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F 000	INITIAL COMMENTS	F 000		

A complaint investigation survey was conducted onsite from 07/31/24 through 08/02/24. Additional information was obtained remotely on 08/05/24. Therefore, the exit date was changed to 08/05/24. Event ID # 5TW911. The following intakes were investigated: NC00210098, NC00211852, NC00212799, NC00217653, and NC00219375. 2 of the 9 complaint allegations resulted in deficiency. Intakes NC00212799 and NC00210098 resulted in immediate jeopardy.

Past Non-Compliance was identified at:

CFR 483.12 at tag F600 at a scope and severity (K)
CFR 483.12 at tag F607 at a scope and severity (K)

The tags F600 and F607 constituted Substandard Quality of Care.

Noncompliance began on 11/17/23 and the F600 and F607 deficiencies were corrected on 11/21/23.

A partial extended survey was conducted.

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F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

§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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/22/2024

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
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 record review and staff interviews the facility failed to protect residents' right to be free from physical abuse perpetrated by Nurse Aide (NA) #2. On the evening of 11/17/23, NA #1 heard a "slapping sound" when 3 nurse aides were providing care. NA #1 turned around and asked NA #2 what happened. NA #2 stated she "popped" Resident #3 on the nose. During the day shift while two aides were providing care on 11/18/23, NA #1 observed NA #2 slap Resident #4 on the face. Resident #4 put her hand to her cheek and had a look of disbelief and shock after she was slapped. During the day shift, 15 minutes later, on 11/18/23 while two nurse aides were providing care, NA #3 observed NA #2 "pop" Resident #6 in the mouth two times. Due to the physical abuse a reasonable person would have experienced intimidation and fear. This was for 3 of 4 residents (Resident #3, #4 and #6) reviewed for abuse.

Findings included:

A summary of the 5 day investigation report submitted to Department of Health and Human Services (DHHS) completed by the Administrator dated 11/23/23 revealed "Nurse Aide [#2] was rough with multiple residents during care.

a. Resident #3 was admitted to the facility on

F 600

Past noncompliance: no plan of correction required.

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04/03/23. Diagnoses included Alzheimer's Disease, vascular dementia with mood disturbance and anxiety.

The Minimum Data Set (MDS) quarterly assessment dated 10/18/23 revealed Resident #3 was severely cognitively impaired. He demonstrated physical behaviors toward others 4-6 days and verbal behaviors directed toward others 1-3 days during this assessment period.

A care plan dated 10/18/23 was in place for psychotropic medication use and resistance to care at times related to Alzheimer's/dementia with mood disturbance and anxiety. Interventions included, in part, to monitor and record reoccurrence of target behavior symptoms, violent aggression towards staff/others.

A witness statement (undated) by Nurse Aide (NA) #1 revealed "on Friday, 11/17/23 at dinner time, me, [NA #2] and [NA #4] went in to provide [activity of daily living] (ADL) care to [Resident #3] on the memory care unit. We were changing him and his bed linens. [Resident #3] became combative, which is his normal response to ADL care. During the care, he hit me in the chest and I responded by raising my voice telling him to stop hitting me. I was holding his hands so he would not hit me or the other caregivers when he attempted to kick us. He was also trying to pull my hands to his mouth so that he could bite me. I do understand that due to his cognitive level he cannot help that he is combative during ADL care. After we got him changed and ready for dinner, I was over by the little area by the doorway looking down getting the laundry and trash ready to take out, when I heard a slapping noise. When I asked what happened [NA #2] responded with "I

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F 600	Continued From page 3	F 600		

popped him on the nose." I asked, "Why would you do that?" and [NA #2] giggled. Then we all left the room."

A phone interview was conducted with Nurse Aide (NA) #1 on 07/31/24 at 3:30 PM. NA #1 reported on 11/17/23, she and NA #2 and NA #4 were providing care for Resident #3 who resided on the memory care unit at about 6:00 PM. She stated Resident #3 had become combative which was a normal behavior for him during care and he hit her in the chest. NA #1 stated she said in a louder voice, but not yelling, to Resident #3 to stop hitting her. NA #1 stated she guided his hands so that he would not hit her or the other caregivers and he began to attempt to kick the three of them while trying to put her hand in his mouth with an attempt to bite her hand. NA #1 stated we had finished getting Resident #3 cleaned up and dressed and she had turned her back to pick up the trash and heard a "slap" sound. NA #1 described the sound as a slapping sound someone would hear when slapping bare skin with an open hand. She turned and asked NA #2 what happened and NA #2 stated she "popped" Resident #3 on the nose. NA #1 stated she asked NA #2 why she would do that and told her she should not do that. NA #1 stated NA #2 giggled. NA #1 reported Resident #3 did not seem bothered that he had been slapped on his nose. NA #1 stated at the time, she did not know if maybe she was over reacting in thinking that this was actual abuse and since she was not certain that this was abuse, she did not notify the nurse regarding this incident. NA #1 stated, in looking back, she should have reported that she heard NA #2 slapping Resident #3 and report what NA #2 said she did to Resident #3 on 11/17/24 because the incidents that occurred

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F 600		F 600		

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afterwards with Resident #4 and Resident #6 may not have happened.

