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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite 07/11/23 through 07/12/23. Immediate Jeopardy at F600 was identified during the Quality Assurance review and the facility was notified of Immediate Jeopardy on 7/25/23. Therefore, the exit date was changed to 07/25/23. The following intakes were investigated: NC00204211, NC00204453 and NC00203814. Two of the three complaint allegations resulted in a deficiency. Intake NC00204211 resulted in Immediate Jeopardy. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J. The tag F600 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/11/2023

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

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, staff, Psychiatric Nurse Practitioner, Nurse Practitioner and Medical Doctor interviews, the facility failed to protect a resident-to-resident injury for 1 of 3 sampled residents reviewed for abuse (Resident #1). On 6/7/23, Resident #1 was punched in the face by Resident #2 causing multiple facial fractures and experiencing increased pain. After the incident Resident #1 was found curled up and crying, and stated he was afraid. Resident #1 was transported to the hospital for evaluation and was diagnosed with right zygomatic arch (bone that is on the outer part of the eye closest to the cheek), lateral (side) orbital wall (eye socket), and anterior (front) maxillary sinus (near the cheeks) fractures and returned to the facility on 06/8/23. Findings included: Resident #1 was admitted to the facility on 4/15/23 with diagnoses that included a disabling disease of the brain and spinal cord (central nervous system), cognitive communication deficit, Alzheimer's disease with late onset, dementia with other behavior disturbance. Review of Resident #1's behavioral care plan dated 04/28/23 revealed he had behaviors related to aggression in the past. Interventions included behavioral outbursts would be minimized and or managed through the next review. The resident or staff would not be injured through the next review. The staff should try to determine the reason for the exacerbation of the Resident #1's behavior if possible and to adjust their approach	F 600	Past noncompliance: no plan of correction required.	

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as appropriate. The staff would remove the resident from other residents as needed. The staff would set and enforce limits on Resident #1's behavior when appropriate. The staff would assist the resident to avoid situations that may cause anger or increased anxiety. The staff would notify the physician and implement orders as appropriate.

The quarterly Minimum Data Set (MDS) dated 5/19/23 revealed the Resident #1 was severely cognitively impaired and had no behaviors during the assessment period. Resident #1 needed extensive assistance with bed mobility and transfers and total assistance with eating and toileting.

A review of Resident #1's nursing note dated 6/7/2023 at 6:52 PM revealed the resident was sent out to the Emergency Department (ED) at 5:45 PM after being struck in the face by another resident. His nose was actively bleeding, and his right eye was puffy and beginning to bruise. Resident #1 returned from the ED at 3:56 AM. On report that was called to the facility from the hospital revealed the ED Doctor stated to follow up with Ear, Nose, and Throat (ENT).

A Computed Tomography (CT) without contrast scan (an x-ray machine that takes several images of bones, blood vessels, and soft tissues that a computer makes into a digital image) completed at the hospital on 6/7/23 revealed Resident #1 had several facial fractures that did not require surgery for repair.

Record review of Resident #1's hospital discharge summary dated 6/7/23 revealed Resident #1 was transported to the hospital for

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evaluation after being hit in the face by his roommate. Resident #1 diagnosed with a right zygomatic arch, lateral orbital wall, and anterior maxillary sinus fractures and returned to the facility on 06/8/23.

Resident #1 was unable to be interviewed due to his cognition. An attempt was made to interview Resident #1 on 7/12/13 at 1:15 PM but he was unable to participate due to his severely impaired cognition.

Resident #2 was admitted to the facility 3/26/22 with diagnosis that included other frontotemporal neurocognitive disorder (The result of damage to neurons in the frontal and temporal lobes of the brain), vascular dementia with other behavioral disturbances, unspecified mental disorder due to known physiological condition, and anxiety disorder.

Review of the behavioral care plan dated 3/16/23 revealed Resident #2 had behaviors related to him being incarcerated which caused insecurities, hoarding, trust problems, as well as anger and aggression. The goals included Resident #2's behavioral outburst will be minimized and or managed through the next review. The resident or staff will not be injured through the next review. The interventions included staff trying to determine the reason for Resident #2's exacerbation of behavior if possible and adjust as appropriate. The staff will remove Resident #2 from other residents as needed. The staff will set and enforce limits on Resident #2' behavior when appropriate. The staff will assist Resident #2 to avoid situations that may cause anger or increase anxiety.

