STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345109	A. BUILDING _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY PLACE	24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 12/13/2021 to 12/16/2021. The facility was found in compliance with the requirement CFR483.73, Emergency Preparedness. Event ID # SKIW11.	E 000		
F 600 SS=D	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 record review, resident and staff interviews, the facility failed to protect a resident's right to be free from mistreatment by a staff member (Nursing Assistant #3) due to being "rough" while provide care and making disrespectful comments to 1 of 1 resident reviewed for mistreatment (Resident#49). The Findings included: Resident #49 was admitted to the facility on 1/3/21with a diagnosis of metabolic encephalopathy and Parkinson's disease.	F 600	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	1/13/22

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

Electronically Signed | 01/13/2022

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F 600	Continued From page 1 The Annal Minimum Data Set (MDS) dated 11/7/21 revealed Resident #49 was cognitively intact. A review of the email correspondence included in the facilities investigation dated 8/24/21 at 10:46 AM from the Facility Supervisor nurse to the Staff Development Coordinator (SDC) read: "[Resident #49] told [Nurse #1] today [8/24/21] that last night [Nursing Assistant (NA) #3] was rough with [Resident #49]. She also explains that [NA #3] kept complaining that her back was hurting. [Resident #49] states that [NA #3] would grab her legs and when they got into the bathroom had to be asked to help her on the toilet. [Resident #49] told [Nurse #1] that when she was getting back to bed [NA #3] had grabbed her legs so hard that she was yelling to let go because of the pain. [Resident #49] then stated that [NA #3] told her 'I did not put them bruises on your legs, I know that is what you white women try to say about us black women'." An email from the Staff Development Coordinator (SDC) on 8/24/21 at 11:20 AM to the Facility Supervisor read; "does she have any bruises". The email response at 8/24/21 at 12:07 PM back from the Facility supervisor to the SDC read: "[Nurse #1] says she does but they were there previously". A review of Resident #49's skin evaluations revealed the following skin assessments: August 20,2021 8:07 PM - skin is warm, dry, fragile. Discoloration noted to both lower extremities (BLE). Some bruising noted to both upper extremities (BUE). No new areas noted. August 25th, 2021- 8:06 AM pressure reducing	F 600	constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. The social worker interviewed Resident #49 on 8/24/21 to discuss concerns and ensure resident felt safe at the facility. Measures were taken to remove NA (nursing assistant) #3 from residents assignment on 8/24/21. An additional 8 alert and oriented residents were interviewed on NA #3 assignment by the social worker, on 8/24/21. No other issues or concerns were voiced during these interviews by other residents on NA#3 assignment. The staff development RN (registered nurse) met with NA #3 on 8/26/21, the next working day for NA #3. The staff development coordinator reviewed the policy on customer service. A written coaching on 8/26/21 was completed by the staff development coordinator to address NA #3 approach, professionalism and customer service with her interaction with resident #49. NA #3 demonstrated understanding of the policy. In addition NA #3 has received additional education including, the policy, Abuse Investigation and reporting for senior services on December 23, 2021. This education was provided by the staff development coordinator. NA #3 demonstrated understanding of the abuse investigation and reporting policy.	

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F 600	Continued From page 2 matters in place to help prevent skin breakdown. August 27th, 2021- 8:30 PM - Skin is warm, dry, fragile. Discoloration noted to BLE. Skin tear to back side of right hand. Some bruising noted to BUE. No new areas noted. There was no skin evaluation documented after the facility became aware of the incident with Resident #49 and NA #3 on August 24, 2021. A review of the Social Workers (SW) interview with Resident #49 included in the facilities investigation dated 8/24/21 read in part; "[Resident #49] felt like [NA #3] was upset about something because she stated to [Resident #49] 'I don't have time to mess with you,' the NA then grabbed Resident #49's calves and squeezed them while she was helping her get up. [Resident #49] screamed because it hurt, and she asked the NA to please not do that, it hurt. When [Resident #49] was being put back to bed, the NA squeezed her calves again. [Resident #49] stated that NA #3 said 'I know what you white women will say to us black women put bruises on you'. [Resident #49] stated she did not know why NA #3 said that". An interview and observation were completed with Resident #49 on 12/14/21 at 9:01 AM. An observation of Resident #49's both lower extremities revealed her legs are very small and skin was red and blotchy. Resident #49 stated a staff member was very rough with her one night back in the fall when she needed to use the bathroom. Resident #49 stated that she had pressed her call light and NA #3 came in and had asked me what I needed, and huffed and said "lordy, lordy then grabbed my legs and snatched them around. Resident #49 mentioned that NA #3 stated to her "I know all about you white people,	F 600	NA#3 no longer provides care for Resident #49. This change occurred on 8/24/21. To ensure no other residents were effected all residents with a BIMS score of 13 or higher were interviewed by the activity director and activity director assistant on 1/11/22. 20 residents were interviewed using the LSC Resident Interview form. This interview form asked specific questions related to safety, abuse and reporting of abuse. 2 grievances were completed from the interviews and the facility followed the grievance procedure to rectify. The administrator reviewed all concerns and grievances logged by the social worker for the past six months to ensure all reports were fully investigated. Review was completed on 1/11/22. Grievances reviewed were from January 11, 2022 through July 1, 2022. No additional issues were found. Measures put into place or systemic changes made to ensure the deficient practice will not recur: Every employee will be in-service by 12/30/21 on the policy titled, Abuse Investigation and Reporting for Senior Services by the staff development coordinator, or staff development coordinator support LPN. Any employee not In-serviced by this date will be in-service prior to their next working shift.	

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F 600	Continued From page 3 you gather together and say anytime you get a bruise you say a black person did it. Resident #49 stated "I really felt mad when that happened. Resident #49 stated that she told NA #3 that she was nothing but a racist because of what she said to me." Resident #49 stated that "her comments still bother me and every time I think about how uncalled for it was. I get along with everyone and I don't know why she (NA #3) was so mean, I guess I am not made to be in nursing homes." An interview was completed with the Social Worker (SW) on 12/14/21 at 2:54 PM who stated she recalled that NA #3 (on 8/24/21) went into Resident #49's room and grabbed her legs and when NA #3 went to put her back to bed grabbed her legs again. The SW stated that Resident #49 told her she that NA #3 made a comment to Resident #49 that 'you white women get together and say black people put bruises on her'. The SW was asked did you ask Resident #49 how this made her feel and the SW responded, "well, she did not like it of course". The SW stated regarding the comment 'I don't have time to mess with you' NA #3 should not have said that." An interview was completed with the SDC and the Facility Supervisor on 12/14/21 at 3:10 PM. The Facility Supervisor stated that she did go in and speak with Resident #49 and did look at her legs but did not chart it. The Facility Supervisor stated that "Resident #49 had stated that the NA #3 did grab her legs and her legs had hurt from what happened. The Facility Supervisor stated she did have scattered bruising but like the Nurse #1 stated the bruising was already there" The Facility Supervisor stated that Resident #49 stated her legs hurt from what happened.	F 600	Abuse training will be provided upon hire, at least annually and upon incidents as issues related to abuse prohibition practices. Abuse Investigation and Reporting for Senior Services Policy provides description of abuse types, prevention interventions and identification, investigation and reporting. This policy includes completing the DHSR Initial Allegation Reporting Form, DHSR (dept health human service regulation) 5 Day Investigation Report, Interviewing person reporting the incident, interviewing the resident (if appropriate), reviewing the medical record, interviewing staff members on all shifts, interviewing roommates, family members and visitors, interviewing other residents to who the employee provides care and or services, reviewing all circumstances and events leading up to the incident. Witness reports will be made in writing, signed and dated. Appropriate authorities notified in compliance with state and federal laws. The administrator will be informed of progress of investigation. The administrator or designee will keep the resident and his/her representative informed of the progress in the investigation. Any accused individuals, employed by the facility will be suspended pending the investigation. While the investigation is taking place individuals not employed by the facility will be denied unsupervised access to the resident. In situation resident to resident abuse, residents will be supervised by staff until appropriate action can be taken to ensure the safety of other residents. Emotional	

