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F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite from 8/6/24 through 8/7/24. Event ID# OOEW11. The following intakes were investigated NC002019415 and NC00216396. Past-noncompliance was identified at: CFR 483.12 at tag F602 at a scope and severity E. CFR 483.12 at tag F603 at a scope and severity E. Two of the two complaint allegations resulted in deficiencies.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents, staff, and physician, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 1 of 4 resident (Resident #2) reviewed for misappropriation of residents' property. The findings included: The facility's Abuse, Neglect, or Misappropriation	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/26/2024

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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of Resident property policy, last revised in August 2024, revealed in part the facility would ensure all residents to remain free from abuse or misappropriation of their property.

Resident #2 was admitted to the facility on 4/22/24 and discharged home on 4/30/24. The admission Minimum Data Set (MDS) dated 4/23/24 indicated Resident #2's cognition was intact.

A review of the physician's order dated 4/22/24 revealed Resident #2 had an order to receive 1 tablet of oxycodone (a semi-synthetic narcotic analgesic for pain) 5 milligrams (mg) every 4 hours as needed for severe pain.

A review of the April 2024 medication administration records (MARs) revealed Resident #2 had received 1 tablet of oxycodone 5 milligram, once daily, as ordered for pain on 4/23/24, 4/24/24, 4/25/24, and 4/26/24.

The initial allegation report dated 4/24/24 revealed the facility became aware of the misappropriation of residents' property on 4/24/24 at 4:30 PM when Resident #2's oxycodone and its controlled medication count sheet could not be found in the medication cart. All medication carts were audited to locate the missing card of oxycodone. All residents were assessed for pain and alert and oriented residents were interviewed for concerns with pain medication administration.

A review of the 5-day investigation report dated 4/30/24 revealed on 4/23/24, a blister card contained 30 tablets of oxycodone 5 milligram and the controlled medication count sheet for Resident #2 were allegedly removed by Nurse #1.

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All nursing staff that worked with the medication cart in the past 24 hours including Nurse #1 were interviewed and indicated that they did not remove any controlled medication sheet from the medication cart in that time frame. Nurse #1 who worked with the medication cart on 4/22/24 and 4/23/24 the day the prescription and narcotic control sheet was delivered and counted off with Nurse #5 was interviewed on 4/25/24. Further investigation by reviewing the camera footage revealed Nurse #1 was seen removing items from the medication cart during her shift on 4/23/24. The allegation of diversion of Residents' drugs was substantiated and Nurse #1 was terminated on 4/26/24.

A review of the controlled medication count sheet for medication cart on the Cascade neighborhood indicated Nurse #1 had removed the medication card of 30 pills (oxycodone) from the controlled medication compartment during her shift on 4/23/24 . Review of the narcotic log and facility camera footage revealed the medication card and narcotic count sheet was missing for Resident #2.

Several attempts to contact Nurse #1 on 8/6/24-8/7/24 were made and Nurse #1 was not available for interview.

An interview was conducted on 8/6/24 at 3:40 PM, with Nurse 4 and Nurse #5. Nurse #5 stated the medication for Resident #2 was delivered and received on 4/22/24 around 7:30 PM. She stated she did a controlled substance count check with Nurse #1. Nurse #1 signed off that she received the 30 oxycodone pills. Nurse #5 stated when she came onto second shift on 4/24/24, Resident #2 requested pain medication. She further stated when she checked the medication cart and

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F 602	Continued From page 3 discovered the prescribed medication was not available in the cart, she began to search the cart because she knew the medication was available two days prior. She contacted Nurse #4 and informed her of the situation. Nurse #4 stated she and Nurse #5 both checked the medication cart and other carts within the facility only to discover the medication and narcotic control count sheet was also missing. Nurse #5 state she offered Resident #2 Tylenol until she could find out what happened to the medication. The resident accepted the Tylenol and reported it was effective. Nurse #4 stated, the Director of Nursing was contacted immediately when the medication and narcotic count sheet was not found. Both reported receipt of the medication and narcotic sheet delivery was made on 4/22/24 and Nurse #1 had received the medication with the sheet on 4/22/24. A telephone interview was conducted on 8/6/24 at 4:00 PM with Nurse #6 s who tated she worked on the medication cart on the morning of 4/23/24 and 4/24/24 when Resident #2 requested pain medication. She stated when she checked the physician orders and the medication cart, the medication was not available. She knew that it may take a day or two for the medication to arrive, so she went to the Pyxis machine to get the 5-milligram dose of oxycodone for the resident. The Pyxis had emergency medication available until medications were delivered, which would be 1 or two days depending on the medication type. Nurse #6 reported she was unaware the medication had been delivered to the facility on 4/22/24. She stated Resident #2 did not miss any dosage of requested pain medication.	F 602		

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A telephone interview was conducted on 8/7/24 at 9:33 AM with the physician who stated she was made aware of the alleged drug diversion incident on the same day 4/24/24 by the Director of Nursing. She added the affected resident (Resident #2) was assessed immediately without any adverse consequences noted. The missing pain medication was obtained from the Pyxis without any delays. She further stated the facility Pyxis backup system contained 5 to 10 doses for emergency until scheduled medications were delivered. She added the expectation would be for nursing to use the Pyxis medication until the indicated all the missing medications were replaced and paid for by the facility later.

