staff on abuse from 02/17/23 to 02/20/23 which included identifying and reporting abuse as well as dealing with the abusive resident which included not providing care for Resident #11 alone and to always have a least two staff when providing care for her. The Nurse insisted that she did not investigate the accusation of bruising on Resident #11 that happened back in February because that was not her job to do that. She indicated the investigation would have been done by the Director of Nursing at the time of the incident.

During an interview with the former Director of Nursing (DON) on 06/22/23 at 2:55 PM the DON reported he was the acting DON from January through most of February 2023. The DON explained that he remembered Resident #11 in that she frequently accused the staff of being abusive to her and they were afraid to go into her room to provide care for her, so he had them go

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in with at least 2 people and to document the care provided. He stated Resident #11 liked to use her call light and bed remote as a lasso and swing at them, threatening to hit them. The DON stated he investigated several incidences involving Resident #11 that happened with the daytime staff but not the nighttime staff and he did not remember investigating anything pertaining to bruising on Resident #11 before he left. The DON stated if he had there would have been documentation of his investigation and he would have assessed the Resident and documented it in Resident 11's chart.

An interview was conducted with the Administrator on 06/21/23 at 10:45 AM who explained that the staff (he could not remember who) informed him in the morning meeting on 02/16/23 that Resident #11 had bruising on her arms and to his knowledge there had been no reports of bruising reported on the Resident before that day. The Administrator stated the Nurse Educator informed him that she had taught the staff to cross the residents' arms in front of them in order to make turning and repositioning easier for the residents but not intending to hurt them. The Administrator continued to explain that he interviewed Resident #11 on 02/16/23 and did not see any bruising nor did he document it in his statement that he wrote. He stated Resident #11 reported to him that a large aide, NA #9 held her hands down during care and that caused the bruising and NA #11 was present at the time. He reported they collected written statements from NAs #9, #10, and #11, who were involved, and NA #9 denied holding the Resident's hands down, NA #10 admitted to holding Resident 11's hands down and NA #11 denied holding the Resident's hands down. The Administrator stated they

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F 607	Continued From page 63 suspended NA #10 pending the outcome of the investigation because she admitted to holding the Resident 11's hands down during care even though Resident #11 stated it was NA #9. The Administrator stated he did not personally interview the named staff about the incident or get a verbal explanation of their written statements because the verbal investigation was done by the Unit Manager and the Nurse Educator. The Administrator stated he only reviewed the NAs written statements, which were all consistent in that Resident #11 was combative during care which made himself and the upper management question whether it was abuse. He stated they did not feel it was abuse and therefore, they did not terminate the employee and explained he must have marked the investigation report as substantiated by mistake. The Administrator stated NA #10 returned to work after the investigation and continued to work at the facility as were NA #9 and #11. During the interview the Administrator was asked how the facility protected the other residents who were under the care of accused NA #10 and the Administrator was unable to explain nor was he able to provide demonstration of the other residents' protection from NA #10 since she continued to work in the facility since the incident on 2/26/23. The Administrator indicated he should have been more thorough with investigating the incident and remarked that he was unfamiliar how things were done in this state coming from another state, but he had learned that he needed to be more detailed and thorough when he investigated abuse and report abuse to local law enforcement and state agencies within the 2-hour timeframe. The Administrator added he did not report the incident to the local law enforcement or the state agency in the two-hour time frame	F 607		

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because he was waiting for direction from upper management to do so but he never received permission.

The Administrator was notified of the immediate jeopardy on 07/12/23 at 4:49 PM.

The facility provided the following IJ removal plan:

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

At approximately 9:00 AM on 2/16/2023 the Administrator was notified that Resident #11 had new discolorations to her right and left arms. The Administrator and Infection Preventionist entered the room to interview Resident #11 to gather information on the new discolorations to her arms. Resident #11 stated that a large black woman held her down last night causing the discolorations. The Administrator asked what led up to the event, Resident #11 stated she could not recall. The Administrator asked when the event occurred, Resident #11 stated last night. The Administrator asked Resident #11 to describe the event, Resident #11 stated "it happened during the time the nursing aides attempted to change me" and the nursing aide put her hands together. Resident #11 then stated it was a nurse aide who held her down. Facility staff interviewed the staff working the hall from the previous night shift, interviews indicate that Resident #11 was combative with staff who attempted to change her clothing and bedding that were soiled.

