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L 000	INITIAL COMMENTS An unannounced complaint investigation was conducted onsite on 06/13/22. Additional interviews were conducted offsite on 06/14/22, therefore the exit date was changed o 06/14/22. A total of 4 allegations were investigated and 3 were substantiated resulting in deficiencies. Intake #NC00188972. Event ID# 27RM11.	L 000		
L 050	.2210(B) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (b) A facility shall ensure that the Division of Health Service Regulation is notified within 24 hours of the facility's becoming aware of any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1). This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not reporting an allegation of abuse to the Division of Health Service Regulation (DHSR) within 24-hours for 1 of 3 residents reviewed for abuse (Resident #1). Findings included: The facility policy titled, "Abuse and Neglect" revised 03/06/22, read in part: "The Administrator or Director of Nursing will submit a report to the State Survey Agency as required by state and federal law. The facility is required to report all	L 050		

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L 050	Continued From page 1	L 050		

suspicions of abuse against a resident within 24-hours to law enforcement and the State Survey Agency. The only exception to this rule is in the event that the crime results in "serious bodily harm" to the resident, in which case, the reporting must be completed within 2 hours."

Review of email correspondence provided by the Administrator on 06/13/22 revealed Nurse #1 sent an email to the Administrator and former Director of Nursing on 09/03/21 at 7:57 AM informing them both of an allegation of verbal abuse involving Resident #1 and Nurse Aide (NA) #1. Nurse #1 reported while visiting a resident next door to Resident #1 on 09/02/21, she overheard a loud commotion coming from Resident #1's room. When she went to Resident #1's room to see what was going on, Nurse #1 reported overhearing NA #1 yelling at Resident #1 in a loud and unkind tone of voice while telling Resident #1 it was all her fault NA #1 was waiting on her. Nurse #1 also indicated in the email Resident #1 was upset over the incident.

Review of the facility's investigation documentation revealed no evidence an initial report was sent to DHSR within 24-hours of being notified on 09/03/21 of the allegation of abuse involving NA #1 and Resident #1. Further review revealed the initial report was not submitted by the facility to DHSR until 09/17/21 at 1:19 PM via fax transmission. The initial report noted the facility became aware of an allegation of verbal abuse by NA #1 toward Resident #1 on 09/17/21 at 10:00 AM.

During an interview on 06/14/22 at 1:11 PM, the former Director of Nursing (DON) confirmed she was notified by Nurse #1 of the allegation of verbal abuse involving NA #1 and Resident #1 on

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L 050	Continued From page 2 09/03/21 and had conducted the investigation. The former DON stated she could not recall the "specifics" of the investigation but was "pretty sure" she had submitted the required reports to DHSR when initially notified of the allegation. During an interview on 06/13/22 at 4:50 PM, the Administrator confirmed both she and the former DON had received the email correspondence from Nurse #1 on 09/03/21 alleging verbal abuse toward Resident #1 by NA #1. She verified the initial report for the allegation of abuse involving NA #1 and Resident #2 was not submitted to DHSR within 24-hours of being notified on 09/03/21. The Administrator explained the former DON had conducted the investigation and had informed the Administrator she had submitted the required reports to DHSR. She added, it wasn't until approximately 09/16/21 she learned the former DON had not submitted the initial report to DHSR and the investigation was reopened on 09/17/21. The Administrator stated ultimately, she was the one responsible for ensuring all abuse allegations were reported and investigated within the regulatory time frames. The Administrator explained she had not reviewed the former DON's investigation documentation prior to the investigation being reopened on 09/17/21 and had trusted the former DON to follow the facility's Abuse policy which would have included submitting the required reports to DHSR.	L 050		
L 051	.2210(C) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (c) A facility shall investigate allegations of any act listed in G.S. 131E-256(a)(1), shall document all information pertaining to such investigation, and shall take the necessary	L 051		

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L 051	Continued From page 3 steps to prevent further incidents while the investigation is in progress. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not ensuring an allegation of abuse was thoroughly investigated after being informed Nurse Aide (NA) #1 allegedly verbally abused Resident #1. The facility also failed to protect Resident #1 from further potential abuse by allowing NA #1 to continue working during the course of the investigation for 1 of 3 sampled residents reviewed for abuse (Resident #1). Findings included: The facility policy titled, "Abuse and Neglect" revised 03/06/22, read in part: "4. Our abuse prevention program includes, but is not necessarily limited to, the following: c) the protection of residents during abuse investigations and e) timely and thorough investigations of all reports and allegations of abuse ...10. Should an incident or suspected incident of resident abuse be reported, the Administrator or his/her designee, will appoint a member of management to investigate the alleged incident ...11. Witness reports will be obtained ...12. Employees of this facility who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed by the Administrator."	L 051		