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F 600	Continued From page 4 The quarterly MDS dated 5/5/23 revealed Resident #2 was severely cognitively impaired and had no behaviors during the assessment period. He needed supervision only for bed mobility and transferring. He was coded as receiving an antidepressant 7 of 7 days during the assessment period, and he was ambulatory with the use of a cane. Resident #2 discharged from the facility on 06/07/23 and was unable to be interviewed. A review of Resident #2's change in condition form dated 6/7/23 revealed in part: Send to ED for evaluation. A review of Resident #2's hospital admission summary dated 6/8/23 revealed in part: Resident #2 was admitted with a history of major neurocognitive disorder followed by Neurology, who presented to the ED with a several week history of increased aggression. A Nurse Practitioner progress note dated 6/8/23 revealed in part Resident #1 was seen for an acute visit regarding a complaint of acute pain and noted in part, Resident #1 was reportedly attacked by his roommate yesterday (Resident #2) evening (06/07/23) resulting in multiple facial and nasal fractures. Resident #1 was evaluated in the Emergency Room (ER) and discharged back to the facility. He was started on Tylenol and Oxycodone (pain medication) with a referral to an Ear, Nose & Throat (ENT) Specialist for further evaluation and management of fractures. An interview on 7/11/23 at 1:51 PM with Nurse Aide (NA) #1 who was present and responsible for the room of Resident #1 and Resident #2 on	F 600		

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6/7/23 revealed when she walked in with the dinner tray, she saw Resident #1 lying in bed and Resident #2 was standing next to him between both beds. She noticed some blood from Resident #1's nose and reported this to Nurse #1 who went in to assess Resident #1. NA #1 stated she never saw the altercation between Resident #1 and Resident #2. NA #1 stated she had no concerns about behaviors from Resident #1.

A phone interview on 7/12/23 at 10:10 AM with Nurse #1 who was Resident #1's Nurse on 6/7/23 revealed NA #1 told her she thought Resident #2 had hit Resident #1 because Resident #1 had a nosebleed. Nurse #1 assessed Resident #1 and he had a little bit of a nosebleed. She recalled another Nurse brought her an ice pack and a washcloth for Resident #1's face. The curtain between Resident #1 and Resident #2 was drawn, and Resident #2 started rambling like "you know you deserved it". Nurse #1 had staff at the desk get the Unit Manger. Upon assessment, Nurse #1 stated there was no redness present upon her initial assessment of Resident #1. Resident #1 was "whimpering and holding his face," but couldn't tell her what happened. The Unit Manager and the Social Worker took care of removing Resident #2 from the room and calling Adult Protective Services (APS), the Police and both Resident's Responsible Parties. Nurse #1 stated she had not worked with Resident #2 often but there were no concerns regarding aggression when she worked with him that day. Nurse #1 stated she had no concerns about Resident #1's behavior but, Resident #1 had attempted to get out of the bed even though he was unable to do so without assistance.

An interview on 7/12/23 at 9:45 AM with the Unit

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Manager revealed on 06/07/23 he was in his office and staff came to him and stated they thought Resident #2 hit Resident #1 because his nose was bleeding. The Unit Manager went into the room and asked Resident #2 about the incident and saw Resident #1's face was swollen. Resident #2 told him he did hit Resident #1. Resident #1 was curled up and crying and stated he was afraid. The ambulance came to the facility and transported both Resident #1 and Resident #2 to the hospital, Resident #2 for a psychiatric assessment and Resident #1 for treatment. The Unit Manager stated Resident #2 was discharged from the hospital and admitted to a new facility with a locked dementia unit. There were no concerns about Resident #2 prior to this event and no indicators of different behavior that day. The Unit Manager revealed he had no concerns about Resident #1's behavior.

An interview with the Director of Social Services on 7/12/23 at 12:12 PM revealed on 06/07/23 she came around to do her daily room checks and saw the nurses were assessing Resident #1 and he was in the bed moaning. She stated you could tell he was in pain. She and the Unit Manger took Resident #2 to the administrator's office and Resident #2 went willingly. The Social Worker was unaware of any concerns about Resident #2's behavior prior to this incident. She had no concerns about the behavior of Resident #1 and Resident #1 rarely spoke.