The incident happened approximately 1:30 AM 2/16/2023. The employees did not inform the

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supervisor nor the Administrator at the time the incident happened. The Administrator was notified approximately at 9:00AM on 2/16/2023 and the incident was reported on 2/16/2023 at 5:24PM. NA #9, NA #10, and NA #11 were suspended pending an investigation. The Administrator failed to report and failed to investigate the allegation per the facility policy which led to further abuse allegations.

On 3/19/23 Nurse Aide #1 entered Resident #1 room and witnessed Resident #2 touching Resident #1 breast and vagina through her clothing. Nurse Aide #1 asked Resident #2 to stop touching Resident #1 and he did immediately. Nurse Aide #1 left the room with the perpetrator present and reported to Nurse #1. Nurse #1 failed to immediately report the incident to her supervisor as directed by the facility's policy. The failure of Nurse #1 to report to the Administrator led to not reporting to law enforcement, Adult Protective Services, not starting an investigation, lack of protection, and then the perpetrator approached the resident again on 3/20/23 attempting to touch her.

All facility staff have the potential to repeat the same deficient practice.

On 6/21/23 the Administrator reviewed 24 hour/5 days for the last 30 days to identify if reporting was completed per policy. There was one issue identified and corrected.

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:

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F 607	Continued From page 66 Initial education was completed on 3/22/23 with current staff including agency regarding identifying and reporting abuse. On 6/21/23 the Director of Nursing and Assistant Director of Nursing educated current staff on Abuse. Education included verbal abuse, sexual abuse, physical abuse, mental abuse, neglect, involuntary seclusion, exploitation, misappropriation of resident property and mistreatment. The staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. The Director of Nursing is responsible for ensuring this is enforced. In the event abuse is witnessed the staff member should stay with the resident providing protection from the abuse. Immediately after removing the abuse the abuse must be reported to the Administrator. The Administrator was educated by the Chief Nursing Officer on 6/21/23 on how he should confirm the abuse and potential has been removed, the perpetrator is monitored, submit an initial investigation to the State, contact the police department and Adult Protective Services and complete a thorough investigation prior to submitting the five-day report to the State. Staff were asked to return information verbally to confirm understanding of education. The Director of Nursing will educate in orientation for newly hired staff, to include agency staff. Education completed 6/21/23. In the event of resident-to-resident abuse the perpetrator will be placed on a 1:1 monitoring until a medical/psychiatric evaluation can be completed to protect the victim and all other residents. The charge nurse on duty is responsible for assigning the 1:1 monitor. Charge nurses were notified of this responsibility on	F 607		

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6/22/23 by the Director of Nursing.

Effective 6/21/2023/2022 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

On 06/28/23 a credible allegation of Immediate Jeopardy removal was conducted in the facility. The facility's current Abuse policy and procedure was reviewed, along with facility reported incidents in the last thirty days to ensure timely reporting. No additional concerns were noted. The education used to re-educate the facility staff on abuse was reviewed along with staff sign in sheets to confirm receipt of the education. Interviews with staff across the disciplines were conducted and staff were able to verbalize the steps they should take if they witness or suspect any type of abuse. The staff were able to verbalize that they must stop the abuse and stay with the resident providing protection from the abuse and then immediately report the abuse to the Administrator. The perpetrator is to be placed on one-on-one supervision immediately for the protection of other residents. The education was verified to be a part of the orientation program for all newly hired staff. The Administrator was able to verbalize his reporting requirements and time frames after becoming aware of any witness or suspected abuse in the facility. The facility's removal date of 06/23/23 was validated.