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F 600	Continued From page 4 An interview was completed on 12/15/21 at 2:53 PM with NA #5 who was asked how she assists Resident #49 to get up out of bed. NA #5 stated she would first get her walker and put this by the bed and then would put her one arm under her thighs and the other around her shoulder and rotate her. NA #4 stated that you do have to be careful of her calf areas as they can be sensitive. An interview was completed on 12/15/21 at 2:53 PM with NA #6 who was asked how she assists Resident #49 to get up out of bed. NA #6 stated that "Resident #49 does hurt a lot and you have to be very careful with her and one must turn her legs straight out and help her sit up. Once she would sit up you cannot rush her as she needs to get her balance. When you grab her [Resident #49's] legs you just lightly pull on her legs to the side and move her by her hips, if you pull to hard you will really hurt her and stated, "Resident #49 will always let you know." An interview was completed on 12/15/21 at 5:13 PM with Nurse #4 who was working third shift on 8/23/21 from 11:00 PM to 7:00 AM who was asked if she had heard any yelling from Resident #49's room that evening. Nurse #4 stated, "I did not hear her [Resident #49] scream." An interview was completed on 12/15/21 at 8:53 PM with NA #3 who stated that it is very hard to get Resident #49 out of bed as you need to hold her walker and hold her at the same time. NA #3 stated that Resident #49 was concerned about the bruises on her legs and NA #3 stated the bruises were not that bad and was trying to re-direct Resident #49 instead of focusing on her	F 600	support will be provided as needed. Reporting, all alleged violations involving abuse, neglect , exploitation or mistreatment including injuries' of unknown origin and misappropriation of resident property are reported immediately but no later than two hours after the allegation is made to the health care personnel registry and to the law enforcement agency, if the events that cause the allegation involve abuse or result in serious bodily injury , or no later than 24 hours if the event that cause the allegation does not involve abuse or serious body injury, to the state agency in accordance with the state law. The administrator or designee is responsible for completion of the Initial Allegation Report to the Health care personnel registry section of DHSR within 2 Hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury. The administrator or designee is also responsible for completion of the Investigation 5 Day report to NC DHSR. A written report of the findings will be included with the DHSR 5 day Investigation report to the NC DHSR and to any other licensing authorities. All abuse investigations conducted by the facility will be reviewed by the corporate nurse consultant to ensure the LSC policy was followed and no further actions need to be taken. The nurse consultant will receive all reported allegations within 2	

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F 600	Continued From page 5 legs. NA #3 was asked if she had grabbed Resident #49's calves and NA #3 stated that she did not remember and stated that "you have to put your hands underneath her calves and bring her legs around to the side of the bed and physically pull her legs and you have to put some energy into it and put pressure on her legs." NA#3 was asked if she was too rough with Resident #49, and she stated she did not think she had been too rough with Resident #49 but there was a lot of pushing and pulling and nothing was intentional. NA #3 stated it had been a rough night. NA #3 stated she did not remember her screaming in pain and was not rushing her. NA #3 stated she knew Resident #49's legs are sensitive, and Resident #49 told NA #3 to go slower. NA #3 stated that she did tell her to "come on" that her back was about to give out. NA #3 was read the statement interview from the SW and Resident #49 which indicated NA #3 stated to Resident #49 'I don't have time to mess with you' 'I know all about you white people, you gather together and say anytime you get a bruise you say a black person did it". NA #3 stated that she did not say those things to Resident #49 and would never put anybody down. NA #3 stated she had not been asked to write any statements about what happened but stated; "I wish they would have, as I cannot remember the details of what happened now."	F 600	hours of the allegation being made. Date of completion 1/13/22 All skilled nursing stations have received an abuse instruction education folder to follow when an allegation or concern is reported by any staff member, resident or any person. This folder includes phone numbers of administration, local law enforcement and Dept of social service, initial Health care personnel registry reporting forms, resident / staff interview forms and a copy of the LSC Abuse Investigation and Reporting for Senior Services Policy. All nurses have been made aware to notify administrator or director of nursing immediately to any concerns or allegation of abuse. All licensed nurses have also been made aware to complete the initial reporting form within two hours of any allegation of abuse or bodily harm and to notify outside law enforcement. All staff have been educated to notify their supervisor immediately on any allegations of abuse. Intervention put in place 1/11/22. A total of 6 residents will be interviewed every week for four weeks to ensure there are no concerns that have not been investigated regarding residents right to be free from mistreatment. Interviews will be conducted by the activity director or social worker. After four weeks, 6 interviews will occur each month for three months until three months of compliance is sustained. Any concerns found during these interviews will immediately be reported to the administrator and	

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F 600	Continued From page 6	F 600	investigated. These weekly interviews will begin 1/13/22. The director of nursing, staff development coordinator, or minimum data set nurse(s) will interview 10 employees each week for four weeks using the form titled, Employee Interviews: Abuse Policy, to ensure all employees can verbally demonstrate understanding of the requirements in the policy titled, Abuse Investigation and Reporting for Senior Services. After four weeks, 10 employees will be interviewed each month for three months until three months of compliance is sustained. These interviews will begin 1/13/22. Facility process to monitor performance to ensure solutions are sustained: The results of the resident / staff audits interviews in regards to ensuring residents rights to be free from mistreatment, will be reported at the monthly QAPI meetings by the social worker or director of nursing until the audit schedule is completed- Resident audit (6 residents will be interviewed every week for four weeks to ensure there are no concerns that have not been investigated regarding residents right to be free from mistreatment. Interviews will be conducted by the activity director or social worker. After four weeks, 6 interviews will occur each month for three months until three months of compliance is sustained.)Teammate Audit- (interviews 10 employees each week for four weeks. After four weeks, 10	

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F 600	Continued From page 7	F 600	employees will be interviewed each month for three months until three months of compliance is sustained). All audits completed by the corporate nursing consultant with allegations of abuse by the facility will be presented at the monthly QAPI meeting over the next 12 months. Completion Date of Plan of Correction 1/13/22	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §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, This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews facility staff failed to follow the facility's Abuse Investigation and Reporting for Senior Services Policy when they failed to promptly report allegations of abuse for 2 of 3 residents, Residents #113, and Resident #49, reviewed for abuse. Resident #113 reported allegations of abuse to a staff member who did not report the allegation to facility management, which resulted in the accused staff member not being removed from the facility and an investigation being	F 607	For Resident #49, The social worker completed an interview with resident #49 on 8/24/21 to discuss concerns regarding NA (nursing assistant)#3. NA (nursing assistant) #3 was removed from residents assignment on 8/24/21. 8 additional interviews were completed with alert/ oriented residents on NA #3 assignment, by the social worker on 8/24/21, no new concerns noted.	1/13/22