A witness statement dated 11/20/23 by Nurse Aide #2 revealed "Friday, 11/17/23 right before dinner [NA #1], [NA #4] and I went to get [Resident #3] of the memory care unit ready for dinner. We were providing ADL care when [Resident #3] hit [NA #1] in the chest to which she responded by yelling "Stop hitting me!" I touched him on the nose and told him "We do not hit women!"

An interview was attempted by the surveyor with NA #2 via phone and text messages on 07/31/24 and 08/01/24. NA #2 did not return the phone calls or respond to the text messages.

A witness statement dated 12/12/23 by Nurse Aide #4 revealed "On 11/17/23 around 6:00 PM, [NA#1], [NA #2] and I went in to provide ADL care for [Resident #3]. He was combative during care which is his normal behavior. Once we had finished his care, [NA #1] was getting the trash up, I was getting the linens, and [NA #2] was over by [Resident #3]. I saw [NA #2] pop [Resident #3] on the nose and tell him we do not hit women. [NA #1] said "Oh my God, we do not do that!" to [NA #2]. We all left the room together."

An interview was attempted with NA #4 on 07/31/24 and 08/01/24 via phone and text messages. NA #4 did not return the phone calls or respond to the text messages.

b. Resident #4 was admitted to the facility on 11/06/19 and expired on 01/09/24. Diagnoses included Alzheimer's Disease, dementia with

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behavioral disturbance, and anxiety.

The MDS quarterly assessment dated 10/09/23 revealed Resident #4 was moderately cognitively impaired and exhibited no behaviors. She had impairment to both sides to her lower extremities and used a wheelchair

A review of the care plan updated on 10/09/23 revealed a plan of care was in place for requiring assistance with ADLs due to impaired mobility and impaired cognition secondary to Alzheimer's and dementia. Resident is combative and resistant to care and refuses medications. Interventions included to encourage the resident to help with ADLs as able, provide simple tasks, and simple cueing/instructions and speak slowly and clearly, assure safe environment, and allow time for the resident to calm down during increased agitation and approach later to provide needed care. A plan of care was in place for Alzheimer's / dementia and the potential to feel confused, restless, and irritable. Resident resists care, can be combative and scream and have aggression. Interventions included intervening as necessary to protect the rights and safety of resident and others, approach/ speak in a calm manner, and divert attention. Monitor behavior episodes and attempt to determine underlying cause.

A witness statement by NA #2 dated 11/20/23 revealed "[Resident #4] a resident of the memory care unit was to be given a bed bath. I asked [NA #1] to help me with her bath. When we go in to start the bed bath, I realized I had forgotten the supplies and asked [NA #1] to get them. [NA #1] returned with the supplies and then left to go help the nurse with another resident.

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F 600	Continued From page 6	F 600		

A statement written by the Administrator on 11/20/23 revealed, in part, video camera footage was reviewed of Resident #4's room from 11/18/23. The video camera footage revealed NA #1 was in Resident #4's room for 8 minutes.

An interview was attempted with NA #2 via phone and text messages on 07/31/24 and 08/01/24. NA #2 did not return the phone calls or respond to the text messages.

A witness statement (undated) by NA #1 revealed "on Saturday 11/18/23 at approximately 1:45 PM, I was asked by [NA #2] to help with a bed bath for [Resident #4], resident on memory care unit. When I came into the room, [NA #2] said she forgot the linens and asked me to get them and she would prepare for the bed bath we were about to give. [Resident #4] is 'feisty" as she punches and hits staff during care because she does not like to be naked. [NA #2] was saying to her "calm down, you do not want to stink, do you?" At that time, [Resident #4] was punching and hitting [NA #2], and in turn, [NA #2] smacked [Resident #4] on the cheek. [Resident #4]'s reaction was one of disbelief and she reached up and put her hand on her face where [NA #2] smacked her. [NA #2] was on the door side of the bed and I was on the window side of the bed facing each other. I told [NA #2] "do not hit my resident and knock it off" and then [NA #2] giggled. I then left the room, leaving [NA #2] in the room because I felt uncomfortable."

A phone interview was conducted with Nurse Aide (NA) #1 on 07/31/24 at 3:30 PM. NA #1 reported on 11/18/23 she was asked by NA #2 to assist with giving Resident #4 a bed bath who resided