2. Review of the facility's abuse policy dated 07/01/13 and revised on 10/24/22 read in part, if the suspected abuse is patient to patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be

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F 607	Continued From page 68 completed. The Center will protect the patient from further harm during an investigation. Anyone who witnesses an incident of suspected abuse, neglect, or involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law. Resident #1 was admitted to the facility on 01/18/23. Review of the significant change Minimum Data Set (MDS) dated 03/13/23 revealed that Resident #1 had clear speech and was able make her needs known and was able to understand others. Resident #1 was moderately cognitively impaired and required limited to extensive assistance with activities of daily living. Resident #2 was admitted to the facility on 04/01/21 with diagnoses that included anxiety, major depressive disorder, vascular dementia, and others. Review of the quarterly MDS dated 03/10/23 revealed that Resident #2 was moderately cognitively impaired, had no delirium, no behaviors, rejection of care, or wandering during the assessment reference period. Resident #2 required limited to extensive assistance with activities of daily living and used a wheelchair for mobility. Review of a facility incident report dated 03/21/23	F 607		

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read, Resident #1 reported that Resident #2 came into her room and started holding her hand and kissing her hand, then proceeded to touch her breast on top of clothing and under clothing then tried to touch her vaginal area. Resident #1 stated that she asked Resident #2 to stop, and he did. Resident #1 was not sure of the exact date and time the incident occurred. Resident #1 was assessed for injuries, and none were noted. Investigation initiated. Resident #2 placed on one-on-one supervision. Resident #1 was sent to the Emergency Department (ED) for evaluation. The report was completed by the Director of Nursing (DON).

Resident #2 was discharged home from the facility on 03/29/23.

Review of the facility's schedule for 03/19/23 revealed that Nurse Aide (NA) #1 was caring for Resident #1 and Nurse #1 was on the unit where Resident #1 resided.

Nurse Aide (NA) #1 was interviewed via phone on 06/20/23 at 2:33 PM who confirmed that she was caring for Resident #1 on 03/19/23. She stated that evening Resident #1 was in her wheelchair in her room and Resident #2 who had been outside smoking entered Resident #1's room in his wheelchair. NA #1 stated that when she entered Resident #1's room, they were both in their wheelchair's facing each other and Resident #1 stated to her, "please tell him to remove his hand from my twat", NA #1 stated that Resident #2's hand was on top of Resident #1's clothes in her vaginal area. NA #1 stated she very sternly asked Resident #2 to stop touching Resident #1 and he did. NA #1 stated that she then left the room with Resident #1 and Resident #2 still in their

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wheelchairs alone facing each other to go and alert Nurse #1 of what had occurred. As NA #1 was returning to Resident #1's room she passed Resident #2 in the hallway in his wheelchair returning to his room on the same unit. NA #1 stated that at the end of her shift she had followed up with Nurse #1 about if she had documented what had occurred. NA #1 stated that Nurse #1 stated she had not documented anything regarding the incident because she felt it was consensual. NA #1 stated that she did not think anything about leaving Resident #1 and Resident #2 in the room together while she went to report to Nurse #1 because "he instantly removed his hand from her when I asked him to." She added that she assumed Nurse #1 had taken care of what she needed to regarding the incident.

Attempted phone interview to Nurse #1 were made on 06/20/23 at 11:12 AM and were unsuccessful.

A statement provided by Nurse #1 dated 03/22/23 at 5:00 AM read on Sunday night 03/19/23 during med pass, staff reported to this writer of witnessing Resident #2 in Resident #1's room and had his hand in Resident #1's brief while both residents were sitting in wheelchairs in the room. This Nurse asked Resident #1 about the incident, and she replied, "so this is my p***y, and I can do what I want." Resident #1 used other foul language and reported to this writer that the incident was consensual between the two parties involved.