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F 607	Continued From page 8 delayed. Resident #49 also reported allegation of abuse to staff, and they failed to report the allegation to the Division of Health Service Regulation and failed to assess Resident #49 and investigated the allegation. The findings included: 1. A review of the Abuse Investigation and Reporting for Senior Services revised on 3/5/2021 revealed facility staff should report observed or suspected incidents of abuse to his/her department manager as soon as he is aware of an incident or potential incident. The nursing supervisor or department manager must notify the administrator and the director of nursing immediately. The administrator or designee is responsible for ensuring the thorough investigation of the allegation. While the investigation is pending, the accused individual employed by the facility will be suspended, pending the results of the investigation. Resident #113 admitted to the facility on 4/9/2019 with diagnoses of heart disease and dementia. Resident #113's Annual Minimum Data Set assessment dated 4/14/2021 indicated she was moderately cognitively impaired and required extensive assistance with bed mobility and set up assistance with her meal trays. A review of an abuse investigation dated 5/14/2021 revealed Resident #113's Family Member called the facility to report Resident #113 had told him, while she was visiting with the Family Member in his home, Nurse Aide #1 had slammed her dinner tray down on her over bed table several weeks ago, causing pain in her legs,	F 607	Nurse #4 and the Charge Nurse were all educated on the policy titled, Abuse Investigation and Reporting for Senior Services by the staff development coordinator RN on 5/14/21. NA (nursing assistant) #1 was educated on policy Investigate and Reporting of Senior Services by the staff development coordinator RN Written education was provided to Nurse Aide # 1 on May 17,2021. NA #1, Nurse #4, and the Charge Nurse all acknowledged understanding and the expectation to follow the LSC policy. Resident #113 was interviewed by the social worker on 5/14/21 and resident #113 was made aware that NA #1 was removed from assignment on 5/14/21. Nurse aide #1 charge nurse, the director of nursing and the administrator were all reeducated on the policy titled, Abuse Investigation and Reporting for Senior Services by the staff development coordinator on 12/23/21. Nurse #4 was educated on the Abuse Investigation and Reporting for Senior Services by the staff development coordinator on 12/22/21. Steps facility will take to identify other residents having the potential to be affected by the same deficient practice: Every resident with a BIMS score of 13 or higher was interviewed by the activity director and assistant activity director on 1/11/22, 20 residents were interviewed. the LSC Resident Interview Tool was	

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F 607	Continued From page 9	F 607		

and had threatened to do it again. The Family Member asked Resident #113 if the incident was an accident and she stated Nurse Aide #1 had meant to do it and she was afraid of him.

During an interview with Nurse Aide #1 on 12/15/2021 at 3:58 pm he stated Resident #113 told him he had hit her with the over the bed table, but he could not remember the date it happened. He stated he told Nurse #4 when the incident occurred that Resident #113 had accused him of hitting her with the over the bed table and he was reassigned to another resident and did not take care of Resident #113 again. Nurse Aide #1 stated he was not suspended when he reported the incident to Nurse #4, and he continued to work that night. Nurse Aide #1 stated about 2 weeks after the incident the Staff Development Coordinator called him and suspended him pending an allegation and then three days later the Director of Nursing called him and told him to come to work early and she interviewed me before I went back to work.

During an interview with Nurse #4 on 12/15/2021 at 5:13 pm she stated Nurse Aide #1 did not report Resident #113's allegation to her when it occurred on 4/30/2021. Nurse #4 stated Resident #113 told her Nurse Aide #1 intentionally slammed the over bed table on her knees on 5/7/2021, a week after the incident happened. Nurse #4 stated she immediately went to Nurse Aide #4, who was working at the time, and asked him what happened, and he told her it was an accident. Nurse #4 stated Nurse Aide #1 stated the over the bed table dropped and hit her knees and he looked at her knees but did not see any injury. Nurse #4 stated she reported the incident to the Charge Nurse on 5/7/2021 when Resident

used. 2 grievances were noted from the interviews. The grievance policy was followed to rectify all concerns.

Measures put into place or systemic changes made to ensure the deficient practice will not recur:
Every employee will be inserviced by 12/30/21 on the policy titled, Abuse Investigation and Reporting for Senior Services by the staff development coordinator, or staff development coordinator support LPN. Any employee not inserviced by this date will be inserviced prior to their next working shift.

Abuse training will be provided upon hire, at least annually and upon incidents as issues related to abuse prohibition practices. Abuse Investigation and Reporting for Senior Services Policy provides description of abuse types, prevention interventions and identification, investigation and reporting. This policy includes completing the DHSR Initial Allegation Reporting Form, DHSR (dept health human service regulation) 5 Day Investigation Report, Interviewing person reporting the incident, interviewing the resident (if appropriate), reviewing the medical record, interviewing staff members on all shifts, interviewing roommates, family members and visitors, interviewing other residents to who the employee provides care and or services, reviewing all circumstances and events leading up to the incident. Witness reports will be made in writing, signed and dated. Appropriate authorities notified in

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#113 reported the allegation to her.

An interview was conducted with the Charge Nurse on 12/15/2021 at 5:38 pm and she stated she did not remember Nurse #4 reporting an allegation of abuse involving Resident #113 and was not aware of the incident.

On 12/16/2021 at 1:05 pm an interview was conducted with the Director of Nursing and she stated she was not aware of Resident #113 reporting the allegation of abuse until the Family Member called the Staff Development Coordinator on 5/14/2021 and reported the allegation. The Director of Nursing stated she was not working when the allegation was reported, and the Staff Development Coordinator had suspended Nurse Aide #1 and obtained the statements from the staff.

The Staff Development Coordinator was interviewed on 12/16/2021 at 2:07 pm and stated he was not aware of the abuse allegation regarding Resident #113 until 5/14/2021 when the Family Member called him to report Resident #113 told him that Nurse Aide #1 intentionally slammed the over the bed table on her legs several weeks ago. He stated he had immediately made the Administrator aware of the allegation and suspended Nurse Aide #1 until the investigation was completed. The Staff Development Coordinator stated the staff receive abuse education at least annually and any time there is an allegation of abuse.

During an interview with the Administrator on 12/16/2021 at 2:21 pm she stated she was not aware Resident #113 had reported the allegation of abuse to Nurse #4 before it was reported by

compliance with state and federal laws. The administrator will be informed of progress of investigation. The administrator or designee will keep the resident and his/her representative informed of the progress in the investigation. Any accused individuals, employed by the facility will be suspended pending the investigation. While the investigation is taking place individuals not employed by the facility will be denied unsupervised access to the resident. In situation resident to resident abuse, residents will be supervised by staff until appropriate action can be taken to ensure the safety of other residents. Emotional support will be provided as needed.

Reporting, all alleged violations involving abuse, neglect , exploitation or mistreatment including injuries' of unknown origin and misappropriation of resident property are reported immediately but no later than two hours after the allegation is made to the health care personnel registry and to the law enforcement agency, if the events that cause the allegation involve abuse or result in serious bodily injury , or no later than 24 hours if the event that cause the allegation does not involve abuse or serious body injury, to the state agency in accordance with the state law.

