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HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted on 05/21/24 through 05/23/24. The exit conference was completed via phone with the Administrator on 5/31/24. Therefore, the exit date was changed to 5/31/24. Event ID #OTS111. The following intakes were investigated NC00216859, NC00217034 and NC00217187. Two (2) of the 4 complaint allegations resulted in a deficiency. Intakes NC00217034 and NC00217187 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J. The tag F600 constituted Substandard Quality of Care. Noncompliance began on 5/9/24. The facility came back into compliance effective 5/16/24. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		

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

Electronically Signed | 06/11/2024

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F 600	Continued From page 1 §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 review, and resident, staff, NP and Law Enforcement Detective interviews the facility failed to protect a resident's right to be free from physical abuse when Nurse Aide (NA) #1 punched Resident #1 in the face. On 5/9/24 Resident #1 was sent to the Emergency Department (ED) for evaluation where it was noted the resident had significant bruising around the left eye and a small laceration at the corner of the left eye. A CT (computed tomography) scan of the head was completed and confirmed comminuted fractures (fracture in at least 2 places) of the left nasal bone, left maxillary sinus wall, left maxilla (the bone that forms the upper jaw) and left orbital rim (broken bone in the outer edge of the eye socket). Resident #1 returned to the facility on 5/10/24. Resident #1 was seen by an ENT (ear, nose, and throat) Provider on 5/21/24 and was scheduled for surgical repair of the fracture of left nasal septum (the thin wall that separates the nostrils) on 6/5/24. A reasonable person would expect to be free from physical abuse in their own home and could experience anger, fear, apathy and depression. This affected 1 of 3 residents reviewed for abuse (Resident #1). The findings included: Resident #1 was admitted to the facility on 8/29/23 with a diagnosis of dementia. A quarterly Minimum Data Set assessment (MDS) dated 4/13/24 indicated Resident #1 had	F 600	Past noncompliance: no plan of correction required.	

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severe cognitive impairment; dependent with toileting hygiene, showering, and dressing; maximal assistance with personal hygiene, bed mobility, sit to stand, lying to sitting on side of the bed, chair/bed to chair transfers; dependent on staff for transfers to toilet and shower; and rejected care 1 to 3 days.

Resident #1 was care planned for the following: 9/11/23 - mood- At risk for combative behaviors during direct care with interventions to administer medications according to physician orders, be alerted to mood changes, sleep pattern, appetite, and behaviors; explain procedures prior to doing care.

8/31/23 - behavioral symptoms- Maintain a calm environment and approach the resident.

During a phone interview on 5/22/24 at 11:14 am Nurse Aide (NA) #2 revealed she worked on 5/9/24 (3:00 pm -11:00 pm shift) and as she entered Resident #1's room about 3:15 pm to pass ice she observed Resident #1 with blood on his face, shirt, bed rail facing the room door and bed sheet. NA #2 further revealed she went to the hall to call for assistance and Nurse #1, the Director of Nursing (DON), and Administrator responded, checked his body and surroundings in the room to see how he could have been injured. NA #2 stated after she assisted the Administrator with cleaning Resident #1's face and changed the sheets, as she was leaving the room, she overheard someone tell Nurse #1 the DON would notify the family that the resident had a fall and take care of the incident report. NA #2 stated about 4:00 pm she informed Nurse #1 that she was going on break before dinner trays came out. NA #2 stated when she returned from break, she

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checked on Resident #1 and found him lying on his left side and there was projectile vomit on the wall, floor and bed. NA #2 revealed she went to get Nurse #1 who came into the room and stated she was going to call the DON to have the resident sent out to the emergency room. NA #2 further revealed she cleaned up the vomit, returned to the hall to continue working and she observed Resident #1's family member arrived on the hall. NA #2 stated the family member asked her to walk with her to the room and wanted to know what happened. When the family member entered the room and observed the resident, she became upset and stated, 'there's no way this was a fall.'