An interview on 7/11/23 at 2:33 PM with the Administrator revealed prior to the incident on 06/07/23 she did not have any concerns that would have led her to believe Resident #2 would have acted out physically to another resident. She recalled Resident #2 was very protective of

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F 600	Continued From page 7 Resident #1 checking on him throughout the day. The Administrator explained Resident #2 would have verbal tiffs with other residents, but nothing that had ever resulted in injury and Resident #2 had no physical altercations or behaviors that would have led the staff to believe he would hurt someone else. Upon his discharge from the hospital, Resident #2 was moved to their sister facility where there were individual rooms and a locked dementia unit. She further stated she had no concerns regarding any behaviors from Resident #1. On 7/11/23 at 12:12 PM an interview with the Psychiatric Mental Health Nurse Practitioner revealed Resident #2 would not be competent enough to explain why the incident with Resident #1 happened. He recalled, when Resident #2 got agitated one time before and brushed someone with a cane, he stated to Psychiatry Staff that he did not hit anyone and was just moving them out of his way. He further stated Resident #2 was intentional with hitting Resident #1; however, Resident #2 was not mentally competent to recall his actions or the consequences of them. Resident #2 was usually calm, and the facility gave him a greeter job and he spent a lot of time with the Administrator. An interview on 7/12/23 at 2:36 PM with the Nurse Practitioner (NP) revealed she was informed about the incident on 06/07/23 between Resident #2 and Resident #1 and saw Resident #1 on 6/8/23. The NP stated in her medical opinion this incident had caused Resident #1 harm. She stated there were no indications that Resident #2 would be physically aggressive with anyone, this was the first incident she was aware of. The only behavior Resident #1 displayed was	F 600		

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a lack of safety awareness. Resident #1 was bed bound and significantly cognitively impaired.

An interview on 7/12/23 at 3:48 PM with the Medical Director (MD) revealed he was informed about the incident on 06/07/23 between Resident #1 and Resident #2 and saw Resident #1 after his return from the hospital on 6/8/23. The MD stated in his medical opinion the incident had caused harm to Resident #1. He stated he wasn't aware of any behavior and never would have expected Resident #2 to become physically violent with anyone prior to that day. The MD further stated he never saw Resident #1 agitated only laying in the bed or in the chair in the hall sleeping. He stated he never saw Resident #1 get up or really move or do anything.

The Administrator was notified of the Immediate Jeopardy on 7/25/23 at 11:19 AM.

The facility provided the following Corrective Action Plan with a completion date of 6/8/23.

1) On 6/7/23, Resident #2 was observed by a staff member standing over his roommate Resident #1 who was lying in bed on his left side, with both fists out. Staff immediately removed Resident #2 from roommate, Resident #1, and placed on 1:1 staff supervision. Nurse was alerted and completed resident assessment and first aid to roommate and notification to MD with orders to send Resident #2 to ER for psych evaluation related to danger to others. Administration notified and made appropriate calls to police, resident representatives, APS and 2-hour NC State report submitted, and investigation initiated to include staff and resident interviews.

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F 600	Continued From page 9 Resident #2 is a long-term care resident who was admitted to the facility on 3/26/23 with the primary diagnosis of frontotemporal neurocognitive disorder and secondary diagnosis of vascular dementia with behavioral disturbances and unspecified mental disorder due to known physiological condition. On 5/4/23 his BIM score was a 4 (severely impaired). He receives ongoing psych services and was last seen on 5/23/23 for a medication review in which no changes were made and remains on Aricept for dementia, Trazadone for agitation and Keppra for seizure disorder. Resident has a history of verbal and physical aggression towards others and care plan includes interventions; allowing resident to express concerns and provide follow-up to resolve issues, try to determine reason for exacerbation of behavior if possible and adjust as appropriate, remove residents from other residents as needed, set and enforce limits on behaviors when appropriate, assist resident to avoid situations that may cause anger or increased anxiety, administer medications as ordered, evaluate effectiveness of medications and side effects, do not argue with resident, give praise and/or positive feedback for attempts of socially acceptable/adaptive behaviors, notify physician and implement orders as appropriate, notify family as appropriate and psych services as appropriate. 2) Because all residents are at risk from being physically abused by other residents, the following plan has been formulated to address this issue: On 6/7/23 at 6:30 PM, Resident #2 was placed on 1:1 staff supervision and assessment completed	F 600		

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F 600	Continued From page 10 by the licensed nurses with no apparent injuries until transferred to the ER at 7:15 PM for psych evaluation. On 6/7/23, the Administrator and Director of Nursing (DON) notified the Vice President (VP) of Clinical Services and VP of Operations to discuss incident, investigative protocol and corrective action to address incident and prevent any further incidence to other residents at risk. A follow-up call was held the following morning on 6/8/23 at 10:00AM to further discuss investigation, root cause analysis and corrective plan. On 6/8/23, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by facility Interdisciplinary Team (IDT) including the Medical Director, VP of Clinical & QAPI and VP of Operations to review the behavioral management policy to ensure the policy was followed and that it included appropriate strategies to identify and manage residents' with behaviors toward others. A review of the Abuse Policy and of the facilities previous F600 Abuse citations and corrective action plans were also reviewed for the 2/25/22 complaint survey and 6/1/22 recertification survey and it was determined that the facility followed the corrective plans and that the 6/7/23 incident would require additional action plans based on different root cause of a resident-to-resident abuse incident. The QAPI committee thoroughly discussed the incident on 6/7/23 and developed an immediate action plan based upon root cause analysis to address and remove immediate and future risk potential. Based upon root cause analysis the IDT determined that the Behavior Management Policy and Abuse Policy was followed and Resident #2's behavior was	F 600		