The administrator or designee is responsible for completion of the Initial Allegation Report to the Health care personnel registry section of DHSR within 2 Hours after the allegation is made if the

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F 607	Continued From page 11 the Family Member to the Staff Development Coordinator on 5/14/2021. The Administrator stated Nurse #4 should have reported Resident #113's allegation of abuse regarding Nurse Aide #1 slamming the over the bed table down on her legs intentionally to her immediately. The Administrator stated Nurse Aide #1 should have reported to Nurse #1 and the Charge Nurse when the resident told him her hurt her legs with the over the bed table. The Administrator stated the staff should follow the facility's policy for Abuse Investigation and Reporting for Senior Services and report any allegations of abuse immediately. 2. Resident #49 was admitted to the facility on 1/3/21with a diagnosis of metabolic encephalopathy and Parkinson's disease. The Annal Minimum Data Set (MDS) dated 11/7/21 revealed Resident #49 was cognitively intact. A review of a policy titled: Abuse Investigations and Reporting for Senior Services revision date 3/5/21 read in part: Identification and Investigation: 2. The administrator or designee is responsible for ensuring the thorough investigation of the allegation. 3. Upon receiving a report of physical abuse, the nursing supervisor (or designee) shall immediately examine the resident. Finding of the examination must be recorded in the resident's record. 5. The director of nursing or designee will begin the abuse investigation which will consist of:	F 607	events that caused the allegation involve abuse or result in serious bodily injury. The administrator or designee is also responsible for completion of the Investigation 5 Day report to NC DHSR. A written report of the findings will be included with the DHSR 5 day Investigation report to the NC DHSR and to any other licensing authorities. All abuse investigations conducted by the facility will be reviewed by a corporate nurse consultant to ensure the LSC policy was followed and no further actions need to be taken. The nurse consultant will receive all reported allegations within 2 hours of the allegation being made. Implemented measure on 1/13/22. All skilled nursing stations have received an abuse instruction education folder to follow when an allegation or concern is reported by any staff member, resident or any person. This folder includes phone numbers of administration, local law enforcement and Dept of social service, initial Health care personnel registry reporting forms, resident / staff interview forms and a copy of the LSC Abuse Investigation and Reporting for Senior Services Policy. These folders were put in place by 1/13/22. All nurses have been made aware to notify administrator or director of nurisng immediately to any concerns or allegation of abuse. All licensed nurses have also been made aware to complete the initial reporting form within two hours of any allegation of abuse or bodily harm. All staff have been	

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F 607	Continued From page 12 " Completing the Division of Health Service Regulation (DHSR) required reporting from the (initial allegation report) " Interviewing the person(s) reporting the incident " Interviewing staff members (on all shifts) that have had contact with the resident during the period of this alleged incident " Reviewing all circumstances and events leading up to the incident 6. Witness reports will be made in writing, signed and dated. Witness reports will be maintained with all written reports. The director of social work or designee will monitor the resident's feeling concerning the incident, as well as the resident's reaction to his/her involvement in the investigation. Reporting: For certified nursing facilities and skilled nursing facilities, all alleged violations involving abuse, neglect, exploitation or mistreatment ...are reported immediately, but not later than two hours after the allegation is made A review of the facility's reportable incidents revealed no reportable investigations were completed related to the allegation of staff to resident abuse for Resident #49. The facility completed an investigation which included the following: Social Worker's (SW) interview with the resident, email correspondence between the Facility supervisor and the SDC, a signed statement from the Administrator and a Employee Coaching/Disciplinary Action Report. There were not signed statements from any staff. A review of the email correspondence included in the facilities investigation dated 8/24/21 at 10:46 AM from the Facility Supervisor nurse to the Staff Development Coordinator (SDC) read: "[Resident #49] told [Nurse #1] today [8/24/21] that last night	F 607	educated to notify their supervisor immediately on any allegations of abuse. Education was provided to all staff members by 12/30/21. A total of 6 residents will be interviewed every week for four weeks to ensure there are no concerns that have not been investigated. Interviews to begin 1/13/2022. Interviews will be conducted by the activity director or social worker. After four weeks, February 17, 2022, 6 interviews will occur each month for three months until three months of compliance is sustained. Any concerns found during these interviews will immediately be reported to the administrator and investigated. These interviews will begin 1/13/2022 The director of nursing, staff development coordinator, or minimum data set nurse(s) will interview 10 employees each week, by 1/13/2022, for four weeks using the Employee Interview Audit: Abuse Policy, to ensure all employees can verbally demonstrate understanding of the requirements in the policy titled, Abuse Investigation and Reporting for Senior Services. After four weeks (February 17,2022), 10 employees will be interviewed each month for three months until three months of compliance is sustained. Facility process to monitor performance to ensure solutions are sustained: The results of the resident / staff audits	

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F 607	Continued From page 13 [Nursing Assistant (NA) #3] was rough with [Resident #49]. She also explains that [NA #3] kept complaining that her back was hurting. [Resident #49] states that [NA #3] had grabbed her legs and then they got into the bathroom had to be asked to help her on the toilet. [Resident #49] told [Nurse #1] that when she was getting back to bed [NA #3] had grabbed her legs so hard that she was yelling to let go because of the pain. [Resident #49] then stated that [NA #3] told her 'I did not put them bruises on your legs, I know that is what you white women try to say about us black women'." An email from the Staff Development Coordinator (SDC) on 8/24/21 at 11:20 AM to the Facility Supervisor read; "does she have any bruises". The email response at 8/24/21 at 12:07 PM back from the Facility supervisor to the SDC read: "[Nurse #1] says she does but they were there previously". A review of Resident #49's skin evaluations revealed the following skin assessments: August 20,2021 8:07 PM - skin is warm, dry, fragile. Discoloration noted to both lower extremities (BLE). Some bruising noted to both upper extremities (BUE). No new areas noted. August 25th, 2021- 8:06 AM pressure reducing matters in place to help prevent skin breakdown. August 27th, 2021- 8:30 PM - Skin is warm, dry, fragile. Discoloration noted to BLE. Skin tear to back side of right hand. Some bruising noted to BUE. No new areas noted. There was no skin evaluation documented after the facility became aware of the incident with Resident #49 and NA #3 on August 24, 2021. A review of the Social Workers (SW) interview	F 607	interviews will be reported at the monthly QAPI meetings, by the social worker or director of nursing until the audit schedule is completed. The following QAPI meeting is scheduled for January 18,2022. The residents audit scheduled is as follows: 6 Residents will be interviewed every week for four weeks to ensure there are no concerns that have not been investigated. These interviews will begin 1/13/2022. Then beginning the week of February 17, 2022, 6 interviews will be conducted monthly by the activity director or social worker. Monthly audits will continue for three months until three months of compliance is sustained. Teammate audits will be conducted by the director of nursing, staff development coordinator, or minimum data set nurse(s). 10 employees each week for four weeks will be interviewed begin by Jan 13, 2002. After four weeks, beginning February 17, 2022 10 employees will be interviewed each month for three months. Teammate audits will continue until three months of compliance is sustained. All audits completed for abuse reporting by the nurse consultant will be reported in the QAPI monthly meeting for the next 12 months. Completion Date of Plan of Correction 1/13/22	

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with Resident #49 included in the facilities investigation dated 8/24/21 read in part; "[Resident #49] felt like [NA #3] was upset about something because she stated to [Resident #49] 'I don't have time to mess with you', the NA then grabbed Resident #49's calves and squeezed them while she was helping her get up. [Resident #49] screamed because it hurt, and she asked the NA to please not do that, it hurt. When [Resident #49] was being put back to bed, the NA squeezed her calves again. [Resident #49] stated that NA #3 said 'I know what you white women will say to us black women put bruises on you'. [Resident #49] stated she did not know why NA #3 said that".

A signed statement from the Administrator dated 8/24/21 read in part; "After reviewing interviews conducted by the social worker on 8/24/21, with [Resident #49] and other residents on that assignment and reviewing recent body assessments of [Resident #49], I concluded that abuse did not take place. The encounter with the third shift [NA #3] and [Resident #49] was inappropriate but the behavior did not meet the definition of abuse defined by the Centers for Medicaid Services (CMS). "Abuse", means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.'(42 CFR 488.301). However, this encounter did not meet the facility's expectation with the standard set-in place for customer service and professionalism. These expectations clearly stated in the LSC (Lutheran Services Carolina) WAY policy." "Teammate [NA #3] was removed from this resident's [Resident #49] assignment".