An observation and interview were conducted with Resident #1 on 06/20/23 at 10:23 AM. Resident #1 was resting in bed and was well

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groomed. She stated that she recalled the incident with Resident #2. She stated she did not know the date or time but stated she was in her room but could not recall if she was in bed or in her wheelchair and Resident #2 came in her room and "touched me on my breast and tried to touch my vagina but I pushed his hand away." She explained that he touched her on top of her clothes, but she did not like to talk about it and stated she tried to block it from her memory because she did not like to think about what had happened to her. Resident #1 explained her spouse had recently passed away and she did not want another man touching her. She added that Resident #2 had never made an inappropriate gesture or passes toward her before but again she did not wish to talk about the incident anymore.

NA #5 was interviewed on 06/20/23 at 2:07 PM who confirmed that she was caring for Resident #1 on 03/21/23.
During care and transfer of Resident #1, NA #5 stated that Resident #1 had tears in her eyes and told her that Resident #2 had his hands down Resident #1's pants and had touched her breasts. NA #5 stated she left the room while NA #6 stayed with Resident #1 and went and told Nurse #4 what Resident #1 had reported. NA #5 was certain that Resident #1 was "sad and had tears in her eyes" when she told her what had happened, and Resident #1 made it very clear she did not want Resident #2 touching her. NA #5 stated that after they reported to Nurse #4, she reported to the DON and Administrator, and they immediately began an investigation.

NA #6 was interviewed on 06/20/23 at 1:04 PM who confirmed that she was caring for Resident

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#1 on 03/21/23 during the day shift. She stated while transferring Resident #1 out of bed she stated that Resident #2 had touched her in places that he should not be touching her, and Resident #1 was very clear she did not want Resident #2 touching her at all. NA #6 stated that Resident #1 stated that Resident #2 had touched her inside her pants and her breast area, and that NA #1 had gotten Resident #1 to stop and reported it to Nurse #1. NA #6 stated that when Resident #1 told her and NA #5 what had happened, they immediately reported it to Nurse #4 who told the DON and Administrator and they began an investigation.

Nurse #4 was interviewed via phone on 06/20/23 at 11:52 AM who confirmed that she was caring for Resident #1 on 03/21/23. She stated that Resident #1 had requested to get out of bed by NA #5 and NA #6 and during the transfer Resident #1 was not acting like her usual self, she was very upset and not joking with them like she normally did. Resident #1 reported that Resident #2 had stuck his hands down her pants and touched her breast and NA #5 and #6 immediately came and reported to Nurse #4 who confirmed that she went and reported to the DON who asked that Resident #1 be sent to the ED for evaluation which she was and returned with no new orders.

Review of a statement recorded by the SW dated 03/21/23 read, the questions were asked by the Administrator to Resident #1: Resident #1 reported that Resident #2 came into her room and "tried to play with my titties" and Resident #1 reported, "I do not like that. He also tried to play with my twat. He tried to kiss on me, and I don't want him kissing on me. I told him to stop." The

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Administrator asked Resident #1 if Resident #2 had been back, Resident #1 stated "yeah, yesterday. I told him I don't like that. I told him my husband was watching him." Resident #1 stated that when he came back, he tried to touch her and kiss her, and she stated she felt unsafe.

The Social Worker (SW) was interviewed on 06/20/23 at 4:30 PM who stated that she was alerted of the incident between Resident #1 and Resident #2 on 03/21/23 and she had gone down to interview Resident #1 along with the Administrator. The SW stated that Resident #1 was not tearful she was "almost angry and upset." She recounted the events that Resident #2 had come into her room and touched on her breast and vaginal area and that she did not want him touching her at all. The SW stated that following the interview she had interviewed the other alert and oriented residents on the unit to see if any other incidents had occurred and none were reported, and she continued to check on Resident #1 daily for a while after the event. The SW could not say what the facility had done for the non-interviewable residents, she stated that maybe the DON would know.