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F 600	Continued From page 7 on the memory care unit. NA #1 stated while assisting Resident #4 with her bath she had become "feisty" as she does and was punching and hitting NA #2. NA #2 was telling Resident #4 to calm down. NA #1 stated at that time Resident #4 was punching and hitting NA #2 and NA #2 smacked Resident #4 on the cheek with an opened hand. NA #1 stated Resident #4 put her hand to her cheek and was shocked that she just got smacked. NA #2 described Resident #4's expression of shock as opening her eyes and mouth open wide while her hand was on her cheek. NA #1 stated she did not see any red marks on her face, but she stated to NA #2 "do not hit my resident and to knock it off." NA #1 stated she left the room and left NA #2 alone with Resident #4 because she was uncomfortable with being in NA #2's presence. NA #1 stated, in looking back, she should not have left NA #2 alone with Resident #4. NA #1 added, she did not react the right way and should have ensured that Resident #4 was safe and protected instead of leaving her alone with NA #2. c. Resident #6 was admitted to the facility on 02/25/22. Diagnosed included Alzheimer's disease, dementia with behavioral disturbance, and psychosis. The MDS quarterly assessment dated 10/24/23 revealed Resident #6 was severely cognitively impaired. She demonstrated physical behaviors directed toward others 1-3 days, verbal behavior directed toward others 1-3 days, other behaviors not directed toward others 1 -3 days, and wandering 1-3 days during this assessment period.	F 600		

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A review of Resident #6's care plan dated 10/23/23 revealed a plan of care for impaired function/thought processes secondary to Alzheimer's/dementia and psychosis. She can be irritable, suspicious of taking medications, short tempered, easily annoyed and physically aggressive with care. Interventions included cue, reorient, and supervise as needed, engage the resident in simple, structured activities that avoid overly demanding tasks, evaluate for situational stressors, have another staff member attempt, or try at a later time when being resistive/combative with care.

A witness statement dated 11/24/23 by Nurse Aide #3 revealed "During the last round about 2:00 PM on 11/18/23, I witnessed [NA #2] pop [Resident #6] on the mouth. We were standing on both sides of her at the end of her bed to provide needed care. [Resident #6] was standing during the care at first, but then she sat on the bed so we could change her pants. [NA #2] had a hold of her hands while I was providing care so that she would not hit us. She started to look like she was going to spit on us, [NA #2] saw this also. At that point, [NA #2] popped her mouth like to tell her "no." [Resident #6] called her the "N" word then [NA #2] popped her mouth again. [NA #2] did not just cover her mouth; she popped her mouth 2 different times, like you would pop a kid's hand who was doing something wrong."

An interview was attempted with NA #3 via phone and text messages on 07/31/24 and 08/01/24. NA #3 did not return the phone calls or respond to the text messages.

A witness statement by Nurse Aide #2 dated 11/20/24 revealed "[Resident #6] resident of the

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memory care unit had wet pants during our last round of the day. [NA #3] asked me to help change her. [Resident #6] was yelling at us but she sat willingly on the edge of the bed. [Resident #6] spat on me, and I covered her mouth with my hand which caused her to try and bite me. I removed my hand and she attempted to spit on me again, and I covered her mouth again and told her "keep your spit in your mouth, that is nasty!" I was upset and had a right to be mad with her spitting on me; it would make anybody feel "some kind of way."

An interview was attempted with NA #2 via phone and text messages on 07/31/24 and 08/01/24. NA #2 did not return the phone calls or respond to the text messages.

A phone interview with NA #1 via phone on 07/31/24 at 3:30 PM revealed she had spoken to NA #3 regarding what she had observed NA #2 with Resident #3 and Resident #4 on 11/18/23 at the end of their shift. NA #1 stated NA #3 reported to her what she had witnessed with NA #2 and Resident #6. NA #1 stated NA #3 had witnessed abuse too. NA #1 stated she had to let Nurse #1 know because there were just too many observations that abuse happened.

A phone interview was conducted with Nurse #1 on 08/01/24 at 10:00 AM. Nurse #1 reported she did not recall being made aware of the alleged abuse allegation of NA #2 with Resident #6, but that it was a long time ago.

An interview was conducted with the Director of Nursing (DON) on 08/02/124 at 2:00 PM. The DON reported she did not know why Nurse Aide #2 would hit any resident. She stated all nursing

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staff had been educated on how to take care of dementia residents when the residents became combative or uncooperative. She stated hitting a resident due to their uncooperative behavior was not acceptable.

An interview was conducted with the Administrator on 08/02/24 at 2:10 PM. The Administrator reported he did not know why Nurse Aide #2 would hit any resident. He stated he did not feel that Nurse Aide #2 was having burn out from being on the memory care unit too long and he added, NA #2 was properly trained on providing care to dementia residents and aware of the abuse policy and procedure.

The Administrator was notified of immediate jeopardy on 08/02/24 at 12:25 PM.

The facility provided the following corrective action plan with a completion date of 11/21/23.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 11/18/23, Nurse Aide (NA) #2 was suspended and told to not return to work until the investigation was complete. On 11/18/23, all affected residents (Residents #3, #4, #6) were immediately physically assessed for any signs of injury with no findings noted by the hall nurse. On 11/18/23, adult protective services was contacted at 9:07 PM and the local police were contacted at 9:07 PM by the Administrator. The affected residents' responsible parties were contacted on 11/19/2023 by the hall nurse. The physician was contacted on the night of 11/18/23 by the hall nurse regarding the affected residents. No new