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An interview and observation were completed with Resident #49 on 12/14/21 at 9:01 AM who stated that a staff member was very rough with her one night back in the fall when she needed to use the bathroom. Resident #49 stated that she "had pressed her call light and NA #3 came in and had asked me what I needed, and huffed and said 'lordy, lordy' then grabbed my legs and snatched them around. She grabbed my legs below the knee and was very rough and squeezed them, she left fingerprints". Resident #49 stated she had used the walker to walk to the bathroom and when NA #3 had put Resident #49 back to bed she "threw" her back into bed and was very rough. Resident #49 described that her right calf was the worst because of the pain. Resident #49 stated that NA #3 said to her "I know all about you white people, you gather together and say anytime you get a bruise you say a black person did it". Resident #49 stated "I really felt mad when that happened. I told NA #3 that she was nothing but a racist because of what she said to me". Resident #49 stated I was not bleeding it just really hurt. Resident #49 stated that NA #3 is no longer able to come into my room. An observation of Resident #49's BLE revealed her legs are very small and skin was red and blotchy. A follow up interview was completed with Resident #49 on 12/15/21 at 5:30 PM who stated that "her comments still bother me and every time I think about how uncalled for it was. I get along with everyone and I don't know why she (NA #3) was so mean, I guess I am not made to be in nursing homes".

An interview was completed with the Social Worker (SW) on 12/14/21 at 2:54 PM who was asked if she had asked Resident #49 how this made her feel and the SW responded, "well, she

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did not like it of course, but was not asked". The SW stated I do not know why it was not reported.

An interview was completed with the SDC and the Facility Supervisor on 12/14/21 at 3:10 PM The Facility Supervisor stated the SDC notified the Administrator, and she did not direct a 24-hour report to be completed. The Facility Supervisor stated that she did go in and speak with Resident #49 and did look at her legs but did not chart it. The Facility Supervisor stated that "Resident #49 had stated that the NA #3 did grab her legs and she did have scattered bruising but like the Nurse #1 stated the bruising was already there". The Facility Supervisor stated that Resident #49 stated her legs hurt from what happened. The SDC and the Facility Supervisor was asked if NA #3 was suspended. The SDC stated that she did not work the next night as she had called out, and by then the investigation was completed and we did not need to suspend her. She was removed from performing care to Resident #49.

An interview was completed with the Administrator on 12/15/21 at 9:16 AM who stated that the facility became aware of the allegation of staff to resident abuse for Resident #49 at 10:45 AM on 8/24/21 and started the investigation. The Administrator was asked what the allegation was about, and the Administrator stated it was an allegation of an unpleasant encounter and Resident #49 was upset about the encounter and the facility wanted to follow up. The Administrator stated the facility did not report this allegation to the state as it did not meet the definition of abuse per the regulation. The Administrator stated that Resident's #49 does have frequent pain and when she if they are moving her legs, she would be in chronic pain regardless of if she had

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complained of pain. The Administrator stated, "Do I think the encounter should have gone differently absolutely, but I don't think the criteria of abuse was met". The Administrator was asked why they did an investigation and the Administrator stated that "we do an investigation with any conduct that does not meet our customers expectations".

An telephone interview was competed with Resident #49's responsible party (RP) on 12/15/21 at 10:45 AM who stated they had visited Resident #49 that morning on 8/24/21. The RP stated they did remember some racial comments that were made. The RP was asked if they remember any way Resident #49 was treated physically and the RP responded, "I do remember [Resident #49] saying that [NA #3] squeezed her legs" but did not recall if she had any marks. The RP stated that "my mom is not one to get upset but would get mad if she thought something was wrong". The RP stated Resident #49 has on-going skin issues and "if the aides would accidentally bump it on a wheelchair or something it causes her discomfort".

An interview was completed on 12/15/21 at 5:13 PM with Nurse #4 who was working third shift on 8/23/21 from 11:00 PM to 7:00 AM and was asked if she was interviewed about the incident with Resident #49 and NA #3. Nurse #4 stated that no one had interviewed her about the incident.

An interview was completed on 12/15/21 at 8:53 PM with NA #3 who stated she did not think she had been too rough with Resident #49 but there was a lot of pushing and pulling and you have to guide her legs and put pressure on them. NA #3 stated she did not remember her screaming in

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pain and was not rushing her. NA #3 stated she knew Resident #49's legs are sensitive, and Resident #49 told NA #3 to go slower. NA #3 stated that she did tell her to "come on" that her back was about to give out. NA #3 stated that she did not recall Resident #49 screaming out in pain. NA #3 was read the statement interview from the SW and Resident #49 which indicated NA #3 stated to Resident #49 'I don't have time to mess with you' 'I know all about you white people, you gather together and say anytime you get a bruise you say a black person did it". NA #3 stated that she did not say those things to Resident #49. NA #3 stated she had not been asked to write any statements about what happened but stated; "I wish they would have, as I cannot remember the details of what happened now."

An interview was completed with the DON on 12/16/21 at 10:11 AM who was asked what the process was for reporting abuse allegations. The DON stated that if the resident said it was on purpose, they would report it and if there was full intent, we would do an investigation. The DON stated that any allegation of abuse should be reported to the state. The DON stated that she did remember that there was an incident with NA #3 and Resident #49 during a transfer and stated that she felt that the NA had moved too quickly for the resident and did not think that NA #3 would do anything intentional. The DON stated that Resident #49 likes to be moved slowly and she will tense up and complain of pain. The DON stated that she thought she had been on vacation during the incident and that is all she could remember.

A follow up interview was completed with the Administrator on 12/16/21 at 2:26 PM who stated

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F 607	Continued From page 19 that "once the interviews were completed with Resident #49 and NA #3 it seemed to be more of a customer service situation, and it was not reported". The Administrator stated that "during an investigation the facility would get interviews and written statements from staff but was not sure if they had gotten one from NA #3". The Administrator stated the night nurse should have been interviewed and a skin assessment should have been completed.	F 607		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record reviews the facility failed to complete significant change Minimum Data Sets (MDSs) for 2 of 2 residents reviewed for a change in status (Resident # 39 and resident # 42). Findings included: 1.Resident # 39 was readmitted to the facility on 03/20/2021 with diagnoses of spinal stenosis,	F 637	Resident #39 had a significant change review with ARD on 1/13/2022 by the interdisciplinary team . Resident #42 had a significant change review with ARD on 1/13/2022 by the interdisciplinary team conducted. The facility addressed other residents having the potential to be affected by reviewing all residents MDS	1/13/22

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F 637	Continued From page 20 peripheral vascular disease (PVD) and transient ischemic attack (TIA). Review of an annual MDS dated 07/07/2021 revealed that Resident # 39 had moderate cognitive impairment and required extensive assist of at least 2 staff for bed mobility ,transfers and toileting. Resident # 39 required supervision to limited assist of 1 staff to eat, was always incontinent of bladder and bowel and had no pain. A quarterly MDS dated 10/06/2021 for Resident # 39 included that Resident # 39 had significant cognitive impairment, felt down, depressed, or hopeless on at least 1day of the review period and 12 to 14 days of feeling bad about herself. Resident # 39 required extensive assist of 1 staff to eat and was frequently incontinent of bladder and bowel. Resident # 39 had no pain. A review of a quarterly MDS dated 11/10/2021 included that Resident # 39 required supervision and set up to eat and she had frequent pain that limited her day-to-day activities. An interview conducted with MDS nurse # 1 on 12/16/2021 at 11:00 AM. MDS nurse #1 stated that a significant change MDS was required if a resident had 2 areas of decline or improvement in resident status as determined by the interdisciplinary team that consisted of MDS nurse #1 and MDS nurse #2. MDS nurse # 1 stated that there had been a difference in MDS coding for Resident # 39 but that she was not certain the MDS was coded correctly. The administrator was interviewed on 12/16/2021 at 1:22 PM. The administrator stated that she expected that significant change MDSs be	F 637	assessments for any areas of decline or improvement that indicate a significant change assessment is required. Review was conducted by 1/13/2022 by MDS RN(minimum data set), and staff development support LPN. 61 residents MDS reviewed. 0 number of residents required a significant change assessment. Measures put into place or systemic changes made to ensure the deficient practice will not recur: The interdisciplinary care plan team, including MDS (minimum data set) nurses, dining services director, social worker, and activity director, director of nursing, administrator and staff development RN was inserviced by the Director of Clinical Compliance Services on 1/12/22 regarding conducting significant changes assessments when a resident experiences a decline or improvement in two or more areas. Nurses were inserviced by the MDS Coordinator and Staff Development Coordinator on 1/13/22 on recognizing and reporting possible significant changes to the MDS coordinator or the nursing supervisor. New nursing team members will be educated on importance of reporting changes in condition to the supervisor or MDS (minimum data set) coordinator during orientation. Residents with potential declines or improvement in condition are reviewed at the weekly risk meeting to determine if a significant change assessment is indicated. Facility process to monitor performance	