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F 600	Continued From page 11 unpredictable and likely associated with his medical diagnosis of frontotemporal neurocognitive disorder, vascular dementia with behavioral disturbances and unspecified mental disorder due to known physiological condition and furthermore, unavoidable. Resident #2's care plan was also thoroughly reviewed and determined appropriate. 3) On 6/8/23, the Administrator and Director of Nursing were educated by the VP of Clinical & QAPI on the Behavior Management policy and prevention and response to residents with aggressive behaviors and emergency situations such as physical abuse of residents. Education included strategies for prevention of resident abuse and identifying the likelihood based upon resident assessments, any exhibited behaviors, triggering and alleviating factors. Beginning 6/8/23, current facility and agency staff on each shift, including Nursing, Activities, Social Work, Dietary, housekeeping and maintenance, were educated by the DON on F600 and the Prevention of Abuse or/and Neglect. The education will be communicated verbally and telephonically by the DON or SDC. Written education will be available for review prior to the staff member working their assigned shift. The Staff Development Coordinator (SDC) will utilize a master employee list to track 100% completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff. Beginning 6/8/23, all current facility and agency staff will be educated by the DON on the facility behavioral management policy to include managing resident behaviors and prevention of	F 600		

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F 600	Continued From page 12 resident-to-resident altercations. This will include identifying contributing factors such as situational, physical environment, and organizational factors. An emphasis will be placed upon ensuring supervision of residents to aid in preventing physical assault between residents. If the resident is displaying aggressive behaviors towards others, the resident will be monitored closely which will include 1 to 1 observation if the resident continues to have behaviors. If the resident continues to have aggressive behaviors towards others despite facility interventions, the facility will transfer the resident to the hospital for an immediate psychological evaluation to protect risk to others. The education will be communicated verbally and telephonically by the DON or SDC. Written education will be available for review prior to the staff member working their assigned shift. The SDC will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff. On 6/8/23, the Director of Nursing completed an audit for F600 via abuse questionnaire with cognitively intact residents and the Licensed Nurses completed body audits on cognitively impaired residents to ensure other residents are free from abuse, including resident-to-resident. No additional concerns identified. On 6/8/23, the IDT reviewed current facility residents with aggressive behaviors or a risk for aggressive behaviors towards others to ensure appropriate care plans are in place and that they are not placed together as roommates. This review included residents with risks for poor impulse control and/or a history of aggression	F 600		

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towards others and of residents involved in resident-to-resident altercations, all current residents with traumatic neurological disorders. All identified residents care plans were reviewed and determined appropriate.

4) Effective 6/8/23, the IDT will complete ongoing weekly risk meeting to discuss residents with aggressive behaviors to ensure the effectiveness of the residents' plan of care to prevent resident abuse.

Effective 6/8/23, the facility Administrator, Director of Nursing, Social Worker or SDC will perform facility tours (including off shifts and weekends) 5 times weekly to observe any residents with behaviors and appropriate staff supervision and response to any behaviors. Additionally, the Administrator and Director of Nursing will monitor daily staffing levels to ensure adequate supervision to prevent resident abuse.

Effective 6/8/23, the facility Administrator or DON will conduct questionnaires weekly with a minimum of 5 Licensed Staff and Nurse Aides to validate understanding of how to appropriately identify, prevent and respond to residents with physical behaviors.
Effective 6/8/23, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this corrective plan.