The DON was interviewed on 06/20/23 at 4:03 PM who stated that on 03/21/23 Nurse #4 had made her and the Administrator aware of the reports from Resident #1 who stated that Resident #2 had touched her inappropriately. She stated that she had gone and done a head-to-toe assessment of Resident #1 and only Resident #1 and then had Nurse #4 send her to the ED for evaluation. The DON stated that Resident #1 stated Resident #2 had touched her breasts on top of her clothes and tried to touch her vaginal area and she stopped him. The event occurred

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on 03/19/23 but was not reported to her until 03/21/23 at which time the investigation was initiated. All staff that were involved were interviewed as well as the residents, Resident #2 was placed on one-to-one supervision until he discharged home a few weeks after the incident. She stated that she had reviewed Nurse #1's statement indicating that the incident was consensual, but she never got that response from Resident #1 and Nurse #1 was ultimately terminated from the facility. The DON stated that NA #1 should not have left Resident #1 and Resident #2 alone together in the room, she should have immediately stopped the abuse and removed Resident #2 from the room then alerted Nurse #1. The DON indicated that NA #1 should have gone up the chain of command and called the next person in line when Nurse #1 did not respond appropriately to the reports of sexual abuse, and they have re-educated the staff to that effect.

The Administrator was interviewed on 06/20/23 at 4:59 PM who stated that he was notified of the incident between Resident #1 and Resident #2 on 03/21/23 and he immediately made sure the residents were separated and began his investigation. He stated Resident #2 was placed on one-on-one supervision and they began interviewing the staff that worked from 03/19/23 through 03/21/23 to find out what had occurred and what was reported. The Administrator confirmed that he had interviewed Resident #1 on 03/21/23 and she reported that Resident #2 came in her and room and touched her on breast and vaginal area and she did not like that. Then Resident #1 reported that on 03/20/23 Resident #2 had again entered her room and tried to touch and kiss on her and she reported feeling "unsafe"

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in the facility. The Administrator stated he notified local law enforcement and Resident #1 was sent to the ED for evaluation and returned. During the conversation the Administrator stated that Resident #1 was very clear this was not consensual, and she did not want Resident #2 touching her. The Administrator stated that he once he became aware of the incident, he immediately began his investigation and educated the staff on immediately protecting the resident who had been abused and ensuring that it was reported and responded to appropriately and if not then continue up the chain of command.

The Administrator was notified of the immediate jeopardy on 06/21/23 at 8:41 AM.

The facility provided the following IJ removal plan:

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

On 3/19/23 Nurse Aide #1 entered Resident #1 room and witnessed Resident #2 touching Resident #1 breast and vagina through her clothing. Nurse Aide #1 asked Resident #2 to stop touching Resident #1 and he did immediately. Nurse Aide #1 left the room with the perpetrator present and reported to Nurse #1. Nurse #1 failed to immediately report the incident to her supervisor as directed by the facility's policy. The failure of Nurse #1 to report to the Administrator led to not reporting to law enforcement, Adult Protective Services, not starting an investigation, lack of protection, and then the perpetrator approached the resident again on 3/20/23 attempting to touch her.

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All facility staff have the potential to repeat the same deficient practice.

On 6/21/23 the Administrator reviewed 24 hour/5 days for the last 30 days to identify if reporting was completed per policy. There was one issue identified and corrected.

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:

Initial education was completed on 3/22/23 with current staff including agency regarding identifying and reporting abuse. On 6/21/23 the Director of Nursing and Assistant Director of Nursing educated current staff on Abuse. Education included verbal abuse, sexual abuse, physical abuse, mental abuse, neglect, involuntary seclusion, exploitation, misappropriation of resident property and mistreatment. The staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. The Director of Nursing is responsible for ensuring this is enforced. In the event abuse is witnessed the staff member should stay with the resident providing protection from the abuse. Immediately after removing the abuse the abuse must be reported to the Administrator. The Administrator was educated by the Chief Nursing Officer on 6/21/23 on how he should confirm the abuse and potential has been removed, the perpetrator is monitored, submit an initial investigation to the State, contact the police department and Adult Protective Services and complete a thorough investigation prior to submitting the five-day report to the State. Staff

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were asked to return information verbally to confirm understanding of education. The Director of Nursing will educate in orientation for newly hired staff, to include agency staff. Education completed 6/21/23.