A review of a nurse's progress note dated 5/9/24 indicated Nurse #1 was approached by a nurse aide (NA) at the beginning of the shift to report resident was bleeding from his face. Nurse #1 walked down the hall with the NA and found the Resident #1 laying in the bed with blood on the sheets and siderail. The resident was bleeding from the left side of face and noted resident had bruising and swelling around left eye, small laceration to left side of face, and right front tooth to be broken and loose. The note further indicated, after evaluating resident Nurse #1 immediately went to get management. Management came to evaluate the resident and stated the resident was in stable condition and they would do a fall report as well as neuro checks every hour. Resident #1 was provided with first aid and ice was applied to left eye. The resident's vitals taken BP 166/82, pulse 79, O2 95 % on room air and temp 98.5. While Nurse #1 was rounding resident was found with emesis in bed and on resident's floor after another assessment from Nurse #1. The DON was

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notified of the resident's condition and Nurse #1's concerns. Nurse #1 recommended that he be sent out for further evaluation. The DON stated Nurse #1 could send him out via EMS to hospital for further evaluation. The family member arrived at the facility shortly after and stated she would like him sent to the hospital for further evaluation. Resident was sent to local ED for further evaluation.

During a phone interview on 5/24/24 at 9:58 am Nurse #1 indicated she was assigned to Resident #1 on 5/9/24 (3:00 pm -11:00 pm shift) and NA #2 came to get her about 3:45 pm to check on Resident #1. Nurse #1 further indicated she directed an NA to get the first aide cart and bring it to Resident #1's room. Nurse #1 stated when she arrived at the resident's room, she observed the resident to have a laceration under the left eye that was swollen and bruised, and a right upper front tooth was broken. Nurse #1 stated the resident's bed was positioned at waist level. Nurse #1 stated she went to get the DON and the Administrator who responded and took over to find out what happened. Nurse #1 was instructed to get an ice pack for the resident's eye then assisted the nurse aides clean Resident #1 and change his bed linen that was stained with blood. Nurse #1 stated the DON indicated she would write the nursing note and contact Resident #1's family to report the incident instead of Nurse #1 writing the note and contacting the family. Nurse #1 stated she started hourly neurological checks (assesses neurological functions, motor and sensory response, and level of consciousness) on the resident and about 5:30 pm she and NA #2 went to the resident's room and discovered the resident had vomited on the wall and fall mat near the window. Nurse #1 stated she messaged the

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DON because she felt the resident needed to be sent out to the emergency room for further evaluation. Nurse #1 stated the resident's family member arrived at the same time the DON gave permission for the resident to be sent out. Nurse #1 stated she contacted 911 emergency services and first responders (medics) arrived within minutes to transport the resident to the hospital. Nurse #1 stated she could not recall the exact time she called 911.

A review of hospital records indicated Resident #1 was transferred from the facility to the emergency department on 5/9/24 after being found in bed with left eye hematoma (significant bruising) and swelling around the left eye due to possible fall but unknown how the injury occurred. The ED Physician observed significant bruising around the left eye and a small laceration at the corner of the left eye. A CT scan of the head noted a comminuted fracturing of the left nasal bone, anterior left maxillary sinus wall, and left maxilla with extension into the root of the left posterior maxillary molars. It was noted that the fracturing extended into the inferior left orbital rim. The ED Physician consulted with an ENT (ear, nose, and throat) Specialist who suggested treatment with Keflex (antibiotic) follow up with his office on 5/13/24 or 5/14/24.

A nursing note dated 5/10/24 entered by Nurse #5 revealed Resident #1 returned to the facility after a short-term emergency room visit with a new order received from emergency room visit for Keflex (an antibiotic) 500mg (milligrams), take 2 capsules by mouth twice a day for 10 days. Nurse #5 also noted the resident had a right front tooth missing; denied any pain and voiced no complaints. The resident was unable to describe

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the incident or hospital visit.

A review of NA #1's written statement dated 5/9/24 indicated he went into Resident #1's room around 2:20 pm during the NA's last round and found the resident had already put himself in bed. The statement further indicated the resident was in his wheelchair prior. NA #1 changed the resident's brief and when he left resident's room, the resident was awake and in his bed with no injury to his face. NA #1's statement also indicated Resident #1 self-transferred several times per day.

