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F 000	INITIAL COMMENTS An unannounced onsite complaint survey was conducted from 03/21/23 through 03/22/23. Event ID # IDQZ11. The following intakes were investigated: NC00199472, NC00199624, NC00199696, NC00199803 and NC00199860. 2 of the 11 allegations resulted in deficiency. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity of (G). Non-compliance began on 3/12/23. The facility was back in compliance effective 03/20/23.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to protect a	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/23/2023

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

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resident's right to be free from mistreatment when 1 of 1 Nurse Aide (NA) #1 and 1 of 1 Treatment Nurse continued to hold a resident on her side, clean her from a bowel movement and continue providing pressure ulcer care after the resident yelled at them to "stop" and told them to let her turn over onto her back because her left leg was hurting and dangling off the bed. This was for 1 of 3 residents reviewed for abuse (Resident #2).

The findings included:

Resident #2 was admitted to the facility on 08/24/2010 with diagnoses which included hypertension, quadriplegia, and anxiety disorder.

Review of the quarterly Minimum Data Set (MDS) assessment dated 12/29/22 revealed she was cognitively intact and was extensive to total care of 1 to 2 staff members with all activities of daily living except eating which varied. Resident #2 was documented as having clear speech, and understood and was able to make all needs known to staff. The assessment also revealed she was incontinent of bowels and had a stage 4 pressure ulcer which required pressure ulcer care and dressing.

Review of a progress note dated 03/12/23 written by the Treatment Nurse at 2:13 PM revealed "at or around 8am to 8:30am I proceeded to Resident #2's room to do her wound care as I entered the room she was already upset because the sheet wasn't completely under her and she was on the edge of the bed. She stated, "no you can't do my wound because I might fall." I left the room and got the aide that was assigned to the room. Resident #2 stated, "push the draw sheet under me first." I said okay but you had a bowel

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movement and I need to clean you up. As we was turning her I removed the dressing so the wound was open and she had bowel movement on her, she stated the NA (NA #1) was pulling her and she need to let her go I was explaining to Resident #2 the dressing is off wait a minute the wound is open and I wouldn't want it to get infected she was screaming at the aide so I replied you didn't do anything wrong I'll be your witness because her morning started out rough. Resident #2 then stated she don't trust me. I explained to her she couldn't hear me say wait you had a bowel movement because by that time she was upset I offered to help the NA #1 clean her up she refused but I was able to change her dressing."

Review of a statement written on 03/12/23 by the Treatment Nurse revealed the following: "At or around 8:00 am to 8:30 am I proceeded to Resident #2's room to do her wound care as I enter the room she was already upset because her draw sheet wasn't completely under her and she was on the edge of the bed. She stated, "no you can't do my wound because I might fall." I went and got the NA (NA#1) to help me. Resident #2 stated "push the draw sheet under me first." I said okay but you had a bowel movement so I need to clean you up. As me and the NA were turning her, she stated that the NA was pulling her and she need to let her go. I was explaining to Resident #2 to hold on because she had bowel movement on her and her wound is open, and I didn't want it to get infected. She was screaming at the NA so I replied we are in here together and you didn't do anything wrong, I'll be your witness because she had a bad start. Resident #2 then stated she didn't trust me. I explained to her that she couldn't hear me say

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wait you had a bowel movement because by that time she was upset. I offered to help the NA clean her up she refused, but her dressings were changed."

On 03/21/23 at 11:43 AM a phone interview was conducted with the Treatment Nurse. The Treatment Nurse stated she went to Resident #2's room on 03/12/23 at around 8:00 AM to 8:30 AM that morning to do her wound care. The Treatment Nurse stated when she entered the room, Resident #2 was upset because the previous shift had not put her draw sheet under her and she had been positioned too close to the edge of her bed. The Treatment Nurse said let me get someone to help me and she left the room to find her NA who was NA #1. She stated they came into her room and NA #1 pulled her over and I pushed her a little further to get her dressing off and she had had a bowel movement so wanted to get her cleaned up. The resident began yelling "no, no, no, stop, let me turn back on my back." The Treatment Nurse stated she told her but wasn't sure she heard her that she couldn't let her turn on her back because she had a bowel movement and she needed to get her cleaned up and do her wound care. She stated the resident again began yelling and screaming "let me lie back, let me back." The Treatment Nurse indicated she told her she couldn't let her back because her dressing was off and she didn't want her wound to get infected with bowel movement so she quickly put a dressing on her wound and cleaned her bowel movement. She said once they were done, they repositioned her and moved her to the middle of the bed. The Treatment Nurse further indicated it would probably have been a better idea to have moved her to the middle of the bed before turning her on

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her side and maybe she would not have been so upset and thinking she was going to fall. She also said she probably should not have taken her dressing off before they cleaned her up from her bowel movement but she was trying to be quick so they could get her positioned. She said she did not recall the resident's leg dangling or falling off the bed but said it could have happened and she just didn't remember.