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L 051	Continued From page 4 Resident #1 was admitted to the facility on 09/12/19 with multiple diagnoses that included vascular dementia. Review of email correspondence provided by the Administrator on 06/13/22 revealed Nurse #1 sent an email to the Administrator and former Director of Nursing on 09/03/21 at 7:57 AM informing them both of an allegation of verbal abuse involving Resident #1 and Nurse Aide (NA) #1. Nurse #1 reported while visiting a resident next door to Resident #1 on 09/02/21, she overheard a loud commotion coming from Resident #1's room. When she went to Resident #1's room to see what was going on, Nurse #1 reported overhearing NA #1 yelling at Resident #1 in a loud and unkind tone of voice while telling Resident #1 it was all her fault NA #1 was waiting on her. Nurse #1 also indicated in the email Resident #1 was upset over the incident. Review of the facility's investigation documentation completed by the former Director of Nursing (DON) revealed there was no evidence statements were obtained from the alleged victim, alert and oriented residents who received care from NA #1, the accused employee (NA #1), witnesses to the incident, or staff working at the time of the alleged incident. Review of the time clock reports for NA #1 revealed she worked at the facility on the following dates: 09/02/21 during the hours of 7:03 AM to 8:16 PM. 09/03/21 during the hours of 2:45 PM to 12:01 AM. 09/05/21 during the hours of 7:20 PM to 7:14 AM. 09/07/21 during the hours of 11:02 AM to 11:15 PM.	L 051		

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L 051	Continued From page 5 09/08/21 during the hours of 7:12 AM to 7:19 PM. 09/10/21 during the hours of 10:58 AM to 11:18 PM. 09/12/21 during the hours of 7:07 AM to 7:28 PM. 09/13/21 during the hours of 3:00 PM to 10:59 PM. 09/14/21 during the hours of 6:58 AM to 7:45 PM. 09/15/21 during the hours of 6:32 AM to 8:07 PM. 09/16/21 during the hours of 6:30 AM to 7:24 PM. Telephone attempts on 06/13/22 at 2:39 PM and 06/14/22 at 10:38 AM for interview with NA #1 were unsuccessful. During an interview on 06/13/22 at 1:05 PM, Nurse #1 could not recall the exact time but stated on 09/02/21 as she was visiting another resident who resided next door to Resident #1, she heard a commotion and loud voices coming from Resident #1's room. Nurse #1 stated as she went into Resident #1's room to see what was going on, she saw NA #1 standing in the doorway of Resident #1's bathroom and NA #1 was "scolding" Resident #1 in a loud tone and telling Resident #1 that it was all her fault NA #1 had to wait on her. She added the way NA #1 acted toward Resident #1 was inappropriate and abusive. Nurse #1 stated she immediately reported what she had witnessed to Nurse #2 and the Unit Manager on 09/02/21 who told her they would "take it from there." Nurse #1 added she sent an email to both the Administrator and former DON the very next morning (09/03/21) informing them both of the incident. Nurse #1 stated she knew when an allegation of abuse was made, there should be an investigation conducted by the facility and the accused employee suspended pending the outcome of the investigation; however, NA #1 was allowed to continue working after the incident was initially	L 051		

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L 051	Continued From page 6	L 051		

reported on 09/02/21. Nurse #1 stated she was not sure if the incident was ever investigated as she was never interviewed and when she questioned the former DON several times over a two-week period following the incident, she was told by the former DON they already had her statement from the email she sent on 09/03/21 and since there was no physical harm to Resident #1, they didn't feel they needed to interview her (Nurse #1) any further.

During an interview on 06/13/22 at 6:38 PM, the Unit Manager (UM) confirmed she and Nurse #2 were notified by Nurse #1 of an allegation of abuse by NA #1 toward Resident #1 on 09/02/21. The UM recalled she was on the phone at the time and did not personally go and assess Resident #1 but recalled Nurse #2 did. The UM stated she was never interviewed by the former DON or Administrator regarding what was reported to her by Nurse #1.