Date of Completion: 6/9/2023

The Corrective Action plan was validated on 07/12/23 and concluded the facility had implemented an acceptable corrective action plan on 06/09/23. Interviews with staff members over various shifts and positions revealed they were

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F 600	Continued From page 14 educated on abuse regarding what abuse looks like, who to call, and what interventions should be in place, such as separate the residents, don't leave them alone, and call for help. Review of the audits and monitoring tools revealed they were completed as outlined in the corrective action plan with no concerns identified.	F 600		
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, including the methodology and frequency for such	F 867		8/9/23

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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; consider the incidence, prevalence, and severity

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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;
(iii) Regularly review and analyze data, including

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F 867	Continued From page 17 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 review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following a complaint investigation survey completed on 03/03/22 and a recertification, revisit and complaint investigation survey completed on 06/01/22. This failure was for one deficiency originally cited in the area of Free from Abuse and Neglect on 03/03/22, recited on 06/01/22 and subsequently recited during a revisit and complaint investigation completed 07/12/23. This continued failure during three 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 referenced to: F600: Based on observation, record review and resident, staff, Psychiatric Nurse Practitioner, Nurse Practitioner and Medical Doctor interviews, the facility failed to protect a resident-to-resident injury for 1 of 3 sampled residents reviewed for abuse (Resident #1). On 6/7/23, Resident #1 was punched in the face by Resident #2 causing multiple facial fractures and experiencing increased pain. Resident #1 was transported to the hospital for evaluation and was diagnosed with right zygomatic arch (bone that is on the outer part of the eye closest to the cheek), lateral (side) orbital wall (eye socket), and anterior (front)	F 867	1) Facility failed to ensure compliance with Quality Assurance and Performance Improvement prevention of previous facility citations. On 7/12/2023, revisit and complaint survey was conducted in facility and F600 was cited at past non-compliance. Facility has had previous F600 citations within the last 3 years. On 6/7/23 at 6:30 PM, Resident #2 was placed on 1:1 staff supervision and assessment completed by the licensed nurses with no apparent injuries until transferred to the ER at 7:15 PM for psych evaluation. Resident #2 no longer resides at the facility. 2) Residents currently residing in the facility are at risk. Therefore, on 6/8/23, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by facility Interdisciplinary Team (IDT) including the Medical Director, VP of Clinical & QAPI and VP of Operations to review the behavioral management policy to ensure the policy was followed and that it included appropriate strategies to identify and manage residents' with behaviors toward others, as well as appropriate room placement. A review of the Abuse Policy and of the facilities previous F600 Abuse citations and corrective action plans were also reviewed for the 2/25/22 complaint survey and 6/1/22 recertification	

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maxillary sinus (near the cheeks) fractures and returned to the facility on 06/8/23. As a result, Resident #1 voiced feeling "fearful" of his roommate, Resident #2. Resident #1 curled up in a ball and was afraid.

During the complaint investigation survey of 03/03/22, the facility failed to implement effective interventions to protect a resident from an unintentional overdose.

During the recertification, revisit and complaint investigation survey of 06/01/22, the facility failed to assess a resident for a fever after he voiced complaints of burning up during the night, failed to obtain vital signs before sending the resident to dialysis, failed to assess and give the resident any medication for fever upon his return to the facility from dialysis, and failed to allow the resident to wait inside the facility for transport to the hospital.

During a telephone interview on 07/25/23 at 11:19 AM, the Administrator stated following the incident with Resident #1 and Resident #2 on 06/07/23, the facility completed a root cause analysis which included implementing an internal plan of correction to prevent recurrence. She stated as part of the process, they had also discussed the previous deficiencies cited for Abuse and Neglect. The Administrator explained the previous deficiencies were both for incidents unrelated to the deficiency on the current survey that involved resident-to-resident abuse and she felt the plans of correction and measures the facility had implemented to correct the previous deficiencies were followed and effective.

F 867

survey and it was determined that the facility followed the corrective plans and that the 6/7/23 incident would require additional action plans based on different root cause of a resident-to-resident abuse incident. The QAPI committee thoroughly discussed the incident on 6/7/23 and developed an immediate action plan based upon root cause analysis to address and remove immediate and future risk potential.

3) The following measures have been put into place to ensure the deficient practice does not recur. On 8/9/23, the Vice President of Clinical and QAPI, provided education to the Administrator and Director of Nursing on the importance of maintaining an effective QAPI program and the necessary components, to prevent repeat citations. On 8/9/2023, the Administrator and Director of Nursing provided education to the interdisciplinary team on maintaining an effective QAPI program to prevent repeat citations. Effective 8/9/23, the facility IDT will meet weekly for twelve (12) weeks to review results of ongoing monitoring tools to ensure the current plan is effective. Changes will be made to the plan if compliance is not being maintained per corrective plan.

4) The Vice President of Clinical and QAPI or a Director of Clinical Services will attend QAPI meetings monthly for three (3) months to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat

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F 867	Continued From page 19	F 867	citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAA improvement activities. Completion Date: 8/9/23	