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orders were received from the physician. On 11/20/23, the social worker interviewed the affected residents to assess their psychosocial well-being and no changes in mood or behavior were noted.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents that reside on the neighborhood where the allegations were stated to have occurred were assessed for any signs of injury by a licensed nurse beginning on 11/18/23 and completed on 11/19/23 with no negative findings. The NA #2 was suspended on 11/18/2023 and had no contact with residents after that day. NA #2's permanent assignment was on the memory care unit but there were times she had worked on other assignments in the past. Every resident on the other neighborhood had a skin assessments with no negative findings since her last worked shift off memory care on 10/31/23. The facility interviewed all alert and oriented residents of that neighborhood on 11/20/23 with no negative findings.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 11/18/23, all staff were reeducated on the Lutheran Services Carolinas policy, Abuse Investigation and Reporting for Senior Services by the Administrator and charge nurse. This policy includes specific language related to how to report suspected abuse or mistreatment and what constitutes abuse, neglect, misappropriation of property and injury of unknown origin. This

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policy also addresses the protection of residents during an investigation by stating individuals employed by the facility will be suspended, pending results of investigation. This education was completed for all staff on 11/18/23, and staff not educated on this date were in-serviced prior to working their next shift by the staff development coordinator, charge nurse for the unit, or administrator. This education is included in the orientation for all new staff and will be repeated at least annually during the annual skills fair and as needed.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

Beginning November 18, 2023, the Administrator, Director of Nursing, and/or designee will monitor at least ten staff/resident interactions per week for one year using the form titled, "Staff/Resident Interaction Form." This monitoring will include interviews with residents, staff, and/or family members as well as observations. Any concerns identified will immediately be addressed by the Administrator.

The plan of correction will be discussed at the next quarterly Quality Assurance Performance Improvement meeting. After that meeting, any negative outcomes will be reviewed with the leadership team in future quarterly Quality Assurance Performance Improvement meetings.

The immediate jeopardy was removed on 11/21/23 and the plan of correction was

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F 600	Continued From page 13 completed on 11/21/23. The Corrective Action Plan was validated on 08/02/24. Interviews with the nursing staff, environmental staff, dietary staff, and administrative staff were conducted and confirmed that education was provided regarding what constitutes abuse, neglect, misappropriation of property and injury of unknown origin. Education was also provided regarding protecting the residents' right to be free from abuse. A review of the audits to monitor the facilities performance to make sure that solutions are sustained included review of the form titled, "Staff/resident interaction form." This form was completed weekly since 11/18/23 to include 10 staff members per week were observed interacting with residents. The completion date of 11/21/23 for the corrective action plan 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		

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F 607	Continued From page 14 §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 record review and staff interviews the facility failed to identify and report abuse on 11/17/23 in the Alzheimer's unit when NA #1 heard a "slapping sound" while NA #1, NA #2, and NA #4 were providing care to Resident #3. NA #1 heard a "slapping" sound and turned around and asked NA #2 what happened. NA #2 stated she "popped" Resident #3 on the nose. NA #1 stated she did not know if what she witnessed was actual abuse and did not report it to Nurse #1 until 11/18/23. The facility failed to protect other residents from physical abuse perpetrated by Nurse Aide (NA) #2 on 11/18/23 when NA #1 and NA #3 failed to report physical abuse to the nurse on the evening of 11/17/23 for Resident #3 and not until 4:00 PM on 11/18/23 for Resident #4 and Resident #6. On 11/18/23, NA #1 and NA #2 were providing care for Resident #4 and NA #1 observed NA #2 slap Resident #4 on the face. During the same day shift on 11/18/23, 15 minutes later, NA #3 and NA #2 were providing care to Resident #6 and NA #3 observed NA #2 "pop" Resident #6 in the mouth	F 607	Past noncompliance: no plan of correction required.	

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two times. NA #1 notified Nurse #1 of the abuse she and NA #3 witnessed on 11/18/23 at 4:00 PM, but Nurse #1 failed to report the abuse allegation to the Director of Nursing until 8:00 PM on 11/18/23 indicating that she was not certain of what was reported to her was actual abuse. More than one vulnerable resident was physically abused as a result of not implementing the abuse policy. All residents residing on the Alzheimer's unit were at risk for abuse. This deficient practice was identified for 3 of 4 residents reviewed for abuse.

Findings included:

The facility's abuse policy dated February 04/19/06 and revised on 01/26/23 titled, "Abuse Investigation and Reporting for Senior Services" read, in part, as follows:

Identification and Investigation: (1) "The person(s) observing or suspecting incidents of resident abuse, neglect, exploitation or misappropriation of property must report such knowledge or suspicion to the nursing supervisor or his/her department managers as soon as he or she is aware of an incident or potential incident" and (2) "The nursing supervisor or department manager must notify the Administrator and Director of Nursing immediately."

Protection: (1) "While the investigation is pending, accused individuals employed by the facility will be suspended pending the result of the investigation."

Reporting: (1) "For certified nursing facilities and skilled nursing facilities, all alleged violations involving abuse, neglect, exploitation, or

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mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately."

a. Resident #3 was admitted to the facility on 04/03/23.