During an interview on 06/14/22 at 9:51 AM, Nurse #2 confirmed she and the UM were both notified by Nurse #1 of an allegation of abuse by NA #1 toward Resident #1 on 09/02/21. Nurse #2 added she was the nurse assigned to provide care to Resident #1 on 09/02/21 and immediately went to Resident #1's room with Nurse #1 to assess Resident #1. Nurse #2 recalled when she and Nurse #1 got to Resident #1's room, NA #1 was out in the hallway stating "I can't deal with her anymore" referring to Resident #1 and when they entered the room, Resident #1 was visibly upset, much more so than normal. Nurse #2 explained once Resident #1 started to calm down, she asked her what had happened to make her so upset but she wasn't really able to explain. Nurse #2 confirmed she was never interviewed by the former DON or Administrator

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L 051	Continued From page 7 regarding the incident. During an interview on 06/14/22 at 1:11 PM, the former Director of Nursing (DON) confirmed she was notified by Nurse #1 of the allegation of verbal abuse involving NA #1 and Resident #1 on 09/03/21 and had conducted the investigation. The former DON stated she could not recall the "specifics" of the investigation but did recall speaking with NA #1. The former DON recalled NA #1 stating she had answered Resident #1's call light and when she realized Resident #1 needed assistance off the toilet, she tried to explain to Resident #1 that she would need to go get another NA to assist her but Resident #1 was screaming and she only raised her tone of her voice so that Resident #1 could hear what she was saying. The former DON stated Nurse #1 reported she heard the interaction while in another room; however, when she went to the room Nurse #1 was in, the former DON stated you might be able to hear noises but not the specific conversation as reported by Nurse #1 and there was no way she could corroborate the allegation. When asked if she had clarified with Nurse #1 about her going into Resident #1's and witnessing the interaction between NA #1 and Resident #1, the former DON could not provide an answer. The former DON confirmed when an allegation of abuse was made against an employee, the facility's policy was to suspend the employee pending the outcome of the investigation. She explained when the allegation of abuse was made on 09/03/21 against NA #1, she did not suspend her at that time because NA #1 was not scheduled to work for the next few days and knew she could complete the investigation before NA #1 was to report back to work.	L 051		

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L 051	Continued From page 8 During an interview on 06/13/22 at 4:50 PM, the Administrator confirmed both she and the former DON had received the email correspondence from Nurse #1 on 09/03/21 alleging verbal abuse toward Resident #1 by NA #1. The Administrator explained when conducting an investigation into alleged abuse, interviews should be conducted with all parties involved in the incident, witnesses, and alert and oriented residents who received care from the accused employee. In addition, the Administrator stated the accused employee should be immediately suspended pending the outcome of the investigation. The Administrator stated the former DON had conducted the investigation of the alleged abuse by NA #1 toward Resident #1 and it wasn't until approximately 09/16/21 when "more information came out about the incident", she learned the former DON had not followed the facility's abuse policy or process by not immediately suspending NA #1 or completing a thorough investigation and the investigation was reopened on 09/17/21. The Administrator stated ultimately, she was the one responsible for ensuring all abuse allegations were thoroughly investigated and when Nurse #1 sent the email to both her and the former DON on 09/03/21, they took that as her statement and did not call or interview her further. The Administrator explained she had not reviewed the former DON's investigation documentation prior to the investigation being reopened on 09/17/21 and had trusted the former DON to follow the facility's Abuse policy which would have included suspending NA #1 and obtaining statements from all parties involved in the incident as well as any witnesses.	L 051		
L 052	.2210(D) REPORTING, INVESTIGATING ABUSE, NEGLECT	L 052		

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L 052	Continued From page 9 10A-13D.2210 (d) A facility shall ensure that the report of investigation is printed or typed and sent to the Division of Health Service Regulation within five working days of the allegation. The report shall include: (1) the date and time of the alleged incident; (2) the patient's full name and room number; (3) details of the allegation and any injury; (4) names of the accused and any witnesses; (5) names of the facility staff who investigated the allegation; (6) results of the investigation; and (7) any corrective action that was taken by the facility. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not reporting the results of an investigation of alleged abuse to the Division of Health Service Regulation (DHSR) within 5 working days of the allegation for 1 of 3 sampled residents reviewed for abuse (Resident #1). Findings included: The facility policy titled, "Abuse and Neglect" revised 03/06/22, read in part: "The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the State Survey Agency and others as may be	L 052		

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L 052	Continued From page 10	L 052		

required by state or local laws, within 5 working days of the reported incident."

Review of email correspondence provided by the Administrator on 06/13/22 revealed Nurse #1 sent an email to the Administrator and former Director of Nursing on 09/03/21 at 7:57 AM informing them both of an allegation of verbal abuse involving Resident #1 and Nurse Aide (NA) #1. Nurse #1 reported while visiting a resident next door to Resident #1 on 09/02/21, she overheard a loud commotion coming from Resident #1's room. When she went to Resident #1's room to see what was going on, Nurse #1 reported overhearing NA #1 yelling at Resident #1 in a loud and unkind tone of voice while telling Resident #1 it was all her fault NA #1 was waiting on her. Nurse #1 also indicated in the email Resident #1 was upset over the incident.