In the event of resident-to-resident abuse the perpetrator will be placed on a 1:1 monitoring until a medical/psychiatric evaluation can be completed to protect the victim and all other residents. The charge nurse on duty is responsible for assigning the 1:1 monitor. Charge nurses were notified of this responsibility on 6/22/23 by the Director of Nursing.

Effective 6/21/2023 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/23/2023

A credible allegation of immediate jeopardy removal was conducted in the facility on 06/28/23. The facility's current Abuse policy and procedure was reviewed, along with facility reported incidents in the last thirty days to ensure timely reporting. No additional concerns were noted. The education used to re-educate the facility staff was reviewed along with staff sign in sheets to confirm receipt of the education. Interviews with staff across the disciplines were conducted and staff were able to verbalize the steps they should take if they witness or suspect any type of abuse. The staff were able to verbalize that they must stop the abuse and stay with the resident providing protection from the abuse and then immediately report the abuse to the Administrator. The perpetrator is to be placed on one-on-one

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F 607	Continued From page 78 supervision immediately for the protection of other residents. The education was verified to be a part of the orientation program for all newly hired staff. The Administrator was able to verbalize his reporting requirements and time frames after becoming aware of any witness or suspected abuse in the facility. The facility's removal date of 06/23/23 was validated.	F 607		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		8/3/23

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including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;

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F 867	Continued From page 80 consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		

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F 867	Continued From page 81 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 09/14/22. This failure was for one deficiency that was originally cited in the area of Resident Rights (F580) that was subsequently recited on the current complaint investigation survey of 07/12/23. The repeat deficiency during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F580: Based on record reviews and staff and Physician interviews the facility failed to notify the Medical Director when a resident (Resident #9) experienced an acute change in condition on 06/13/23 as described by Nurse Aide (NA) #3 as restless, pale in color, struggling to breathe, and a change in urinary continence and as described by NA #4 as restless and up and down all night for 1 of 1 resident reviewed for notification of change. A few hours later Resident #9 was found slumped over in his wheelchair in cardiac arrest. Resident #9 expired in the facility on 06/13/23. During the recertification and complaint survey of 09/14/22 the facility failed to notify the Physician	F 867	F867 QAPI/QAA Improvement Activities 1. The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F580 on 7/25/23 2. Current residents are affected by the current deficiency. 3. The Regional Director of Operations educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI committee and the purpose of the Committee to include identifying issues and correct repeat deficiency related to F580 on 7/25/23. 4. On 7/25/23 the Regional Director of Operations educated the QAPI committee members consisting of the Medical Director, Administrator, Director of Nursing, Assistance Director of Nursing, Unit Manager, Dietary Manager, Director of Rehabilitation, Social Worker, Receptionist and HR Manager at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. QAPI Committee team members were educated on the meeting agenda, information each	

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of medication unavailability for 1 of 1 resident (Resident #38) reviewed for pain.

The Administrator was interviewed on 06/22/23 at 4:14 PM who stated that the QA committee met monthly and included all the department heads in the facility along with the consultant pharmacist who attended quarterly. The Administrator stated that he directed the meeting and followed an agenda that he had put into place. He stated that the committee would identify a goal and put a plan into place then discuss it until they achieved their desired results. The Administrator could not say if the facility currently had any performance improvement plans in place but stated that any repeat citations he received would be starting from scratch and building a plan, then monitoring the plan to achieve the compliance they desired.

F 867

individual is to provide, discussion, planning and the intent of the committee's meeting. In addition to the QAPI committee will continue to meet monthly.

5. The Quality Assurance Committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to the repeat deficiency. The monitoring procedure to ensure the plan of correction is effective and the specific cited deficiency remains correct and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility’s progress, review corrective actions and date of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training of other interventions.

6. Date of completion August 3, 2023.