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	345103	A. BUILDING _____ B. WING _____	C 08/02/2024

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MATTHEWS HEALTH & REHAB CENTER	600 FULLWOOD LANE MATTHEWS, NC 28105

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F 000	INITIAL COMMENTS A complaint survey was conducted from 7/30-31/2024 and 8/2/24 onsite, with offsite activity 8/1/2024. The following intakes were investigated NC00219439, NC00219372, and NC00217264. 1 of the 6 complaint allegation(s) resulted in deficiency. Intake NC00219372 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F609 at a scope and severity (D) The tag F600 constituted Substandard Quality of Care. Non-noncompliance began on 7/13/24. The facility came back in compliance effective 7/16/24. 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.	F 600		

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

Electronically Signed | 08/13/2024

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff, physician and family interviews, the facility failed to protect a resident's (Resident #1) rights to be free from physical abuse when Resident #2 yelled for his roommate, Resident #1 (who was severely cognitively impaired), to leave his stuff alone and then hit Resident #1 3 times with a closed fist on the back of Resident #1's head and neck. This resulted in Resident #1 being transported to the local emergency department (ED) on 7/13/24, where a computerized tomography (CT) scan of the head determined that Resident #1 had a 4-millimeter (mm) hyperdense focus (increased area of density that could indicate bleeding or a stroke) in the right frontal region of his brain that was questionable for focal hemorrhage, subarachnoid (space between the brain and membrane covering the brain) bleeding, or contusion. Resident #1's Glasgow Coma Scale (GCS) was 15 (mild head injury). Resident #1 was transferred to a trauma center, where he was hospitalized on 7/14/24. Resident #1 received a repeat CT of the head 6 hours after the original CT, neuro checks every 4 hours, and deep vein thrombosis prophylaxis. Resident #1 was discharged from the hospital to another skilled nursing home on 07/24/24 with orders to follow up with his primary care physician in 1 to 2 weeks. A reasonable person would be traumatized by this type of physical abuse. This was for 2 of 4 residents reviewed for abuse.	F 600	Past noncompliance: no plan of correction required.	

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The findings included:

Resident #1, who was 84 years old, was admitted to the facility on 06/27/24, with diagnoses to include dementia, cognitive communication deficit, anxiety disorder, and generalized muscle weakness.

Resident #1's admission Minimum Data Set (MDS) dated 07/03/24 revealed Resident #1 was severely cognitively impaired with fluctuating inattention and disorganized thinking. The MDS also revealed behaviors were present, but no physical or verbal behaviors were exhibited. According to the MDS, Resident #1 had clear speech, adequate vision and hearing.

Resident #2, who was 60 years old, was admitted to the facility on 01/17/24, with diagnoses to include abnormalities of gait and mobility, muscle weakness, intellectual disabilities, and a cognitive communication deficit.

Resident #2's most recent MDS dated 07/12/24 indicated that Resident #2 was cognitively intact, with no physical, verbal, and/or cognitive behaviors exhibited. He was independent for self-care and used a manual wheelchair for mobility.

A review of Nurse #1's progress note for Resident #1 dated 07/13/24 at 8:15 pm revealed that Nursing Assistant (NA) #2 informed him that Resident #2 was "assaulting" Resident #1. Nurse #1 heard Resident #2 yelling as he approached the room. Upon entering the room, he observed Resident #2 behind the privacy curtain and Resident #1 hitting him in the back of the head. Nurse #1 intervened by holding Resident #2's

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arms, asking NA #2 to take Resident #1 out and away from Resident #2, and asking other staff members to call 911. Nurse #1 documented a small tear on the right side of Resident #1's head, with stable vital signs, and noted the need to send Resident #1 to the hospital for assessment. Nurse #1 notified Resident #1's family, the on-call provider, the Director of Nursing (DON), and the Administrator. Staff "continued to monitor."

A review of Nurse #1's progress note for Resident #2 dated 07/13/24 at 8:15 pm documented that Nurse #1 assessed Resident #2 who verbalized no complaints of pain or discomfort, and noted no cuts or bruises. Nurse #1 documented that Resident #2 stated that he "snapped" because Resident #1 was "going through my clothes." Resident #2, who was educated and encouraged to report concerns to a staff member, was transferred to an alternate room on another hall. Nurse #1 notified Resident #2's family, the on-call provider, the DON, and the Administrator. Staff "continued to monitor."