During a phone interview on 5/21/24 at 5:23 pm NA #1 stated he worked on 5/9/24 and was assigned to Resident #1 on the 7:00 am - 3:00 pm shift. The NA revealed towards the end of his shift, he entered Resident #1's room to change the resident's brief but the resident did not want to be changed and lunged at NA #1. NA #1 stated he pushed Resident #1 backwards in the bed and the Resident hit his head on the side rail of the bed causing a skin tear and blood in the corner of his eye. NA #1 stated he then wiped the blood from the resident's face, continued with incontinent care and left the room. NA #1 stated after he left the facility on 5/9/24, he received a call from the DON and was asked about his interaction with Resident #1. NA #1 stated he lied to the DON and Administrator about not knowing what happened to Resident #1. NA #1 stated after he was re-interviewed by law enforcement 5/13/24 and 5/14/24, he agreed to take a polygraph test on 5/15/24 and did not pass it. NA #1 stated after he did not pass the polygraph test, he told law enforcement he pushed Resident #1 causing injuries to his face when he hit his head on the bed rail. NA #1 stated he was

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re-interviewed via telephone by the Administrator on 5/15/24 and was terminated from the facility after he told her that he pushed the resident.

During a phone interview on 5/21/24 at 6:02 pm NA #4 indicated she worked 7 am - 3 pm on 5/9/24 and stated she last observed Resident #1's feet in bed but did not see his face because the curtain was pulled when she and other NAs walked the hall together to give report to the next shift. NA #4 stated when she asked who put the resident to bed and changed him, NA #1 stated when he put the resident to bed and changed him, everything was good.

During a phone interview on 5/21/24 at 6:46 pm NA #5 revealed she worked 7 am - 3 pm on 5/9/24 and completed rounds (around 2:55 pm) by performing brief changes and checking on her residents before her shift ended. She completed walk-downs (walked past each resident's room with the next shift and gave report) with the next shift. NA #5 further revealed she observed Resident #1's lower half of his body covered with a blanket and the curtain was drawn halfway. NA #5 stated she did not see the resident's face. She did not do rounds on resident because NA #1 stated he already rounded on the resident.

During an interview on 5/22/24 at 12:09 pm Resident #1's family member revealed she received a phone call from a nurse at the facility on 5/9/24 about 4:00 pm and was told multiple times during the call that everything was okay but Resident #1 "face planted" (fell on his face). The family member stated she "lost it" when she walked into the room and saw Resident #1's injuries. The family member then stated Resident #1 hardly ever complained of pain because his

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dementia was so bad, and she could tell Resident #1's injuries did not look like the results of a fall while trying to get out of his wheelchair and into bed and hitting his head on the bed rail. The family member stated she went to speak with Nurse # 1 to inquire why Resident #1 had not been transported to the hospital and Nurse #1 stated she was in the process of having the resident sent out to the hospital. The family member stated she went to the hospital after the resident was transported via medic and she was informed the Resident sustained a broken nose, cheek and bone in the eye area. The family member stated she took pictures of the resident before he left the facility and after he arrived at the hospital. The family member stated the resident also lost a tooth and another tooth was cracked/loosened. The family member stated she contacted law enforcement about the incident while she was still at the hospital, and they went to the facility to investigate. The family member stated she received a voicemail message from the DON about 10:00 pm the same evening. The family member recalled she met with the Director of Nursing (DON) and the Administrator on the following morning of 5/10/24 to discuss the incident and the family member informed the DON and Administrator that while at the hospital, she contacted law enforcement about the incident because the explanation on how Resident #1's injuries occurred, just did not add up. The family member stated the resident was discharged from the hospital and was transported back to the facility after 3:00 am on 5/10/24. The family member recalled during the meeting with the DON and Administrator, they informed her that the first shift staff did not find the resident with injuries. The family member indicated when she arrived at the facility to pick up the resident for the

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appointment with the ENT Provider, he did not feel good, and the appointment was rescheduled to 5/21/24. As a result of the rescheduled follow-up appointment, it was determined the resident would need surgery to place stents (a sinus stent is a device that can be implanted in the sinus cavity after surgery to help maintain the surgical openings) in his nose to remove the bone that was blocking the nasal passageway and surgery was scheduled for 6/5/24.

A review of the ENT provider examination dated 5/21/24 indicated Resident #1 had complete obstruction of his left nasal cavity, moderate severe left septal deviation at the nasal valve region on left side. Recommendations: undergo open reduction internal fixation of nasal septal fracture (the nasal septum is the thin wall that separates the nostrils) and bilateral turbinoplasty (surgical procedure that shrinks the size of the small, bony structures inside your nose to improve airflow and breathing); hold aspirin one week prior to surgery, get clearance from his facility physician.