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F 637	Continued From page 21 completed as stated in the regulation and the Resident Assessment Manual (RAI). 2. Resident #42 was admitted to the facility on 05/05/21 with diagnoses that included muscle weakness and gait abnormalities. A review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated 08/04/21 was conducted. The functional status section of the MDS reported the resident required supervision only for transfer, dressing, toilet use and personal hygiene and the assistance of 1 person. For eating she required supervision only with meal set up assistance. She needed limited assistance from staff for bed mobility with the assistance of 1 person. Locomotion occurred only 1-2 times with 1 person assist on the unit. A review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated 10/27/21 was conducted. The functional status section of the MDS reported the resident required supervision only with eating and one person physical assist. She required extensive assist of 2 staff with bed mobility, extensive assist with 1 person assist for transfer, dressing, toilet use and personal hygiene An interview was conducted with MDS Nurse #1 on 12/15/21 at 9:45 AM regarding the decline in the functional status on Resident #42's Quarterly assessments from 08/04/21 to 10/27/21. The MDS nurse stated the resident had not changed much and did not indicate a need for a significant change assessment to be completed. She stated they looked at the Activities of Daily Living (ADL's), but they can fluctuate and if they need a significant difference in care and had 2 or more differences in care, they might do one.	F 637	to ensure solutions are sustained: To monitor performance, the Director of Nursing or Staff Development Assistant LPN will review 3 residents MDS assessments weekly for four weeks and then review 6 MDS assessments monthly to determine if a significant change was warranted. If a significant change was needed the Director of Nursing or Staff Development Assistant LPN will audit to see if a comprehensive care plan was completed to address the changes. Audits findings will be reported to the QAPI committee by the Director of Nursing or Staff Development Nursing monthly until 3 months of compliance is sustained. Completion Date of Plan of Correction 1/13/2022	

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F 637	Continued From page 22 An interview was done on 12/15/21 at 10:33 AM with Nurse #5 regarding Resident #42. He stated the resident used to be very independent and after one of her falls, she now required a lot more assistance. An interview was done on 12/15/21 at 11:11 AM with PT #1 that completed the requested rehabilitation evaluation after some falls. He stated he evaluated her post falls on 09/15/21 and she had she absolutely refused to participate. He noted she would not stand when asked or actively participate and had become more non-compliant since completing therapy in June 2021. Record review indicated Resident #42 had 7 falls since admission including 08/31/21 and 11/14/21. Record review of X-rays from 9/17 indicated a pelvis fracture. A follow-up interview was done on 12/16/21 at 12:03 PM with MDS Nurse #1 and she was asked why a significant change assessment was not done with 2 or more changes, and with several functional area declines. She stated the final decision if a significant change needed to be done was made by the Interdisciplinary Team, which consisted of the 2 MDS nurses. An interview was done on 12/16/21 at 1:05 PM with the Administrator. She stated if there were changes on the MDS assessment in 2 or more areas and the changes were for a prolonged time, a significant change should be done.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		1/13/22

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F 656	Continued From page 23 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 24 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement comprehensive care plans for 2 of 2 residents (Resident #42, Resident #59) reviewed for care plans. The findings included: 1. Resident #42 was admitted to the facility on 05/05/21 with diagnoses that included cognitive communication deficit, muscle weakness and gait abnormalities. A review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated 08/04/21 was conducted. The functional status section of the MDS reported the resident required supervision only for transfer, dressing, toilet use and personal hygiene and the assistance of 1 person. For eating she required supervision only with meal set up assistance. She needed limited assistance from staff for bed mobility with the assistance of 1 person. Locomotion occurred only 1-2 times with 1 person assist on the unit. A review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated 10/27/21 was conducted and indicated several areas of decline. The functional status section of the MDS reported the resident required supervision only with eating and one person physical assist. She required extensive assist of 2 staff with bed mobility, extensive assist with 1 person assist for transfer,	F 656	Corrective action for residents found to be affected by deficient practice: Resident #42□s care plan was revised on 1/12/2022 by the MDS (minimum data set)nurse(s) to reflect residents current status and assistance needs with ADLS. Resident #59□s care plan was revised on 12/16/21 by the MDS Rn(s) (minimum data set) to address nutritional status and weight loss. Interventions were included on the care plan to monitor weights, supplements as ordered, snacks as needed, and monitor labs. Changes were made to the electronic medical record system to ensure nurses could see the full care plan on 1/7/22 by the Director of Quality and Life and Care. Steps facility will take to identify other residents having the potential to be affected by the same deficient practice: The facility addressed other residents having the potential to be affected by reviewing all residents□ care plans to ensure assistance with ADLS were accurate and that nutritional status and weight loss were addressed. Review was conducted by MDS RN(s) and completed on 1/12/22. 61 reviews were completed. Revisions were made to 0 residents care plans. All care plans were also audited to ensure they were visible to nurses on 1/7/22 by the corporate nurse consultant.	

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F 656	Continued From page 25 dressing, toilet use and personal hygiene A review of Resident #42's care plan initiated on 05/25/21 and most recently revised on 10/29/21 indicated a care area for "Help with my ADL's." The care area only addressed oral hygiene and refusal of care for her ADL's. An interview was conducted with MDS Nurse #1 on 12/15/21 at 9:45 AM regarding the care plan not reflecting the ADL decline in the functional areas. She stated she did not know what the staff would see on Resident #42's care plan as she had a different view. She stated the ADL information displayed in her view. A follow-up interview was done with MDS Nurse #1 on 12/15/21 at 12:03 PM. She stated the nurses were not able to view the ADL functional need information on Resident #42's care plan and she did not know why. The MDS nurse noted that usually the care plan had more information than just oral care such as transfers, bathing and mobility in the care plan. An interview was done on 12/16/21 at 1:05 PM with the Administrator regarding Resident #42's ADL decline and her care plan. She stated the care plan should be all inclusive and everyone should be able to see the care areas and interventions. 2. Resident # 59 was admitted to the facility on 08/27/2021 with diagnoses that included dementia, insomnia, and a history of falls. A significant change Minimum Data Set (MDS) dated 11/17/2021 included that Resident # 59 had severe cognitive impairment and required	F 656	Measures put into place or systemic changes made to ensure the deficient practice will not recur: Measures were put into place to ensure the practice does not recur. The interdisciplinary care plan team was inserviced on 1/12/22 by the Director of Clinical Compliance Services regarding ensuring care plans are developed and implemented that accurately reflect the care of the residents. The MDS RN(s) (minimum data set) was inserviced by the dietary consultant by 1/11/22, regarding addressing nutritional status and weight loss as part of the care plan. Residents with changes in condition or weight loss are reviewed in the weekly at risk meeting. Licensed nursing staff and certified nursing staff were educated on how to view care plans, care plan changes and update notifications, and reporting of changes in condition by the Minimum Data Set RN - MDS RN and the Staff Development Coordinator. This education was provided on 1/13/22. Facility process to monitor performance to ensure solutions are sustained: To monitor performance, the Director of Nursing, Staff Development Coordinator or MDS RN(s) will audit 6 care plans each month to determine if the resident□s care plan is appropriate and viewable to nursing staff. Findings will be reported to the QAPI committee monthly until 3 months of compliance is sustained. Completion of Plan of Correction Date	