A phone interview was conducted with Nurse Aide (NA) #1 on 07/31/24 at 3:30 PM. NA #1 reported on 11/17/23, she and NA #2 and NA #4 were providing care for Resident #3 who resided on the memory care unit at about 6:00 PM. She stated Resident #3 had become combative which was a normal behavior for him during care and he hit her in the chest. NA #1 stated she said in a louder voice, but not yelling, to Resident #3 to stop hitting her. NA #1 stated she guided his hands so that he would not hit her or the other caregivers and he tried to kick the three of them while trying to put her hand in his mouth with an attempt to bite her hand. NA #1 stated we had finished getting Resident #3 cleaned up and dressed and she had turned her back to pick up the trash and heard a "slap" sound. NA #1 described the sound as a slapping sound someone would hear when slapping bare skin with an open hand. She turned and asked NA #2 what happened and NA #2 stated she "popped" Resident #3 on the nose. NA #1 stated she asked NA #2 why she would do that and told her she should not do that. NA #1 stated NA #2 giggled. NA #1 stated at the time, she was not certain that this was abuse and she did not report this incident to the nurse. NA #1 stated she did not know if maybe she was overreacting in thinking that this was actual abuse. NA #1 stated, in looking back she should have reported what she heard NA #2 doing and what NA #2 said she did to Resident #3 on 11/17/23 because the

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F 607	Continued From page 17 incidents that occurred afterwards with Resident #4 and Resident #6 may not have happened. An interview was attempted with NA #2 via phone and text messages on 07/31/24 and 08/01/24. NA #2 did not return the phone calls or respond to the text messages. An interview was attempted with NA #4 on 07/31/24 and 08/01/24 via phone and text messages. NA #4 did not return the phone calls or respond to the text messages. A phone interview was conducted with Nurse #1 on 08/01/24 at 10:00 AM. Nurse #1 reported at 4:00 PM on 11/18/23, NA #1 came to her stated she had a "moral dilemma." Nurse #1 stated NA #1 reported she had witnessed some instances of abuse by NA #2 during their shifts on 11/17/23 and 11/18/23. Nurse #1 stated NA #1 wanted to keep her name anonymous about the reporting of abuse and did not tell Nurse #1 anything until her shift was over on 11/18/23 and NA #2 already had left the facility. Nurse #1 stated had NA #1 reported what she witnessed on 11/17/23, the reoccurrences of the alleged physical abuse by NA #2 to Resident #4 and Resident #6 may not have happened on 11/18/23. Nurse #1 stated she was not certain what happened was abuse and spoke with Nurse #2 who told her she needed to report what was told to her by NA #1. Nurse #1 stated she notified the Director of Nursing on her way home that evening about 8:00 PM. Nurse #1 stated she should have notified the Director of Nursing immediately after NA #1 informed her of what she and NA #3 had witnessed on 11/17/23 and 11/18/23. b. Resident #4 was admitted to the facility on	F 607		

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11/06/19 and expired on 01/09/24.

A phone interview was conducted with Nurse Aide (NA) #1 on 07/31/24 at 3:30 PM. NA #1 reported on 11/18/23 she was asked by NA #2 to assist with giving Resident #4 a bed bath who resided on the memory care unit. NA #1 stated while assisting Resident #4 with her bath she had become "feisty" as she does and was punching and hitting NA #2. NA #2 was telling Resident #4 to calm down. NA #1 stated at that time Resident #4 was punching and hitting NA 2# and NA #2 smacked Resident #4 on the cheek with an open hand. NA #1 stated Resident #4 put her hand to her cheek and was shocked that she just got smacked. NA #2 described Resident #4's expression of shock as opening her eyes and mouth open wide while her hand was on her cheek. NA #1 stated she did not see any red marks on her face, but she stated to NA #2 "do not hit my resident and to knock it off." NA #1 stated she left the room and left NA #2 alone with Resident #4 because she was uncomfortable with being in NA #2's presence. NA #1 stated, in looking back, she should not have left NA #2 alone with Resident #4. NA #1 added, she did not react the right way and should have ensured that Resident #4 was safe and protected instead of leaving her alone with NA #2. NA #1 stated she should have reported her observation of abuse on Resident #4 immediately to the Nurse.

An interview was attempted with NA #2 via phone and text messages on 07/31/24 and 08/01/24. NA #2 did not return the phone calls or respond to the text messages.

A phone interview was conducted with Nurse #1 on 08/01/24 at 10:00 AM. Nurse #1 reported at

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4:00 PM on 11/18/23, NA #1 came to her stated she had a "moral dilemma." Nurse #1 stated NA #1 reported she had witnessed some instances of abuse by NA #2 during their shift. Nurse #1 stated she should have implemented the abuse policy and procedure as soon as she was notified of the incident that NA #1 observed with NA #2 and Resident #4 in order to protect all the other residents from any further abuse.

c. Resident #6 was admitted to the facility on 02/25/22.