During an interview on 5/21/24 at 7:00 pm the Administrator indicated Nurse #3 came to her office on 5/9/24 about 3:20 pm and informed her that she needed to go to Resident #1's room. Upon arrival, the Administrator stated she observed the Resident in bed with his face leaning against the assist bar and there was blood coming from a cut under his left eye/ check bone. The Administrator indicated she asked the resident what happened, and the resident stated, "I hope she falls just like I did and dies." The Administrator stated she sent for the DON, who came to the room. The Administrator recalled the DON removed Resident #1's right front tooth that

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was dangling to prevent him from swallowing it. The Administrator stated while nursing staff was cleaning up the resident, she instructed the DON to contact all first shift staff to inquire about their contact with Resident #1 that day. The Administrator revealed the DON contacted NA #1 who stated Resident #1 had already self-transferred back to bed when NA #1 arrived and was not combative when NA #1 provided incontinent care about 2:20 pm on 5/9/24. The Administrator further revealed all staff from the 1st and 2nd shift were interviewed appropriately, Resident #1's family was contacted, and it was determined Resident #1 had an unwitnessed fall. Neuro checks were initiated and about 7:00 pm the Administrator received a call from the DON that Resident #1 had a change in condition related to drowsiness/vomiting and was being sent out to the hospital. The Administrator stated the DON contacted her on 5/9/24 at 9:56 pm and informed her law enforcement arrived at the facility to investigate the resident's injuries related to an unwitnessed fall. The Administrator stated on 5/9/24 at 10:15 pm she received an update from the DON who had received a copy of the hospital CAT scan that showed a fractured left nasal bone, left maxillary sinus wall and left maxilla with extension into the root of the left maxillary molars, fracturing extends into the interior left orbital rim. The Administrator stated she and the DON met with the family member the following morning of 5/10/24 at 10:15 am and the family member did not indicate she called law enforcement because she suspected abuse. The Administrator noted the facility had already taken steps to schedule a follow up appointment with the eye/sinus/allergy provider as well as the dentist who was scheduled to be in the facility on 5/10/24.

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A review of the DON's written statement dated 5/16/24 indicated on 5/9/24 at approximately 3:15 pm/ 3:20 pm Nurse #4 came to tell her that she was needed in Resident #1's room with the Administrator. The DON stated upon entering the resident's room, she recalled Nurse #1, NA #2, the Administrator, and Nurse # 4 were present, and she noticed a small amount of blood coming from the corner of the resident's left eye, a cut under his left eye, and his right front tooth was dangling. The DON stated she asked the resident what happened, and he responded, 'a girl threw a rock and hit his eye from Afghanistan.' The DON's statement also indicated she asked the resident if he fell and he replied 'no.' She then asked the resident if someone hurt him and the resident replied 'no, a girl in a truck spinning rocks.' The DON obtained and applied a bag of ice wrapped in a towel to the resident's eye until the resident could no longer tolerate it. The DON's written statement indicated she began calling the three NAs who worked the first shift (NA #1, NA #4 and NA #5) to get a timeline and to see if any of them knew anything about the resident. The written statement further indicated the DON and other staff started investigating what could have happened and concluded that the resident must have self-transferred and fell or hit the side rail. The DON's written statement indicated the Administrator asked the DON to make the nurse's note and to contact the resident's family. The written statement indicated the DON contacted the family member around 3:45 pm, informed her of the resident's injuries and she would be notified if anything changed. The DON was notified by the facility that law enforcement had arrived at the facility between 9:45 pm and 10:00 pm on 5/9/24 and they were

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told to contact the DON or Administrator. The law enforcement detective returned to the facility on 5/13/24 around 11:00 am, then spoke with the Administrator and the resident before going to the resident's room to observe where the incident occurred. The law enforcement detective met with the DON and Administrator then returned to get employee names and phone numbers. The DON contacted NA #3, NA #4, and NA #5 to let them know the detective would be contacting them for a statement. In addition, the detective interviewed other employees that were present.

Attempts to contact the DON by phone were not successful and she did respond to voice mails.