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F 656	Continued From page 26 supervision of 1 staff with meals. Resident # 59 weighed 109 pounds and was not on a physician prescribed weight loss regimen. Review of a nutritional progress note dated 11/17/2021 at 12:07 PM included that Resident # 59 had a significant weight loss. She received a regular diet and a nutritional supplement two times a day. Resident # 59 was recorded to consume an average of 49% of meals. On 12/16/2021 the care plans for resident # 59 were reviewed and had been updated on 09/16/2021 and on 11/23/2021. The nutritional status and weight loss of resident # 59 was not included in the comprehensive care plans. MDS # 1 was interviewed on 12/16/2021 at 11:00 AM. MDS nurse #1 reviewed the current care plans for Resident # 59 and stated that she did not see nutritional or weight loss care plans for Resident # 59 and that there should be care plans to address those areas. The facility administrator was interviewed on 12/16/2021 at 1:22 PM and she stated that she expected care plans to be implemented and revised to reflect the status of the resident.	F 656	1/13/2022	
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		1/13/22

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F 686	Continued From page 27 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interview, the facility failed to provide pressure ulcer treatment for 1 of 1 resident (Resident #61) reviewed for pressure ulcers. The findings included: Resident #61 was admitted to the facility on 12/1/20 and readmitted to the facility on 11/5/21 with multiple diagnoses that included Dementia, muscle weakness and pressure ulcer. Resident #61 had a significant change Minimum Data Set (MDS) dated 11/12/21 which revealed she was moderately cognitively impaired with a Stage 4 facility acquired pressure ulcer. She required extensive assistance with bed mobility, toileting and eating. Resident #61 was incontinent of bowel and bladder. The care plan updated on 11/24/21 indicated Resident #61 had a Stage 4 wound to the coccyx and the goal was to heal without signs or symptoms of complications or infection in three months. One of the interventions was to provide treatment as ordered. Resident #61 had a physician order dated 11/16/21 to apply menthol zinc oxide to buttocks every shift to excoriated areas. Review of the Treatment Administration Records revealed there	F 686	Corrective actions were taken for resident #61. Resident #61 was seen by the wound doctor on 12/21/21, 1/4/22 & 1/11/22 . New treatment order clean coccyx normal saline, apply collagen to wound bed, pack with Aquacel AG and cover with dry dressing daily. The facility addressed other residents having the potential to be affected by reviewing all medical records of residents having wounds to ensure appropriate orders and care plans for wounds are in place, and that treatments are being completed as ordered. Review performed on 1/10/2022 by MDS RN(s) (minimum data set RN). 8 treatments were noted missing in last 30 days. All residents with missing treatments were seen by the wound care physician on 1/11/22. The wound physician reassessed for wound healing. No residents suffered adverse consequences as a result of a missed treatment. Measures were put into place to ensure the practice does not recur. Nursing staff inserviced by Staff Development Rn and MDS (minimum data Set RN) by 1/13/21	

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F 686	Continued From page 28 was no documentation of the application of menthol zinc oxide to the buttocks on: " 11/17/21 " 11/20/21 " 11/21/21 " 11/24/21 " 11/27/21 " 11/30/21 " 12/11/21 " 12/12/21 Resident #61 had a physician order dated 11/30/21 to clean coccyx pressure ulcer, pack with silver alginate dressing then cover and secure. Change daily every morning until healed. Review of the November Treatment Administration Record revealed no documentation of treatment to the coccyx on: " 11/13/21 " 11/14/21 " 11/15/21 " 11/20/21 " 11/21/21 " 11/24/21 " 11/27/21 Review of the medical record revealed Wound Care Physician measurements of coccyx wound were as follows: 11/9/21 0.6x0.5x0.6 centimeters (cm.) (length x width x depth) 11/30/21 0.9x0.9x0.5 cm. (length x width x depth) Resident #61 had a physician order dated 12/7/21 to clean right buttock with normal saline, apply silver alginate dressing, gauze and secure and change daily to area of moisture associated skin damage. Review of the December Treatment Administration Record revealed there was no	F 686	regarding importance of carrying out all treatments as ordered. If designated wound nurse or treatment aide is unable to complete treatments for any reason, the nursing supervisor will ensure that treatments are completed for that shift. The weekend supervisor will ensure that treatments are completed on weekends. Daily treatment reports will be reviewed to ensure treatments are completed by facility supervisor RN. Residents with wounds will be reviewed in the weekly at risk meeting, including confirming that treatments are being done as ordered. 4. Facility process to monitor performance to ensure solutions are sustained: To monitor performance, the Director of Nursing or Staff Development Coordinator will audit treatment records for 5 residents monthly to ensure treatments are being completed as ordered. Findings will be reported to the QAPI committee monthly until 3 months of compliance is sustained.	

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F 686	Continued From page 29 documentation of the treatment to the coccyx and right buttock areas on " 12/8/21 " 12/11/21 " 12/12/21 Review of the medical record revealed Wound Care Physician measurements of coccyx wound were as follows 12/7/21 1.1 cm x 1.1 cm x 0.8 cm (length x width x depth) 12/14/21 0.9 cm x 0.9 cm x 0.5 cm (length x width x depth) During an interview on 12/15/21 at 10:37 AM, Treatment Aide II stated she worked Monday through Friday and was responsible for treatments. She stated she was reassigned to the floor to provide patient care at times and then the floor nurses were responsible for completing wound care. During an interview on 12/15/21 at 11:16 AM, the Wound Care Nurse stated she worked Monday through Friday. She stated the Treatment Aide II provided wound care Monday through Friday. On the weekends and in the absence of an assigned treatment nurse, the nurse on the floor provided the wound care. She stated she rounded weekly with the Wound Care Physician. She further stated she did not review the Treatment Administration Records to ensure treatments were completed. Record review of the facility Daily Assignment Sheets revealed the following assignment for treatments: 11/20/21: Nurse #2 11/21/21: no assigned nurse	F 686		

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F 686	Continued From page 30	F 686		

11/24/21: no assigned nurse
11/27/21: no assigned nurse
12/8/21: floor nurses' complete own treatments
12/11/21: no assigned nurse
12/12/21: no assigned nurse
During an interview via phone on 12/15/21 at 3:18PM, Nurse #1, indicated she was aware of her responsibility to administer the wound treatments to her assigned residents including Resident #61 in the absence of Treatment Aide II or designated treatment nurse. She had not completed the assigned wound care for Resident #61 on dates listed below and was unable to verbalize why:
" 11/13/21
" 11/14/21
" 11/15/21
" 11/20/21
" 11/21/21
" 11/24/21
" 11/27/21
" 11/30/21
" 12/8/21
" 12/11/21
" 12/12/21
During an interview on 12/16/21 at 10:33 AM, Nurse #2 indicated initially on 11/20/21 she was assigned to do all treatments but one of the nurses went home early, and the schedule was changed. She was reassigned to a medication cart and resident assignment. Nurse #2 indicated she had not completed the treatment for Resident #61 prior to the assignment change and that she informed the nurses of the change in the schedule and that they were to complete their assigned residents' treatments.