A review of the Incident Report dated 07/13/24 was completed by Nurse #1 and revealed that Resident #2 exhibited physical aggression towards Resident #1, causing cuts/skin tear on the right side of Resident #1's head.

A telephone interview was conducted with NA #3 on 07/31/24 at 9:49 am. She recounted that she was at the nursing station when she heard Resident #2 yelling that he told another person "Not to mess with my stuff;" then, she ran to the room's doorway where she saw Resident # 1 and Resident #2 behind the privacy curtain. NA #3 stated that she remained halfway in the residents' room and halfway out of the room, and did not

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enter the room for her safety. NA #3 stated that she asked NA #2, who arrived behind her, to call for assistance. NA #3 stated that Nurse #1 arrived and "bear-hugged" Resident #2, who was standing, as he pulled Resident #2 away from Resident #1, while NA #2 pushed Resident #2, who was in his wheelchair, to the nursing station. NA #3 stated that she heard "punches" from the hallway at the time that Nurse #1 entered the room and approached Resident #2, but was unsure of how many punches she heard. NA #3, who did not recall any conflicts between Resident #2 and Resident #1 (or any residents), stated that Resident #2 was concerned that his family would think that Resident #2 did not appreciate the new clothes they had given to Resident #2 if they saw Resident #1 wearing the clothes.

During a telephone interview with NA #2 on 07/31/24 at 10:18 am, he stated that he was in another resident's room when he heard Resident #2 talking loudly to Resident #1, so went to check on them. NA#2 did not report hearing Resident #2 hitting Resident #1. Upon his arrival to the entryway of the room, NA #2 found NA #3 standing in the doorway, and Resident #2 standing behind Resident #1 who was seated in his wheelchair. He stated that he did not see Resident #2 hitting Resident #1, and did not notice Resident #1 guarding himself. NA #2 left NA #3 to monitor the residents while he ran to get the assistance of Nurse #1. NA #2 stated that he never noticed Resident #1 looking through Resident #2's clothing, but "would not rule it out."

A telephone interview was conducted with Nurse #1 on 07/31/24 at 11:14 am, at which time he explained he thought NA #2 was kidding when he beckoned Nurse #1 to assist with an altercation

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between Resident #1 and Resident #2 on 07/13/24. Nurse #1 stated that he ran to the room to find Resident #1 seated in his wheelchair, between Resident #1's bed and the window. Nurse #1 stated that Resident #2, whose wheelchair was on the other side of the room near Resident #2's bed and the door, was standing behind Resident #1, hitting Resident #1 in the back of his head/neck area 3 times. Nurse #1 stated he "bear-hugged" Resident #2 and instructed NA #2 to push Resident #1 to the nursing station for safety, then to have staff call for medic and police dispatch. Nurse #1 stated Resident #1 was transferred to the ED; however, Resident #2, who denied injuries, agreed to be assessed but refused medic transport to the hospital. Nurse #1 shared that Resident #1 was sometimes confused. To ensure Resident #1's safety, Nurse #1 moved Resident #2 to an alternate room on another hallway where there were no other residents who may have wandered into Resident #2's room.

A review of the Police Department Report dated 07/13/24 indicated that Resident #1, who appeared confused, stated he did not know why Resident #2 punched him. The report continued, Resident #2 informed the officer that Resident #1 was trying to steal his clothing, didn't stop doing so when asked, thus Resident #2 began hitting Resident #1 in the back of his head to "defend my property." The report noted that Resident #1 was transported by emergency medical services (EMS) to the ED and Resident #2 was evaluated on scene by EMS, however his injury did not necessitate transfer to the ED. The report stated that the Officer declined to cite Resident #2 for the assault due to his physical condition and his reliance on medical staff.

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A review of Resident #1's ED records dated 07/13/24 at 10:17 pm included CT scans of his head and his facial bones with impressions of tiny potential focus of hemorrhage in the high right frontal region, and a recommendation for follow-up. CT scans of Resident #1's facial bones without contrast and cervical spine indicated no CT evidence of facial injury and no CT evidence of cervical injury, respectively. The physician assistant's (PA's) physical exam noted abrasions to the face of Resident #1. The PA's discussion with the neuro intensive care unit resulted in the recommendation that Resident #1 be transferred to another hospital equipped with trauma services for examination and observation.