Review of a statement written on 03/12/23 by Nurse Aide (NA) #1 revealed the following: "Today I was assigned to Resident #2. The wound nurse asked me to come help her with Resident #2. When I walked in the room I could tell she was already annoyed because she was fussing about the draw sheet that was under her. We proceeded with cleaning her bottom and she started saying she was in pain and to let her go. The nurse told her that she had bowel movement on her and that it had to be cleaned off her so her wound won't get infected. She still was yelling and screaming for me her aide to let her go while the wound nurse was cleaning the bowel movement off of her. She then started to yell at me to get out her room and that she didn't want me in her room. She was yelling so loud another resident came out of her room. She kept yelling and screaming that I needed to leave her room."

On 03/13/23 at 2:08 PM a phone interview was conducted with NA #1 who was assigned to care for Resident #2 on 03/12/23 from 7:00 AM to 3:00 PM. The interview revealed on 03/12/23 at around 8:00 AM to 8:30 AM, the Treatment Nurse asked her to assist her with wound care on Resident #2. She stated when they entered the room the resident was complaining about her draw sheet not being under her and was not

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happy about it not being under her like she wanted it. She stated when she pulled her over on her side the resident started yelling and screaming at her to let her go, let her go and the nurse told her to hold her so she could get her cleaned up and get her wound care done and dressing on. She stated the resident again yelled and screamed at her to let her go, let her go and the Treatment Nurse told her she was cleaning her and doing her wound care and she couldn't let her go because her dressing was off and if she let her go she would get bowel movement on her wound. She further stated the Treatment Nurse told her that she was not doing anything wrong and she was in the room with her and could be her witness that she had not done anything wrong. She stated once the Treatment Nurse was done, they left the room. NA #1 stated when she and the Treatment Nurse reported it to Nurse #1 and the Scheduler, they were asked to write statements and Nurse #1 after talking with the resident told NA #1 not to return to Resident #2's room and another NA was assigned to care for her the rest of the day. NA #1 stated she worked the rest of her shift but did not go back into Resident #2's room.

Review of a Grievance Reporting Form dated 03/12/23 and completed by Nurse #1 revealed Resident #2 was filing a grievance. Description of Grievance: Resident #2 complained about two staff members (Nurse Aide #1 and the Treatment Nurse) not honoring her request to not turn her over due to her leg hurting. Also wanted to complain about the Treatment Nurse making statement that she was the NAs witness that she didn't do anything wrong. The grievance was referred to the Director of Nursing (DON). Steps Taken: The DON spoke with Resident #2 and

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F 600	Continued From page 6 she stated "her leg was swollen and hurting. Also stated that no one told her that she had bowel movement on her. They didn't stop when told." The DON spoke with the Treatment Nurse who stated resident was already upset with something when they got into the room. Stated they were trying to clean her up to complete treatment, there was no pushing and pulling. Stated Resident #2 was yelling and screaming and really became upset when she stated she would be witness for NA because she didn't do anything wrong. Stated they tried not to lay her back onto her bowel movement - able to complete clean up and treatment as best resident would allow." Conclusion of investigation: Staff should have stopped care when requested by resident. Confirmed: yes. Corrective Action Taken: Staff members will be terminated. Investigation findings and actin reported to Resident #2 on 03/17/23 and she was satisfied with report/findings. Education was given to all staff - no date provided. Reported to outside agency on 03/14/23. The DON completed the investigation on 03/17/23. On 03/22/23 at 10:38 AM an interview with Nurse #1 revealed she had been requested to come into Resident #2's room after the incident with she and the Treatment Nurse and NA #1. Nurse #1 stated Resident #2 always asked for her when she was working if she had a problem. She said she and the Scheduler went into the resident's room and Resident #2 explained to her that the Treatment Nurse and NA #1 did not listen to her when she had asked them to stop and turn her back on her back. Nurse #2 stated Resident #2 told her the Treatment Nurse and NA #1 had turned her on her right side and she was on the edge of the bed and afraid of falling so she had	F 600		

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told them "no, no, no, turn me back over," and told Nurse #1 instead of listening to her they continued holding her over and providing care despite her screaming and yelling for them to turn her back over. Nurse #1 indicated the resident was also upset when the Treatment Nurse told NA #1 that she had not done anything wrong and she was in the room and would be her witness. Nurse #1 further indicated Resident #2 had told her that her left leg was hurting as well and it had fallen off the bed during the incident and the Treatment Nurse had come around and picked it up and pushed it back on the bed. According to Nurse #1 the resident did not allege abuse during their conversation.