Review of the facility's investigation documentation revealed no evidence an initial report was sent to DHSR within 24-hours of being notified on 09/03/21 of the allegation of abuse involving NA #1 and Resident #1. The initial report was not submitted by the facility to DHSR until 09/17/21 at 1:19 PM via fax transmission. The initial report noted the facility became aware of an allegation of verbal abuse by NA #1 toward Resident #1 on 09/17/21 at 10:00 AM. Further review revealed the 5-day investigative report was submitted via fax transmission to DHSR on 09/22/21 at 11:02 AM and noted the allegation was substantiated.

During an interview on 06/14/22 at 1:11 PM, the former Director of Nursing (DON) confirmed she was notified by Nurse #1 of the allegation of verbal abuse involving NA #1 and Resident #1 on 09/03/21 and had conducted the investigation.

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L 052	Continued From page 11 The former DON stated she could not recall the "specifics" of the investigation but was "pretty sure" she had submitted the initial and 5-day investigative reports to DHSR within the regulatory time frames. During an interview on 06/13/22 at 4:50 PM, the Administrator confirmed both she and the former DON had received the email correspondence from Nurse #1 on 09/03/21 alleging verbal abuse toward Resident #1 by NA #1. The Administrator explained the former DON had conducted the investigation and had informed the Administrator she had submitted the required reports to DHSR. She added, it wasn't until approximately 09/16/21 she learned the former DON had not submitted the initial report to DHSR within 24 hours of being notified on 09/03/21 or submitted the 5-day investigative report within 5 working days of the allegation and the investigation was reopened on 09/17/21. The Administrator stated ultimately, she was the one responsible for ensuring all abuse allegations were reported and investigated within the regulatory time frames. The Administrator explained she had not reviewed the former DON's investigation documentation prior to the investigation being reopened on 09/17/21 and had trusted the former DON to follow the facility's Abuse policy which would have included submitting the required reports to DHSR.	L 052		
L415	131E-117 Declaration of Patient Rights All facilities shall treat their patients in accordance with the provisions of this Part. Every patient shall have the following rights: (1) To be treated with consideration, respect, and full recognition of personal dignity and	L415		

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individuality;

(2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules;

(3) To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on file in the facility and available for inspection;

(4) To have on file in the patient's record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed acknowledgements by the patient, shall be retained by the facility in the patient's file;

(5) To receive respect and privacy in the patient's medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient's transfer to another health care institution or as required by law or

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(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) COMPLETE DATE
L415	Continued From page 13 third party payment contract; (6) To be free from mental and physical abuse and, except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need; (7) To receive from the administrator or staff of the facility a reasonable response to all requests; (8) To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive mail promptly and unopened, unless the patient is unable to open and read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery, and postage; (9) To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law. Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs. In the event that the facility manages the patient's financial affairs, it shall have an accounting available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to	L415		

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manage the patient's financial affairs at any time upon five days' notice.

(10) To enjoy privacy in visits by the patient's spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room;

(11) To enjoy privacy in the patient's room;

(12) To present grievances and recommend changes in policies and services, personally or through other persons or in combination with others, on the patient's personal behalf or that of others to the facility's staff, the community advisory committee, the administrator, the Department, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination;

(13) To not be required to perform services for the facility without personal consent and the written approval of the attending physician;

(14) To retain, to secure storage for, and to use personal clothing and possessions, where reasonable;

(15) To not be transferred or discharged from a facility except for medical reasons, the patient's own or other patients' welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days' advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate transfer, and these actions, and the reasons for them, shall be documented in the patient's

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medical record;

(16) To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. The patient's responsible family member or guardian shall also be notified. (1977, c. 897, s. 1; 1983, c. 775, s. 1; 1989, c. 75; 1997-443, s. 11A.118(a).)

This Rule is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure residents were treated in a dignified manner when Nurse Aide (NA) #1 was observed speaking to Resident #1 using a loud and unkind tone for 1 of 3 sampled residents reviewed.

Findings included:

Resident #1 was admitted to the facility on 09/12/19 with multiple diagnoses that included vascular dementia.

Review of email correspondence provided by the Administrator on 06/13/22 revealed Nurse #1 sent an email to the Administrator and former Director of Nursing on 09/03/21 at 7:57 AM informing them both of an allegation of verbal abuse involving Resident #1 and Nurse Aide (NA) #1. Nurse #1 reported while visiting a resident next door to Resident #1 on 09/02/21, she overheard a loud commotion coming from Resident #1's room. When she went to Resident #1's room to see what was going on, Nurse #1 reported overhearing NA #1 yelling at Resident #1 in a loud

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and unkind tone of voice while telling Resident #1 it was all her fault NA #1 was waiting on her. Nurse #1 also indicated in the email Resident #1 was upset over the incident.