A review of the EMS run sheet dated 07/14/24 revealed that Resident #1 was transported by critical care transport from the local ED to the main hospital's trauma ED for admission to the trauma department. Orders were for a repeat CT of Resident #1's head 6 hours after the original CT, neurological checks every 4 hours, and deep vein thrombosis prophylaxis.

A review of Resident #1's hospital records dated 07/14/24 at 3:05 am revealed a Glascow coma scale of 15 (used to score Resident #1's level of consciousness, from 3 to 15, with 15 indicating mild traumatic brain injury (TBI) or a concussion). The repeat CT of the head revealed Resident #1 had a 4 mm hyperdense focus in the right frontal region questionable for focal hemorrhage, subarachnoid, or contusion, which was unchanged from the previous CT scan of the head. The physician concluded that Resident #1's bones were osteopenic (loss of bone density) which limited evaluation and Resident #1 had no

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acute fractures or dislocations. Hospital treatment included a repeat CT of Resident #1's head 6 hours after the original CT, neuro checks every 4 hours, and deep vein thrombosis prophylaxis. During hospitalization, Resident #1 received neurological surgical consultation that determined no further interventions were needed. Resident #1 was discharged to an alternate nursing facility on 07/24/24 with orders to follow up with his primary care physician in 1 to 2 weeks. New medication orders for Resident #1 included an over-the-counter pain medication, and gabapentin (an antiseizure medication that is used to treat nerve pain) 300 milligrams by mouth as needed to treat neurological pain.

During a telephone interview with Resident #1's family on 07/30/24 at 4:03 pm, Family Member #1 reported since the incident on 7/13/24 Resident #1 was more forgetful, much more fearful, and appeared to be afraid of another attack.

A review of the physician progress note dated 07/17/24, which included a psychiatric assessment, revealed that Resident #2 was at baseline mental status and functional status with normal behavior and no homicidal ideations. In addition, the physician stated that Resident #2, who was placed on 1:1 observation immediately following the physical abuse of Resident #1, did not need 1:1 observation.

An interview was conducted with the residents' physician on 07/31/24 at 11:02 am. The physician described Resident #1 as having major neurocognitive disorder who sometimes strayed from the topic during conversation (but could be redirected) and did a lot of repeating which was consistent with his dementia, though medically

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stable despite his cognitive deficits. He denied concerns regarding Resident #1's upper extremity range of motion (ROM), and felt that Resident #1 had the ability to guard himself. The physician, who denied observed tension between Residents #1 and #2, stated that neither resident verbalized complaints about one another to him prior to the altercation. The physician shared Resident #2 never appeared to be abusive based on his medical assessment. He stated that his 07/17/24 physical and psychiatric examination of Resident #2 revealed that Resident #2 was alert, awake, calm with no resistance to care. In addition, he denied that Resident #2's intellectual and/or cognitive diagnoses impacted Resident #2's actions.

An interview was conducted with Resident #2 on 07/30/24 at 4:30 pm. He stated he did not appreciate Resident #1 going through his clothes. Resident #2 reported that he informed "the lady that passed meds" that Resident #1 was going through his clothing, but was not sure of her name. He stated that she "kinda brushed it off," and told Resident #2, "you need to stop doing {hitting}" Resident #2 stated that he did report his concern at a Resident Council meeting, but felt that others did not understand and could not relate to his concern. Resident #2 stated that he is normally in the Common Area, but returned to his room on 07/13/24 because he was not feeling well, and found Resident #1 going through his clothing. Resident #2 continued, "I got mad, and I hit him with my right hand - with my knuckles." He stated that Resident #1 hollered, then Nurse #1 came into the room, "put his arms around me, and I just dealt with it. It kinda clicked in my mind, 'You stop.'" On 07/13/24, after hitting Resident #2 shared regret that he hit Resident #1 with Nurse

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#1. He stated, "I'm sorry. And, I hope to handle other conflicts better. I learned my lesson."

A review of the Grievance and Complaint Log from 01/01/24 to 07/30/24 revealed no complaints about clothing being taken from Resident #2 and/or other residents.

A review of Resident Council Minutes, from 01/01/24 to 07/30/24, had no reported concerns of residents' personal property being disturbed, and revealed that Resident #2 attended the 05/27/24 meeting but noted no reported concerns.