A written statement dated 11/24/23 by NA #3 revealed "During the last round about 2:00 PM on 11/18/23, I witnessed NA #2 pop Resident #6 on the mouth. We were standing on both sides of her at the end of her bed to provide needed care. Resident #6 was standing during the care at first, but then she sat on the bed so we could change her pants. NA #2 had a hold of her hands while I was providing care so that she would not hit us. She stated to look she was going to spit on us, NA #3 saw this also. At that point NA #2 popped her mouth like to tell her "no." Resident #6 called her the N word then NA #2 popped her mouth again. NA #3 did not just cover mouth; she popped her mouth 2 different times, like you would pop a kid's hand who was doing something wrong.

An interview was attempted with NA #3 via phone and text messages on 07/31/24 and 08/01/24. NA #3 did not return the phone calls or respond to the text messages.

An interview was attempted with NA #2 via phone and text messages on 07/31/24 and 08/01/24. NA #2

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did not return the phone calls or respond to the text messages.

An interview with NA #1 via phone on 07/31/24 at 3:30 PM revealed she had spoken to NA #3 on 11/18/23 regarding what she had observed NA #2 with Resident #3 on 11/17/23 and Resident #4 on 11/18/23 and NA #3 reported to her what she had witnessed NA #2 with Resident #6 on 11/18/23. NA #1 stated NA #3 told her that she had witnessed abuse too. NA #1 stated she had to let Nurse #1 know because there were a number of observations that abuse happened.

An interview with Nurse #1 via phone on 08/01/24 at 10:00 AM reported she did not recall being made aware of the alleged abuse allegation of NA #2 with resident #6, but that it was a long time ago.

An interview with Nurse #2 on 08/02/24 at 11:36 AM revealed Nurse #2 stated she and Nurse #1 did report on 11/18/23 at change of shift. Nurse #2 reported Nurse #1 stated she needed her opinion regarding an anonymous report on potential or possible abuse, but that she did not believe the perpetrator in question (NA #2) had done what was reported to her. Nurse #2 asked Nurse #1 if she notified the Director of Nursing or the Administrator and Nurse #1 replied "no" because she did not feel NA #2 was guilty of anything. Nurse #2 stated she told Nurse #1 it was not up to her to determine whether or not it happened and that she needed to report it immediately. Nurse #1 stated to Nurse #2 she would call the Director of Nursing (DON) on the way home. Nurse #2 stated she was concerned about the delay in reporting, so she notified the Assistant Director of Nursing (ADON) on 11/18/23

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F 607	Continued From page 21 to make her aware of what Nurse #1 reported to her and to make sure that the ADON notified Nurse #1 to make sure she contacted the DON. Nurse #2 stated the ADON told her that Nurse #1 had made the DON aware. Nurse #2 stated Nurse #1 reported she completed skin checks on Resident #3, Resident #4, and Resident #6 before she left on 11/18/23. An interview was conducted with the Director of Nursing (DON) on 08/02/24 at 2:00 PM. The DON reported she was made aware of the abuse allegation by Nurse #1 on 11/18/23 at around 8:00 PM. The DON stated Nurse #1 reported to her that an anonymous staff member had reported to her at 4:00 PM that abuse had occurred, and that more than one resident was involved. The DON stated she explained to Nurse #1 the importance of calling the Administrator and the DON immediately if abuse was suspected so that they could suspend the perpetrator pending the investigation to ensure all the residents were protected from abuse. The DON informed Nurse #1 to notify the Administrator right away. The Administrator was made aware at 8:45 PM. The DON reported NA #1 notified her via phone as well on 11/18/23 at 9:18 PM and she instructed NA #1 to notify the Administrator immediately. An interview was conducted with the Administrator on 08/02/24 at 2:10 PM. The Administrator reported there was a delay in reporting and that NA #1 and NA #3 should have identified and reported the abuse they witnessed immediately to their supervisor. He stated Nurse #1 should have notified the Director of Nursing and him once she was made aware of what the nurse aides witnessed at 4:00 PM. The	F 607		

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Administrator stated he notified law enforcement and Adult Protective Services on 11/18/23 at 9:09 PM and submitted his report to Department of Health and Human Services via fax at 10:01 PM on 11/18/23.

The Administrator was notified of immediate jeopardy on 08/02/24 at 12:25 PM.

The facility provided the following corrective action plan with a completion date of 11/21/23.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 11/18/23, NA#2 was suspended and told to not return to work until the investigation was complete. On 11/18/23, all affected residents (residents #3, #4, #6) were immediately assessed for any signs of injury with no findings noted by the hall nurse. On 11/18/23, adult protective services were contacted at 9:07 pm and the local police were contacted at 9:07 pm by the administrator. The affected residents' responsible parties were contacted on 11/19/2023 by the hall nurse. The physician was contacted on the night of 11/18/23 by the hall nurse regarding the affected residents. No new orders were received from the physician. On 11/20/23, the social worker interviewed the affected residents to assess their psychosocial well-being and no changes in mood or behavior were noted. Nurse Aide (NA) #1, #3, and Nurse #1 were educated prior to their next shift on Lutheran Services Carolinas policy Abuse Investigation and reporting for Senior Services. NA #1 and Nurse #1 were given final warnings for not reporting