During an interview on 5/23/24 at 1:43 pm the Nurse Practitioner (NP) revealed on 5/13/24 she reviewed Resident #1's hospital discharge note that indicated three fractured facial bones and recommendation for surgery to repair the resident's nose. The NP stated she was made aware Resident #1 initially suffered an unwitnessed fall on 5/9/24 and she was later made aware there was an allegation of abuse. The NP stated although she believed what she was told, she was surprised the resident was found in bed with those injuries. The NP stated on 5/13/24, she assessed the resident post readmission while he was sitting in a wheelchair at the nurse's station, and he did not present with any pain. The NP further revealed the left side of Resident #1's face was swollen, bruised and the laceration under his left eye was scabbed over. The NP stated she cleared the resident for nose surgery scheduled for 6/5/24.

During a follow- up interview on 5/22/24 at 10:03 am the Administrator revealed on 5/14/24 she

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spoke with the law enforcement detective to determine the status of their investigation and the Administrator was told by the detective abuse was being alleged and NA #1 had agreed to take a polygraph exam on 5/15/24. The Administrator then stated she received a call from law enforcement on 5/15/24 and was informed NA #1 failed the polygraph exam then confessed that he pushed Resident #1, causing injuries to his face. The Administrator indicated she contacted NA #1, reinterviewed him and terminated his employment after the NA confirmed he did push Resident #1 on 5/9/24, causing injuries to the face. The Administrator stated it was her expectation that all residents are free from abuse and neglect. The Administrator stated she initiated the abuse investigation, followed protocol for abuse and alleged past non-compliance.

During an interview on 5/21/24 at 12:45 pm the Law Enforcement Detective indicated he charged NA #1 with abuse on 5/15/24, after the NA failed a voluntary polygraph test then admitted that he had not been truthful about what had occurred on 5/9/24 with Resident #1, when he was previously interviewed by law enforcement on 5/13/24 and 5/14/24. The Law Enforcement Detective further indicated during an interview on 5/13/24, NA #1 stated on 5/9/24 his last interaction with the resident was when he went into the resident's room at shift change, to change the resident's brief, the resident was "flopped" (lying in bed kind of sideways with his legs hanging off) in bed. The Law Enforcement Detective stated NA #1 reported he straightened (repositioned) the resident and changed his brief. The Law Enforcement Detective NA #1 then reported the resident was fine and he left the resident in bed with no injuries. The Law Enforcement Detective

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revealed he re-interviewed NA #1 on 5/14/24 because he struggled with the details on how the resident had an unwitnessed fall and got back in bed by himself, if a previous interview with NA #5 indicated she had assisted a therapist with getting the resident out of bed around 12:30 that day. The Law Enforcement Detective stated NA #1 reported the resident did not get out of bed when he left him at 2:20 pm and was found in bed by the next shift. The Law Enforcement Detective then asked NA #1 if the resident was still in bed and never got out of bed, how did the resident get injured. The Law Enforcement Detective stated when NA #1 did not provide a definitive answer, he asked NA #1 to submit to a polygraph test and NA #1 stated "yes." The Law Enforcement Detective indicated NA #1 submitted to a polygraph test on 5/15/24 and failed the test. During a post polygraph interview on 5/15/24, the Law Enforcement Detective indicated NA #1 told a different version of the incident once he was informed, he failed the test. The Law Enforcement Detective stated NA #1 admitted to pushing Resident #1 when he became aggressive toward him, then the resident fell back onto the bed and was unharmed when NA #1 left the room. The Law Enforcement Detective stated after NA #1 was questioned further about the resident's injuries, NA #1 admitted to pushing the resident, who hit the side rail on his bed and there was blood on the resident's face. NA #1 reported to the Law Enforcement Detective he wiped the blood off the resident's face and left him in the bed because he looked fine. The Law Enforcement Detective also stated NA #1 reported he knew the policy of the facility was to disengage and not go hands on and that was why he lied. The Law Enforcement Detective stated he asked the NA if any complaints had been filed

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against him in the past and the NA stated there were complaints that had been investigated and closed.

During a follow up phone call on 5/24/24 at 10:16 am the Law Enforcement Detective revealed after he viewed pictures of Resident #1's injuries on 5/23/24, he determined the injuries were probably not consistent with a push backwards in the bed. The Law Enforcement Detective reinterviewed NA #1 in person on 5/24/24 and showed him the pictures. As a result, NA #1 stated he had been thinking about things for the past few days and it was time for him to stop lying because God had been talking to him. NA #1 admitted he punched the resident one time (instead of pushing him), saw the blood on his face, wiped it off since the resident was not fighting anymore, thought the resident was fine and left the room. instead of pushing him, as he previously stated on 5/15/24.