During an interview with the DON and the Corporate Consultant on 07/31/24 at 2:34 pm, they stated that they both spoke with Resident #2 after the altercation. The DON and Corporate Consultant said that Resident #2 told them that he overheard Resident #1 speaking with his family over the phone about Resident #1's upcoming discharge. Resident #2, who had given Resident #1 items in the past, was concerned that Resident #1 planned to take Resident #2's clothing home with him. They stated that all staff had been re-educated on policies, which included resident abuse/neglect, resident rights, de-escalation, and reporting allegations.

During a telephone interview with the Facility Administrator on 08/01/24 at 1:13 pm, he reported that there were no known prior triggers to indicate that Resident #2 would abuse Resident #1, other residents, or staff, based on the facility's investigation.

The facility Administrator was notified of Immediate Jeopardy on 07/31/24 at 4:15 pm.

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The facility provided the following corrective action plan for immediate jeopardy removal:

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

On 7/13/2024, around 8:15pm, NA #2 and NA #3 heard yelling coming from room 101 and observed Resident #2 up behind Resident #1. Resident #2 was yelling for Resident #1 to stop touching his stuff. Resident #2 did not respond to verbal requests to calm down. NA #2 immediately ran to get the Nurse #1 to assist while NA #3 remained with residents in room. Resident #2 started punching Resident #1 and NA #3 was not able to stop attack and seconds later, NA #2 and Nurse #1 returned to room 101. Nurse #1 grabbed Resident #2 in a "bear hug" to prevent Resident #2 from continuing to punch Resident #1 and instructed NA #2 to remove Resident1 from the room and to notify 911. Facility staff immediately separated residents. Resident #1 and Resident #2 were assessed for injury. Resident #1 noted with blood coming from right side of head. Nurse #1 notified Resident #1's Doctor and received order to transfer Resident #1 to the hospital for evaluation. Responsible Party for Resident #1 and Resident #2 were notified of the altercation and injuries. At approximately 8:20pm, paramedics and police arrived to facility. Resident #1 was assessed by paramedics and Resident1 was transferred to hospital for further evaluation. Resident #2 was relocated to a private room off the unit for close observation.

On 7/13/2024, at approximately 8:24pm the Director of Nursing and the Nursing Home

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Administrator were notified of the Resident-to-Resident altercation.

On 7/13/2024, at approximately 10:07pm, The Nursing Home Administrator submitted initial self-reported incident to DHSR.

On 7/15/24, Resident #2 was relocated back to room 101 and placed on 1:1 observation. 1:1 observation will remain in place. The discontinuation of 1:1 observation will be determined by QAPI committee and psychiatric services.

On 7/15/24, the nursing home administrator notified Adult Protective Services.

On 7/15/2024, the social worker notified the consulting psychiatrist and consent was obtained for Resident #2 to be evaluated by psychiatric services.

On 7/15/2024, Resident #2 was evaluated by Nurse Practitioner. No new orders.

On 7/15/2024, Regional Director of Clinical Services, Director of Nursing and Nursing Home Administrator completed Root Cause Analysis. Root cause determined as roommate incompatibility. Root Cause Analysis reviewed by QAPI committee.

On 7/17/2024, Resident #2 was evaluated by Attending Physician. No new orders.

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

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On 7/15/2024, to identify other potential like residents, current residents with a BIMS of 12 and above were interviewed by facility social worker related to roommate compatibility, safety, and overall well-being. Three rooms were identified with potential roommate compatibility issues. Room(s) 114, 130, 106

On 7/15/2024, Social worker contacted resident family for Resident 114, family declined room change. On 7/15/2024, social worker contacted Responsible Party for resident's residing in room 130. Both resident Responsible Party's declined changing a room. On 7/15/2024, social worker offered a room change to Resident in 106b. Resident declined a room change.

On 7/15/2024, The RN Unit Manager performed head to toe skin assessments on all residents that had a BIMS score less than 12. No adverse findings.

On 7/15/2024, the Regional Director of Clinical Services and facility Clinical Quality Specialist reviewed all facility progress notes and care plans for the past 30 days to identify residents with documented behaviors and to ensure resident care plans were up to date
On 7/15/2024, the MDS coordinator reviewed all resident medical records with similar diagnoses to ensure behaviors indicated were care planned appropriately with interventions. No concerns found.