On 03/21/23 at 4:19 PM an interview with the Scheduler revealed Resident #2 had asked to speak with Nurse #1 and she had accompanied her to Resident #2's room. She said Resident #2 had explained to Nurse #1 that the Treatment Nurse and NA #1 held her on her side when she wanted to be let go and return to her back and they had not listened to her as she had requested for them to turn her back on her back. The Scheduler stated Resident #2 further explained the Treatment Nurse had told NA #1 that she would be her witness to she had not done anything wrong in Resident #2's room. She said Nurse #1 asked Resident #2 if she wanted her to file a grievance for her and she said yes so Nurse #1 completed a grievance regarding the incident. The Scheduler stated Resident #2 never used the term abuse.

On 03/21/23 at 10:50 AM an interview was conducted with Resident #2. She stated on 03/12/23 at around 8:30 AM the Treatment Nurse came into her room to do wound care on her

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F 600	Continued From page 8 pressure ulcer on her left sacral area. Resident #2 stated the Treatment Nurse left the room to get a NA to assist her with holding the resident over on her side. The Treatment Nurse returned to her room with NA #1, whom Resident #2 had previously asked not to care for her. The Treatment Nurse told Resident #2 there was no one else available to assist with her care so the Treatment Nurse and NA #1 proceeded to place her left leg over her right leg and turn her onto her right side. As they were turning her, Resident #2 said the Treatment Nurse was pushing her and NA #1 was pulling her and she felt like she was going to fall off the side of the bed and she yelled and screamed at them to "stop, no, no, turn me back on my back." The Treatment Nurse told her no that she had removed her dressing and she had had a bowel movement and she needed to clean her and do her wound care before she could turn her on her back. Resident #2 further stated she yelled and screamed again at them to "stop, no, turn me back on my back," and she said at that point the Treatment Nurse pushed harder and NA #1 pulled harder and her left leg dangled off the bed and said she screamed at them to stop they were hurting her. Resident #2 stated NA #1 seemed nervous and the Treatment Nurse told her not to worry, that she had not done anything wrong and she would be her witness to her not doing anything wrong. The Treatment Nurse then came around the bed and lifted her legs and "tossed them onto the bed" and went back around and finished her dressing. Resident #2 stated once they were finished they both left the room. Resident #2 indicated sometime later in the afternoon (couldn't remember what time), maybe even on 2nd shift (3:00 PM to 11:00 PM) another NA or nurse (couldn't remember who) came in and helped her get comfortable in the	F 600		

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bed and that Resident #2 was upset about the way she had been treated and the resident was crying. Resident #2 stated she told the nurse and NA that she didn't want the Treatment Nurse or NA #1 back in her room to take care of her because of the way they had treated her earlier in the day. Resident #2 further indicated after she had talked with the nurse and NA about the incident the Treatment Nurse came in and apologized to her but said it was not a true apology and she had said, "I'm sorry if you felt like I did something wrong." Resident #2 further indicated she had gotten a copy of the investigation report but was not happy with the investigation because she was not upset before the Treatment Nurse and NA #1 came into her room like was indicated in the report and stated she was not upset about her draw sheet but was upset about the Treatment Nurse and NA #1 not stopping pushing and pulling her when she told them to stop and let her turn onto her back. Resident #2 explained she had had a fall at another facility and since that time had a fear of falling out of the bed.

On 03/21/23 at 3:56 PM a phone interview was conducted with Medication Aide (MA) #1. He stated he was assigned to pass medications to Resident #2 on 03/12/23 on the 7:00 AM to 3:00 PM shift. MA #1 stated the resident had complained to him about the way NA #1 and the Treatment Nurse (TREATMENT NURSE) had treated her while in her room providing wound care. He stated Resident #2 had told him NA #1 and the TREATMENT NURSE had not stopped care and let her turn back onto her back as requested when they were in her room that morning.