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possible abuse timely. Nurse #1 received final verbal warning from Director of Nursing (DON) on 11/18/23 by phone and documentation followed of final warning on 11/22/23. NA # 1 received verbal final warning from DON on 11/20/23, NA # 1 did not return to work after 11/20/23 thus DON was unable to complete written documentation of final warning.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents that reside on the neighborhood where the allegations were stated to have occurred were physically assessed for any signs of injury by a licensed nurse beginning on 11/18/23 and completed on 11/19/23, with no negative findings. NA # 2 was suspended on 11/18/2023 and had no contact with residents after that day. NA #2's permanent assignment was the memory care unit but had worked on another long-term care unit in October. NA #2's last day worked off memory care was 10/31/23. Every resident on that neighborhood had a skin assessment with no negative findings since her last shift worked off memory care on 10/31/23. The facility interviewed all alert and oriented residents of that neighborhood on 11/20/23 with no negative findings.
The interviews were completed on 11/20/23 by Administrator and Social Worker.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 11/18/23, all staff were reeducated on the Lutheran Services Carolinas policy, Abuse

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Investigation and Reporting for Senior Services by the administrator and charge nurse. This policy includes specific language related to how to report suspected abuse or mistreatment and what constitutes abuse, neglect, misappropriation of property and injury of unknown origin. This policy also addresses the protection of residents during an investigation by stating individuals employed by the facility will be suspended, pending results of investigation. This education was completed for all staff on 11/18/23, and staff not educated on this date were in-serviced prior to working their next shift by the staff development coordinator, charge nurse for the unit, or administrator. This education is included in the orientation for all new staff and will be repeated at least annually during the annual skills fair and as needed.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

Beginning 11/18/23 the administrator, director of nursing, and/or designee will monitor at least ten staff/resident interactions per week for one year using the form titled, "Staff/Resident Interaction Form". This monitoring will include interviews with residents, staff, and/or family members as well as observation. Any concerns identified will immediately be addressed by the administrator.

The plan of correction was discussed at the next quarterly Quality Assurance Performance Improvement meeting. After that meeting, any negative outcomes will be reviewed with the

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	345554	A. BUILDING ______ B. WING ______	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 25 leadership team in future quarterly Quality Assurance Performance Improvement meetings. The immediate jeopardy was removed on 11/21/23 and the plan of correction was completed on 11/21/23. The Corrective Action Plan was validated on 08/02/24. Interviews with the nursing staff, environmental staff, dietary staff, and administrative staff were conducted and confirmed that education was provided regarding what constitutes abuse, neglect, misappropriation of property and injury of unknown origin. Education was also provided regarding identifying abuse, protecting the residents' right to be free from abuse, and reporting abuse. A review of the audits to monitor the facility's performance to make sure that solutions are sustained included review of the form titled, "Staff/resident interaction form." This form was completed weekly since 11/18/23 to include 10 staff members per week were observed interacting with residents. During an interview with the SDC nurse, she stated if she identified abuse during the audits then she would report it immediately to the Administrator and Director of Nursing. The completion date of 11/21/23 for the corrective action plan was validated.	F 607		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		8/25/24

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F 684	Continued From page 26 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and the Medical Director's interviews the facility failed to complete neurological assessments for a resident who experienced an unwitnessed fall and received an anticoagulant medication. This occurred for 1 of 3 residents (Resident #1) reviewed for falls. Findings included. Resident #1 was admitted to the facility on 11/13/18 with diagnoses including congestive heart failure, cerebral vascular accident (CVA), and hemiplegia involving the left non dominant side. A care plan dated 03/19/24 revealed Resident #1 had the potential for falls related to a history of falls, left hemiparesis, and weakness with impaired mobility. Interventions included in part to encourage him to use the call light and assist with transfers and remind him to ask for help. The Minimum Data Set (MDS) quarterly assessment dated 04/09/24 revealed Resident #1 had moderate cognitive impairment. He required extensive 2-person assistance with bed mobility, transfers and toileting. He received anticoagulant medication. A physician's order dated 04/16/24 for Resident #1 revealed Xarelto (an anticoagulant) 15 milligrams daily for cerebral vascular accident.	F 684	Resident #1 was sent to the local emergency department for evaluation on 6-11-24 at 7:45pm following the incident that occurred on 6-11-24 and 4:45pm. The visit to the emergency department revealed no concerns or negative findings due to the decreased number of neurological assessments completed following the fall. On 8-22-24, the Director of Nursing and Administrator completed a chart review for all residents with falls during the previous 30 days to confirm that neurological assessments were initiated. There were no negative outcomes related to neurological assessments for any of the residents during this period. By 8-25-24, all nursing staff will be educated by the Staff Development Coordinator on the Neurological Assessment policy and on fully completing the Neurological Vital Sign Check List for any resident that are indicated necessary by the policy or physician orders. Any nursing staff not educated by 8-25-24 will be educated before working their next shift by their supervisor. All new nursing staff will be educated during orientation by the Staff Development Coordinator. All falls will be audited the following business day by the Director of Nursing or Neighborhood Coordinator to ensure that	

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A post fall evaluation note dated 6/11/24 at 6:46 PM documented by Nurse #3 revealed in part; on 06/11/24 at 4:45 PM Resident #1 had an unwitnessed fall in the bathroom. Resident #1 was reaching for an item at the time of the fall. He was found on the floor with the call light in his hand. He was assisted to bed, the skin tear was cleansed and dressed. Resident #1 was not hospitalized, the provider was notified.