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

On 7/15/24, the Director of Nursing/designee

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	345103	A. BUILDING _____ B. WING _____	C 08/02/2024

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re-educated current staff on the abuse policy and procedure, including providing quality of care and services to each resident based on the plan of care and potential trigger behaviors and de-escalation techniques/process. The Director of Nursing will ensure that newly hired employees will receive education during facility orientation on the facility abuse policy and procedure, including quality of care and services to each resident based on the plan of care and potential trigger behaviors and de-escalation techniques.
On 7/15/2024, the Nursing home administrator and the Director of Nursing were re-educated by the Regional Director of Clinical Services on the revisions made to the orientation education detailed above.

On 7/15/24, the Regional Director of Clinical Services educated IDT on Grievance Process to ensure resident grievances are followed up with appropriately and timely.
On 7/15/2024, an Ad Hoc QAPI was completed.

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

On 7/15/2024, to monitor and maintain ongoing compliance the facility social worker/designee will conduct 5 resident interviews weekly for 4 weeks, then monthly for 2 months to ensure there are no issues with behaviors, abuse/neglect, or roommate compatibility issues. Any concerns identified will be reported immediately to the Administrator. Interview results will be submitted to the QAPI committee for further review and recommendation.

On 7/15/2024, to monitor and maintain ongoing

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compliance the facility director of nursing/designee will conduct 5 staff interviews weekly for 4 weeks then monthly for 2 months to ensure there are no issues with behaviors, abuse / neglect, or roommate compatibility issues. Any concerns identified will be reported immediately to the Administrator. Interview results will be submitted to the QAPI committee for further review and recommendation.

On 7/15/2024, to monitor and maintain ongoing compliance the facility Interdisciplinary Team, to include Administrator, Admission Coordinator, Director of Nursing, Social worker, will review potential admissions for roommate compatibility prior to accepting patient. Criteria to determine compatibility was explained to social worker and admission coordinator by the Administrator on 7/15/2024.

Roommate compatibility is a multifactorial determination based on medical diagnoses affecting cognition and inappropriate behaviors.

Above responsibilities were discussed during Ad-hoc QAPI completed on 7/15/2024.

Alleged Compliance date: 7/16/24

The corrective action plan was reviewed onsite and validated on 08/02/24.

Interviews with current staff revealed they received education and training on resident-to-resident abuse, resident rights, de-escalation, and reporting abuse. Staff education was reviewed. Monitoring of staff interviews was reviewed. Roommate compatibility was reviewed. The audits conducted on 07/15/24

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F 600	Continued From page 15 revealed that residents were interviewed about abuse and concerns with roommates, and skin assessments were completed on non-interviewable residents. The education provided to the Administrator by the Regional Director of Clinical Services, audits conducted by the Regional Director of Clinical Services and the Ad Hoc QAPI meeting notes from 7/16/2024 were reviewed. The Administrator, Director of Nursing, and Regional Director of Clinical Services were interviewed. The facility compliance date of 07/16/24 was validated. Immediate jeopardy was removed 7/16/24.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

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F 609	Continued From page 16 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an allegation of resident-to-resident abuse to Adult Protective Services (APS). This deficient practice was for 1 of 3 facility reported incidents reviewed. The findings included: The Initial Allegation Report of resident-to-resident abuse was submitted to North Carolina Health Care Personnel Registry (NC HCPR) on 07/13/24 at 10:15 pm. The facility reported that NA #2 and NA #3 heard arguing from a resident room. NA #2, NA #3, and Nurse #1 immediately went to the room, where they observed Resident #2 punching Resident #1. Staff intervened by separating the residents. Resident #1, who had bleeding coming from his face, was sent to the hospital for evaluation. Resident #2 was moved to a private room and placed on 1 on 1 observation. The Facility Administrator and local law enforcement were notified by staff on 07/13/24. The report did not indicate that APS was notified. During a telephone interview with the Facility Administrator on 08/01/24 at 1:13 pm, he stated that he was informed about the altercation between Resident #2 and Resident #1 on	F 609	Past noncompliance: no plan of correction required.	