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F 600	Continued From page 10 On 03/21/23 at 4:33 PM an interview with the Administrator revealed he was corporate and had stepped into the role of Administrator effective 03/13/23. He stated he had received a grievance from the DON on Resident #2 and had gone into her room that afternoon to talk with her about the grievance. He stated during the conversation with Resident #2 she had used the word abuse to describe what had happened to her on 03/12/23. He stated the grievance originally had not reported the incident as abuse but once the resident said it they began an abuse investigation. The Administrator said they had substantiated the allegation of abuse. He explained after the incident all staff were educated on abuse. On 03/22/23 at 12:13 PM a phone interview with Resident #2's private Medical Doctor (MD) revealed Resident #2 had called the office on 03/13/23 and spoken with one of the Medical Assistants in their office and told her that she had chronic wounds and during wound care at the facility on 03/12/23 where she resided, she had been physically abused and the staff had pulled and tugged at her during care. The MD stated she had an obligation to act on any allegation of abuse and had instructed her staff to call the abuse in to the proper authorities to be investigated. On 03/22/23 at 12:49 PM a phone interview with the Medical Assistant at Resident #2's private MD's office revealed she had spoken with Resident #2 on 03/13/23 via phone and again on 03/15/23 by phone and she had complained about being abused during her wound care on 03/13/23. She stated Resident #2 told her that during her wound care she had complained about	F 600		

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her left leg hurting and despite her request for them to turn her off her side and back on her back, they ignored her request and continued to provide care. She stated the resident said during the care NA #1 was pulling her and the Treatment Nurse was pushing her despite her yelling at them to stop and said when she had yelled at them to stop, they pulled and pushed harder until her leg fell off the bed and was dangling. The Medical Assistant said she told her when her leg fell off the bed the Treatment Nurse came around the bed and "threw her leg back on the bed." The Medical Assistant stated their office had reported the abuse because the resident had called and made them aware of what had happened to her and they had an obligation to their patient to report it.

The facility provided the following Corrective Action Plan:

Affected Resident:
Resident #2 currently resides in the facility. She is being monitored by facility staff to prevent any additional injuries to her. Resident #2 did not suffer any persistent adverse effects from the alleged deficient practice.
Residents with the Potential to be Affected:
All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing or designee interviewed all alert and oriented residents regarding any incidents of injuries of unknown origin, resident to resident or staff to resident abuse. This was completed by 3/18/2023. No resident reported any incidents. A skin assessment was completed on any resident that was unable to be interviewed to determine if there were any injuries of unknown origin or any signs of physical abuse. There were no identified

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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) COMPLETION DATE
F 600	Continued From page 12 suspicious injuries or other signs of abuse. A 24 hour/5-day report was sent to the state agency for the incident that occurred on 3/12/23 with Resident #2. The Treatment Nurse and NA #1 were terminated from the facility on 3/13/2023. Systemic changes: The Corporate Compliance Manager educated the Administrator, Director of Nursing and Assistant Director of Nursing/Infection Preventionist on 3/10/2023 and 3/17/2023 on the following. The Director of Nursing and Corporate Nurse Manager educated all facility staff on the following. This will be completed by 3/19/2023. Education included: o A review of the Abuse Policy: o Prevention of Abuse, Neglect, Misappropriation of resident property, and exploitation; injuries of unknown origin. o Signs and symptoms of abuse, neglect, misappropriation of resident property and exploitation; This education was provided to ensure residents are kept free from abuse and neglect. Any staff out on leave or PRN status will be educated by the ADON/IP, Corporate Nurse Manager, or Director of Nursing prior to returning to duty. Any newly hired staff will be educated by the ADON/IP or Human Resources Coordinator during orientation. All staff will continue to be educated on the above annually. Monitoring: An audit tool was developed which included the following: o Progress notes reviewed o Point of Care Documentation - Behaviors QAPI All audits will be brought to Quality Assurance and Performance Improvement (QAPI)	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING ______ B. WING ______	C 03/22/2023

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F 600	Continued From page 13	F 600		

Committee meeting monthly x 3 months by the Administrator for review and further recommendations to ensure compliance with the plan of correction.

Compliance date 3/20/23

Validation of Compliance: On 3/21/23, the facility's corrective action plan was validated by the following: Staff interviews revealed they had received education on the abuse policy and how to recognize abuse. Additionally, they provided monitoring tools in the form of questionnaire to all alert and oriented residents regarding abuse, feeling safe, and retaliation for reporting abuse and mistreatment to staff, skin assessments completed on residents that were not alert and oriented, and education provided regarding forms of abuse and the abuse policy. There was plan in place to discuss auditing tools in QAPI for 3 months and review and revise as recommended; however, a meeting had not yet occurred.