A review of the neurological and vital sign check list revealed; vital signs and neuro checks were to be conducted every 15 minutes for 1 hour; every 30 minutes for 1 hour; every hour for 4 hours; then every 4 hours for 24 hours.

A review of the neurological assessments that were completed for Resident #1 following the fall on 06/11/24 at 4:45 PM revealed the following:

06/11/24 at 4:45 PM: pulse rate 68 beats per minute (bpm), blood pressure 92/64 (systolic/diastolic). Pupils normal, level of consciousness was cooperative. Movement with left side weakness, right side strong. Speech was clear.

06/11/24 at 5:27 PM: pulse rate 68 beats per minute (bpm), blood pressure 114/67 (systolic/diastolic). Pupils normal, level of consciousness was cooperative. Movement with left side weakness, right side strong. Speech was clear.

06/11/24 at 6:00 PM: pulse rate 68 beats per minute (bpm), blood pressure 105/71 (systolic/diastolic). Pupils normal, level of consciousness was cooperative. Movement with left side weakness, right side strong. Speech was

F 684

neurological assessments are being completed when needed per policy and that they are fully completed. This will occur every business day for one month, then once per week for one month, then once per month for three months.

Results of the neurological assessment audits will be reported to the administrator weekly for two months and then monthly for three months. The administrator will report all audit results to the QA committee during each QAPI meeting until audits complete.

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clear.

There were no neurological assessments conducted at 5:00 PM, 5:15 PM, 5:45 PM, or 6:30 PM following Resident #1's fall on 06/11/24 at 4:45 PM.

A nursing progress note dated 06/11/24 at 6:52 PM documented by Nurse #3 revealed Resident #1's blood pressure was 92/64. No further vital signs or neurological assessments were documented at 6:52 PM.

During an interview on 07/31/24 at 2:45 PM Nurse #3 stated she was the assigned nurse for Resident #1 on 06/11/24 when the fall occurred. She stated Resident #1 had just returned from the hospital around lunchtime on the day of the fall. He had been hospitalized for congestive heart failure. She stated the afternoon of 06/11/24 he was alert and oriented to person, and place and could follow direction. She reported the fall occurred in the bathroom. Nurse Aide #6 along with another nurse aide took him in the bathroom and assisted him to the toilet using stand and pivot assistance with a gait belt and told him to call using the call light when he was ready. She reported that Resident #1 had lived there for several years, and he preferred to be left alone in the bathroom for privacy. She stated during that time Resident #1 fell off of the toilet, the call light alarmed, and she heard him calling when he fell. The nurse aides came in with the nurse along with the unit manager/house coordinator. She assessed him then they got him up and into bed. She reported at that time he had complaints of only mild pain, they put him in the bed, and he appeared settled. She reported she notified the physician following the fall. The

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physician told her to monitor him but there was no order received to send him to the hospital at that time. She stated neuro assessments and vital signs were initiated. She stated she did not complete all of the neuro assessments due to being busy and not delegating other tasks to be done to the nurse aides and she tried to do everything herself. She stated she was aware of the facility policy and frequency to conduct neuro assessments following an unwitnessed fall in order to identify a change in condition.

During an interview on 07/31/24 at 3:00 PM Nurse #4 the unit manager/house coordinator stated Resident #1 had lived in the facility for several years and had a history of CVA with left sided weakness, he was wheelchair bound but could stand and pivot with a gait belt for transfers. She stated the fall occurred in the afternoon and he had just returned from the hospital earlier that day. She stated following the fall two nurses went in to assess him and he had a skin tear. His vital signs and a neuro assessment was completed by Nurse #3 at that time. She stated neuro checks were to be conducted every 15 minutes following a fall for 1 hour, then every 30 minutes for one hour, then every 1 hour for 4 hours. She indicated she was not aware that all of the neuro assessments were not completed.

During an interview on 08/02/24 at 2:00 PM the Director of Nursing (DON) stated Resident #1 was assessed by Nurse #3 following readmission on 06/11/24 and he was at his baseline. Prior to hospitalization he could be assisted to the toilet by 2 staff and left alone per his request for privacy. She stated following the fall on 06/11/24 Nurse #3 should have completed the neuro assessments according to their policy to assess

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F 684	Continued From page 30 for any change in condition. During an interview on 08/02/24 at 3:00 PM the Nurse Practitioner indicated neuro assessments were to be completed in full and timely following an unwitnessed fall in order to assess for any changes. During a phone interview on 08/02/24 at 4:30 PM the Medical Director indicated neuro assessments following an unwitnessed fall should be conducted to determine the need for further evaluation and/or hospitalization.	F 684		