During an interview via phone on 12/16/21 at 9:53 AM the Wound Care Physician revealed wound

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F 686	Continued From page 31 care was ordered daily for Resident #61 and should be followed as written. She indicated she visits the facility briefly each week. She indicated wound healing could be impacted by not changing the dressing daily as ordered. During an interview on 12/16/21 at 1:00 PM, the Director of Nursing indicated that the nurses were aware to complete wound care in the absence of a wound care aide or nurse. She stated she was not aware of any problems with completing daily wound treatments and she does not review Treatment Administration Records.	F 686		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to provide effective oversight to ensure abuse allegations made by 2 of 3 residents, Resident #113 and Resident #49, were assessed, investigated, and reported according to the facility's Abuse Investigation and Reporting for Senior Services Policy. Findings included: This tag is cross referenced to: F607- Based on record review and family and staff interviews facility staff failed to follow the	F 835	For Resident #49 The social worker completed an interview with resident #49 on 8/24/21 to discuss concerns regarding NA (nursing assistant)#3. NA (nursing assistant) #3 was removed from residents assignment on 8/24/21. 8 additional interviews were completed with alert/ oriented residents on NA #3 assignment, by the social worker on 8/24/21, no new concerns noted. Nurse #4 and the Charge Nurse were all educated on the policy titled, Abuse Investigation and Reporting for Senior	1/13/22

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	345109	A. BUILDING _____ B. WING _____	12/16/2021

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F 835	Continued From page 32 facility's Abuse Investigation and Reporting for Senior Services Policy when they failed to promptly report allegations of abuse for 2 of 3 residents, Residents #113, and Resident #49, reviewed for abuse. Resident #113 reported allegations of abuse to a staff member who did not report the allegation to facility management, which resulted in the accused staff member not being removed from the facility and an investigation being delayed. Resident #49 also reported allegation of abuse to staff, and they failed to report the allegation to the Division of Health Service Regulation and failed to assess Resident #49 and investigated the allegation. The Administrator was interviewed on 12/16/2021 at 2:21 pm and stated the staff should report any allegation of abuse to their supervisor immediately and then the supervisor should report the allegation to the Director of Nursing and Administrator. The Administrator stated the staff are educated on abuse at least once a year and whenever an incident occurs. .	F 835	Services by the staff development coordinator RN on 5/14/21. NA (nursing assistant) #1 was educated on policy Investigate and Reporting of Senior Services by the staff development coordinator RN Written education was provided to Nurse Aide # 1 on May 17,2021. NA #1, Nurse #4, and the Charge Nurse all acknowledged understanding and the expectation to follow the LSC policy. Resident #113 was interviewed by the social worker on 5/14/21 and resident #113 was made aware that NA #1 was removed from assignment on 5/14/21. Nurse aide #1 charge nurse, the director of nursing and the administrator were all reeducated on the policy titled, Abuse Investigation and Reporting for Senior Services by the staff development coordinator on 12/23/21. Nurse #4 was educated on the Abuse Investigation and Reporting for Senior Services by the staff development coordinator on 12/22/21. Steps facility will take to identify other residents having the potential to be affected by the same deficient practice: Every resident with a BIMS score of 13 or higher was interviewed by the activity director and assistant activity director on 1/11/22, 20 residents were interviewed. the LSC Resident Interview Tool was used. 2 grievances were noted from the interviews. The grievance policy was followed to rectify all concerns.	

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F 835	Continued From page 33	F 835	Measures put into place or systemic changes made to ensure the deficient practice will not recur: Every employee will be in-service by 12/30/21 on the policy titled, Abuse Investigation and Reporting for Senior Services by the staff development coordinator, or staff development coordinator support LPN. Any employee not In-serviced by this date will be in-service prior to their next working shift. Abuse training will be provided upon hire, at least annually and upon incidents as issues related to abuse prohibition practices. Abuse Investigation and Reporting for Senior Services Policy provides description of abuse types, prevention interventions and identification, investigation and reporting. This policy includes completing the DHSR Initial Allegation Reporting Form, DHSR (dept health human service regulation) 5 Day Investigation Report, Interviewing person reporting the incident, interviewing the resident (if appropriate), reviewing the medical record, interviewing staff members on all shifts, interviewing roommates, family members and visitors, interviewing other residents to who the employee provides care and or services, reviewing all circumstances and events leading up to the incident. Witness reports will be made in writing, signed and dated. Appropriate authorities notified in compliance with state and federal laws. The administrator will be informed of progress of investigation. The	

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F 835	Continued From page 34	F 835		

administrator or designee will keep the resident and his/her representative informed of the progress in the investigation. Any accused individuals, employed by the facility will be suspended pending the investigation. While the investigation is taking place individuals not employed by the facility will be denied unsupervised access to the resident. In situation resident to resident abuse, residents will be supervised by staff until appropriate action can be taken to ensure the safety of other residents. Emotional support will be provided as needed.

Reporting, all alleged violations involving abuse, neglect , exploitation or mistreatment including injuries' of unknown origin and misappropriation of resident property are reported immediately but no later than two hours after the allegation is made to the health care personnel registry and to the law enforcement agency, if the events that cause the allegation involve abuse or result in serious bodily injury , or no later than 24 hours if the event that cause the allegation does not involve abuse or serious body injury, to the state agency in accordance with the state law.

The administrator or designee is responsible for completion of the Initial Allegation Report to the Health care personnel registry section of DHSR within 2 Hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury. The administrator or designee is also

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F 835	Continued From page 35	F 835	responsible for completion of the Investigation 5 Day report to NC DHSR. A written report of the findings will be included with the DHSR 5 day Investigation report to the NC DHSR and to any other licensing authorities. All abuse investigations conducted by the facility will be reviewed by the corporate nurse consultant to ensure the LSC policy was followed and no further actions need to be taken. The nurse consultant will receive all reported allegations within 2 hours of the allegation being made. Date of completion 1/13/22 All skilled nursing stations have received an abuse instruction education folder to follow when an allegation or concern is reported by any staff member, resident or any person. This folder includes phone numbers of administration, local law enforcement and Dept of social service, initial Health care personnel registry reporting forms, resident / staff interview forms and a copy of the LSC Abuse Investigation and Reporting for Senior Services Policy. All nurses have been made aware to notify administrator or director of nurisng immediately to any concerns or allegation of abuse. All licensed nurses have also been made aware to complete the initial reporting form within two hours of any allegation of abuse or bodily harm and to notify outside law enforcement. All staff have been educated to notify their supervisor immediately on any allegations of abuse. Intervention put in place 1/11/22.	

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F 835	Continued From page 36	F 835	A total of 6 residents will be interviewed every week for four weeks to ensure there are no concerns that have not been investigated. Interviews will be conducted by the activity director or social worker. After four weeks, 6 interviews will occur each month for three months until three months of compliance is sustained. Any concerns found during these interviews will immediately be reported to the administrator and investigated. The director of nursing, staff development coordinator, or minimum data set nurse(s) will interview 10 employees each week for four weeks using the form titled, Employee Interviews: Abuse Policy, to ensure all employees can verbally demonstrate understanding of the requirements in the policy titled, Abuse Investigation and Reporting for Senior Services. After four weeks, 10 employees will be interviewed each month for three months until three months of compliance is sustained. Facility process to monitor performance to ensure solutions are sustained: The results of the resident / staff audits interviews will be reported at the monthly QAPI meetings by the social worker or director of nursing until the audit schedule is completed and compliance as is sustained for three months for both resident and staff interviews regarding abuse notification. All audits completed by the corporate nursing consultant with	

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F 835	Continued From page 37	F 835	allegations of abuse reporting by the facility will be presented at the monthly QAPI meeting over the next 12 months. Completion Date of Plan of Correction 1/13/22	