The Administrator was notified of the immediate jeopardy on 5/23/24 at 6:20 pm.

The facility provided the following corrective action plan.

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

On May 9th, 2024, Resident #1 sustained a 0.3 mm (approximately 0.01 in) laceration on the inferior portion of the nose just proximal to the left eye, comminuted fracture of the left nasal bone, and fracturing of the left maxilla with extension into the left orbital rim. The facility initiated an investigation of the incident and suspected the injury occurred from Resident #1 attempting to

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self-transfer resulting in an unwitnessed fall. The hospital discharge report under Emergency Department (ED) Course and Medical Decision-making revealed that it appeared that resident had fallen and injured the left side of his face. Nurse Aides (NAs) were interviewed including NA #1 and revealed Resident #1 was last seen at 2:20pm by NA#1 and he was in bed with no concerns noted.

A police officer arrived at the facility on May 9th, 2024, at approximately 10:45pm to follow up with a report they had received regarding Resident #1. He briefly interviewed multiple staff and asked if the Administrator was the same and who was the Director of Nursing. The staff gave him the Director of Nursing's information. No calls from the officers were made to the Administrator or the Director of Nursing on May 9th, 2024, nor did the officer request the presence of the Administrator or Director of Nursing at the facility.

On May 10th, 2024, at approximately 10:00am, the Administrator and Director of Nursing met with Resident #1's family member to discuss the incident. Per Administrator and Director of Nursing report, Resident #1's family member stated that she called the police per instruction from another family member. She stated she had no specific complaints or allegations with specific person but thought the police could investigate to find the cause of the injury. The Administrator and Director of Nursing stated during the meeting that they suspected that resident sustained an unwitnessed fall while trying to get into bed, resulting in documented injury. At approximately 4:15pm, two employees from Adult Protective Services (APS) entered the facility and interviewed the Administrator and Director of

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Nursing regarding Resident #1. Health care records for Resident #1 were provided per request. The APS employees visited Resident #1 in his room and exited the building with no allegation or concern of abuse made.

On May 13th, 2024, a Detective with the police department arrived at the facility around 11:00 AM to begin investigation on the report filed on May 9th, 2024. Several staff members were interviewed in-person and via telephone by the Detective at this time. The Detective indicated to the Administrator that he was just investigating the incident and did not indicate abuse had been alleged.

On May 14th, 2024, the Detective entered the facility at approximately 11:00 AM to further interview Nurse Aide (NA) #1, NA #1 was the last one to provide care to Resident #1 before NA #2 found him with injuries. The Detective informed the Administrator there were inconsistencies regarding his investigation. Upon the Detectives exit, the Regional Operator put in a call to the Sargeant Detective to try and obtain further detail as to what was being alleged on May 14th at approximately 4:30pm. It was reported they were investigating abuse per what was reported from Resident#1's family member to the police on 5/9/24. Nurse Aide #1 was suspended pending investigation. The facility began abuse investigation and submitted 24-hour report to DHSR. Resident's responsible party, law enforcement, Ombudsman and Adult Protective Services were notified that facility investigation of abuse was initiated.

On May 15, 2024, the facility was notified that during Nurse Aide#1's voluntary polygraph test he

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told the detective he pushed Resident #1 when he became combative during care. Nurse Aide #1 was terminated effective May 15, 2024, and was interviewed during a call with Administrator to notify of termination. During interview with NA#1, he stated, "I went in to change Resident#1 and he was already in bed. He lunged at me, and I pushed him back and he hit the bed rail. He had one little skin tear with a small amount of blood, and I wiped it with a paper towel. He appeared fine and I left the room."

On May 15, 2024, facility abuse investigation continues. Staff interviews were conducted. They were asked if they were aware of any abuse, neglect or exploitation of residents and if they were aware of any concerns related to abuse. Staff working on Resident #1's unit (B Hall) provided written statements regarding this allegation and day.

On May 17, 2024, a 5-day investigation report was made to DHSR which included the facility investigation.

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

All other residents are at risk of suffering from the deficient practice and residents who are resistive to care were identified as more at risk for abuse.