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07/13/24 "shortly after" 8:15 pm by the charge nurse. He reported APS was not contacted on 07/13/24 because the screening criteria was not met. The Administrator stated an APS report was made on 07/15/24 because the facility was not sure if Resident #1 would be returning to the facility. In addition, the Administrator restated the corrective action plan implemented by the facility after the altercation, including the outcome of the QAPI Ad Hoc meeting on 07/15/24.

The facility submitted the following corrective action plan.

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

On 7/13/2024, around 8:15pm, NA #2 and NA #3 heard yelling coming from room 101 and observed Resident #2 up behind Resident #1. Resident #2 was yelling for Resident #1 to stop touching his stuff. Resident #2 did not respond to verbal requests to calm down. NA #2 immediately ran to get the Nurse #1 to assist while NA #3 remained with residents in room. Resident #2 started punching Resident #1 - NA #3 was not able to stop the attack and seconds later, NA #2 and Nurse #1 returned to room 101. Nurse #1 grabbed Resident #2 in a "bear hug" to prevent Resident #2 from continuing to punch Resident #1 and instructed NA #2 to remove Resident #1 from the room and to notify 911. Facility staff immediately separated residents. Resident #1 and Resident #2 were assessed for injury. Resident #1 was noted with blood coming from right side of head. Nurse #1 notified Resident #1's Doctor and received order to transfer Resident #1 to the hospital for evaluation.

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Responsible Party for Resident #1 and Resident #2 were notified of the altercation and injuries. At approximately 8:20pm, paramedics and police arrived at the facility. Resident #1 was assessed by paramedics and Resident #1 was transferred to hospital for further evaluation. Resident #2 was relocated to a private room off the unit for close observation.

On 7/13/2024, at approximately 8:24pm the Director of Nursing and the Nursing Home Administrator were notified of the Resident-to-Resident altercation.

On 7/13/2024, at approximately 10:07pm, The Nursing Home Administrator submitted an initial self-reported incident to DHSR.

On 7/15/24, Resident #2 was relocated back to room 101 and placed on 1:1 observation. 1:1 observation will remain in place. The discontinuation of 1:1 observation will be determined by QAPI committee and psychiatric services.

On 7/15/2024, the Regional Vice President of Operations was contacted by the Nursing Home Administrator regarding the incident on 7/13/2024. The Regional Vice President of Operations asked the Nursing Home Administrator if Adult Protective Services was notified at the time of the incident. The Nursing Home Administrator informed the Regional Vice President of Operations that Adult Protective Services had not been notified and the Regional Vice President of Operations instructed the Nursing Home Administrator to notify Adult Protective Services immediately.

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F 609	Continued From page 19 On 7/15/2024, the Nursing Home Administrator notified Mecklenburg County Adult Protective Services of the Resident-to-Resident Abuse. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 7/15/2024, to identify other residents having the potential to be affected by the same deficient practice, the Regional Director of Clinical Services reviewed all Facility Reported Incidents during the last 30 days to ensure Adult Protective Services was notified timely. No adverse findings. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 7/15/2024, the Regional Director of Clinical Services re-educated Director of Nursing and Nursing Home Administrator on requirements of notifying the Regional Director of Operations, and, or Regional Director of Clinical Services immediately for all allegations of resident abuse. On 7/15/2024, the Regional Director of Clinical Services re-educated Director of Nursing and Nursing Home Administrator on timely notification of all allegations of resident abuse to Adult Protective Services. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: On 7/15/2024 an Ad Hoc QAPI meeting was conducted and the decision to monitor was made. To maintain ongoing compliance the Regional	F 609		

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Director of Operations, and, or Regional Director of Clinical services will review all facility reported incidents for timeliness of notification to Adult Protective Services. Audit results will be submitted to the QAPI committee for further review and recommendation.

Alleged Compliance date: 7/16/24

The facility's corrective action plan was validated on 8/2/2024 by the following:

Interviews with current staff revealed they received education and training on abuse/neglect, resident rights, de-escalation, and reporting abuse. The audits conducted on 07/15/24 revealed that residents were interviewed about abuse and concerns with roommates, and skin assessments were completed on non-interviewable residents. The education provided to the Administrator by the Regional Director of Clinical Services, audits conducted by the Regional Director of Clinical Services and the Ad Hoc QAPI meeting notes from 7/16/2024 were reviewed. The Administrator, Director of Nursing, and Regional Director of Clinical Services were interviewed. The compliance date of 7/16/2024 was validated.