Telephone attempts on 06/13/22 at 2:39 PM and 06/14/22 at 10:38 AM for interview with NA #1 were unsuccessful.

During an interview on 06/13/22 at 1:05 PM, Nurse #1 could not recall the exact time but stated on 09/02/21 as she was visiting another resident who resided next door to Resident #1, she heard a commotion and loud voices coming from Resident #1's room. Nurse #1 stated as she went into Resident #1's room to see what was going on, she saw NA #1 standing in the doorway of Resident #1's bathroom and NA #1 was "scolding" Resident #1 in a loud tone, telling Resident #1 that it was all her fault NA #1 had to wait on her. Nurse #1 explained Resident #1 did have dementia with behaviors but was able to rationalize and remain calm, had moments of clarity where she could make clear comments and often stated she felt no one listened to her. She added the way NA #1 acted toward Resident #1 was inappropriate and abusive. Nurse #1 stated she immediately reported what she had witnessed to Nurse #2 and the Unit Manager on 09/02/21 who told her they would "take it from there." Nurse #1 added she sent an email to both the Administrator and former DON the very next morning (09/03/21) informing them both of the incident.

During an interview on 06/13/22 at 6:38 PM, the Unit Manager (UM) confirmed both she and Nurse #2 were notified by Nurse #1 on 09/02/21 of a staff member raising their voice and yelling at Resident #1. The UM stated she was on the

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phone at the time and did not personally go and assess Resident #1 but recalled Nurse #2 did. The UM explained as Resident #1's disease progressed, she started displaying more behaviors that were difficult to manage and recalled after the incident with NA #1 on 09/02/21, Resident #1's behaviors seemed to escalate and she appeared "a little more agitated."

During an interview on 06/14/22 at 9:51 AM, Nurse #2 confirmed both she and the UM were notified by Nurse #1 of an allegation of abuse by NA #1 toward Resident #1 on 09/02/21. Nurse #2 added she was the nurse assigned to provide care to Resident #1 on 09/02/21 and immediately went to Resident #1's room with Nurse #1 to assess Resident #1. Nurse #2 recalled when she and Nurse #1 got to Resident #1's room, NA #1 was out in the hallway stating "I can't deal with her anymore" referring to Resident #1 and when they entered the room, Resident #1 was visibly upset, much more so than normal. Nurse #2 explained once Resident #1 started to calm down, she asked her what had happened to make her so upset but she wasn't really able to explain.

During an interview on 06/14/22 at 1:11 PM, the former Director of Nursing (DON) confirmed she was notified by Nurse #1 of the allegation of verbal abuse involving NA #1 and Resident #1 on 09/03/21 and had conducted the investigation. The former DON stated she could not recall the "specifics" of the investigation but did recall speaking with NA #1. The former DON recalled NA #1 stating she had answered Resident #1's call light and when she realized Resident #1 needed assistance off the toilet, she tried to explain to Resident #1 that she would need to go get another NA to assist her but Resident #1 was

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screaming and she only raised her tone of her voice so that Resident #1 could hear what she was saying. The former DON stated Nurse #1 reported she heard the interaction while in another room; however, when she went to the room Nurse #1 was in, the former DON stated you might be able to hear noises but not the specific conversation as reported by Nurse #1 and there was no way she could corroborate the allegation.

During an interview on 06/13/22 at 4:50 PM, the Administrator confirmed both she and the former DON had received the email correspondence from Nurse #1 on 09/03/21 alleging verbal abuse toward Resident #1 by NA #1. The Administrator stated the former DON had conducted the investigation of the alleged abuse by NA #1 toward Resident #1 and it wasn't until approximately 09/16/21 when "more information came out about the incident", she learned the former DON had not followed the facility's abuse policy or process and the investigation was reopened on 09/17/21. The Administrator stated ultimately, she was the one responsible for ensuring all abuse allegations were thoroughly investigated and had trusted the former DON to follow the facility's Abuse policy and "do what she was supposed to do." The Administrator explained Resident #1 was very difficult to manage as far as behaviors and confirmed it was never acceptable for staff to scold a resident or treat them disrespectfully, such as using an improper tone and/or body language. She added prior to the incident on 09/02/21, staff received abuse and dementia training during orientation and annually and since then they have been provided with more in-depth training, specifically on how to manage residents with dementia and difficult behaviors.

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