On May 15, 2024, all residents with a Brief Interview of Mental Status (BIMS) of 12 or above were interviewed by the Administrator or designee to determine if they have experienced any type of resident abuse or were fearful in any way. No concerns were found.

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On May 15, 2024, an audit consisting of thorough skin assessment of all residents with a BIMS of 11 or less was completed by licensed nurses to determine if there is evidence of abuse. No concerns were found.

An ad hoc Quality Assurance (QA) meeting was held on May 15, 2024, to discuss the deficient practice and to initiate a plan of correction and education for staff regarding abuse and neglect, audits and inclusion in QA.

What measures will be put in place or systemic changes will be made to ensure deficient practice will not recur.
0n May 15, 2024, education was provided to the Administrator and the Assistant Director of Nursing by the Regional Operations Manager, regarding the definition of abuse as defined in the abuse policy and the resident's right to be free from abuse.

On May 15, 2024, after being reeducated as outlined above, education for all staff was completed in person and via phone by the Administrator or designee. The education consisted of the following:
- The definition of abuse, neglect and misappropriation of property and the need to immediately notify the Administrator or Director of Nursing of all issues related to these infractions. If Administrator or Director of Nursing are not present in the facility, supervisors must be notified, and they must inform the Administrator or Director of Nursing immediately in person or by phone.
- Signs and symptoms of abuse and mental anguish such as loss of interest, change in

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routine, mood alterations, or difficulty eating.
- Our facility does not condone and has zero tolerance for resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.
- The education focused on tactics to deal with difficult residents such as walking away to allow for de-escalation, providing time/place orientation, using a soothing tone of voice, providing gentle tactile cueing, use of gestures, offering distractions such activities, music, or person-centered strategies (pictures, personal memorabilia)

This training will be provided by the Administrator and/or designee to new employees upon hire, during orientation. All facility staff, in all departments, received this training on 5/15/2024, staff had to complete a posttest after training was received to ensure it was understood. Any staff trained over the phone were given a posttest before working. A list of all employees who were educated by phone is reviewed by the Unit Managers daily to capture the staff as they enter the building to take the post test before they start their shift. The Unit Managers were notified on 5/15/2024 that they were responsible for ensuring all staff posttest are provided prior to working their shift. The Administrator will be responsible for keeping a list of training and any staff member that has not received training will not be allowed to work until received. The Assistant Director of Nursing was informed by the Regional Operations Manager on 5/15/2024 that she would be responsible for providing in-person education and posttest to all staff members before working their

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next scheduled shift. The Administrator will be responsible for notifying the Assistant Director of Nursing. Staff will continue to receive this education yearly and as needed thereafter. The Administrator was notified by the Regional Operations Manager of the need to provide this training to new hires on 5/15/2024

Indicate how the facility plans to monitor its performance to make sure solutions are sustained.

To prevent this from reoccurring, residents will be interviewed if they have a BIMS of 12 or above or a skin check will be completed if they have a BIMS of 11 or below on 15 random residents for 4 weeks, 10 random residents for 4 weeks, and 5 random residents for 4 weeks to ensure residents do not express any concerns or fear of abuse and body is free from any unknown injuries or signs of abuse.

The nursing administrative team will also complete an audit of care provided for cognitively impaired residents that are care planned as having combative or resistive behaviors. These audits will be completed on 15 random residents for 4 weeks, 10 random residents for 4 weeks, and 5 random residents for 4 weeks.

The Administrator will submit the findings of these audits to the QAPI committee monthly x 3 months for further review or need to continue audits.

Alleged IJ removal date is 5/16/2024.

On 05-30-24, the facility's corrective action plan by the following: Staff interviews revealed they had received education on resident abuse,

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F 600	Continued From page 22 neglect and misappropriation of property, reporting abuse, signs and symptoms of abuse, and interventions to deal with difficult residents. The education further revealed a post-test was also completed after training for all staff. Credible allegations also included residents with a BIM 12 or higher were interviewed and residents with a BIMs of 11 and lower had a skin check completed. Also included were audits of care provided for cognitively impaired residents that are care planned as having combative or resistive behaviors. These audits will be completed on 15 random residents for 4 weeks, 10 random residents for 4 weeks, and 5 random residents for 4 weeks. It was concluded the facility provided all the information to ensure the credible allegations had been conducted. The compliance date of 5/16/24 was validated.	F 600		