A telephone interview was conducted on 8/7/24 at 11:48 AM, with Resident #2 who stated she was notified of the alleged drug diversion on 4/24/24 and received oxycodone as ordered when requested. She further stated she had also been informed the facility reordered and paid for the missing oxycodone. Resident #2 indicated she did not experience any problems getting her pain medication in a timely manner.

An interview was conducted on 8/6/24 at 9:00 AM, the Director of Nursing stated a complete investigation was initiated when it was discovered that Resident#'2 oxycodone medication and substance control sheet was missing from the medication cart. She stated Nurse #4 and Nurse # 5 contacted her and reported on 4/24/24, that Resident "2's medication and control sheets were missing. The investigation included reviewing the staff schedule of all person's working the cart from 4/22/24-4/24/24. The Director of Nursing reviewed the previous substance control form and discovered Nurse #1 had signed off with Nurse

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F 602	Continued From page 5 #5 and the medication had been delivered on 4/22/24. She reported the Clinical Coordinator contacted the pharmacy to verify the delivery of medication. The Director of Nursing reported and audited of all the pertinent pharmacy packing slips, MARs, prescription order tracking records, controlled medication return sheets, and comparing controlled medications in all the medication carts were conducted and it was concluded that a total of 30 tablets of oxycodone 5 mg for Resident #2 were missing and Resident #2 was the only resident affected by this incident. The Director of Nursing and the Administrator reviewed the facility camera footage to develop timeline of events on 4/23/24, resulting in facility observation of Nurse #1 removal of the medication card and control sheet for Resident #2. Nurse #1 was called in for an interview on 4/25/24 and terminated on 4/26/24. She reported the incident to the Department of Health and Human Services (DHHS), law enforcement agent, North Carolina Board of Nursing, and the Adult Protective Services. In addition, the Medical Director, Resident #2, and her family were all notified. The missing oxycodone was reordered and paid for by the facility. All residents were assessed, and alert and oriented residents were interviewed for possible harm. In-service related to narcotic accountability and process was conducted to all the current employees, agency staff, and new hired. She audited all medication carts and residents who received controlled substance once weekly for 4 weeks and then monthly for 2 months. The audit report was presented to the weekly Quality Assurance Performance Improvement (QAPI) meeting for 3 months. After the incident, she did not recall having any additional incident related to controlled medication discrepancies or drug diversion.	F 602		

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The facility provided the following corrective action plan with a completion date of 5/03/24:

Corrective action for resident(s) affected by the alleged deficient practice:

On 4/24/24 Resident #2 requested pain medications and the 2nd shift Nurse #5 noted that she was unable to locate the Oxycodone that she had signed in on 4/22/25. Nurse #3 notified the second shift supervisor Nurse #4 who immediately notified the Director of Nursing.

Nurse #5 immediately checked back with Resident #2 who stated that she preferred Tylenol and Nurse #5 administered the medication per the resident request and upon evaluation of pan, the Tylenol was noted to be effective.

On 4/24/24 the Clinical Coordinator, contacted pharmacy to verify that the medication in question had not been received and that it had not been subsequently returned.

On 4/24/24, the Oxycodone medication was not found after immediate investigation, it was confirmed that Resident #2's pain was able to be controlled by conducting and audit of the Capsa machine to verify pain medication haven been allocated and pulled for the resident and available for future use.

On 4/24/24, the Clinical Coordinator immediately audited all medication carts in the facility for the possibility of the missing care and all narcotics in each neighborhood were checked and accounted for. It was assessed that each resident who had pain medication ordered had it appropriately

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available.

On4/24/24 Coaching was completed for Nurse #4 and Nurse #5.

On 4/25/24, the Social Worker and Administrator began an investigation and submitted a 24-report. Administrator began reviewing the facility camera footage to investigate the missing medication card. The local police department was notified of the investigation.
On 4/25/24, during the investigation of the missing medication, it was identified that the narcotic count sheet could possibly be clearer and institutive related to explanation of narcotics on and off unit. A discussion was held with the pharmacist to develop a new and more concise form.

Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 4/24/24, other residents on the unit that were being monitored and treated for pain were interviewed by the Social Worker and Director of Nursing whom all denied having issues with uncontrolled pain or had not received pain medication appropriately.
All narcotics in each neighborhood were checked and accounted for. No other discrepancies identified. No other residents noted with uncontrolled pain.

Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:

On 4/26/24 a discussion was held with pharmacy and new form for narcotic count check was developed and initiated and staff were educated on the new form and process. Pharmacy shared

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a new form which included a process for new medications to be received and/or returned to pharmacy of any medication changes in the narcotic and/or count to be documented of any changes as an alert to oncoming nurses there had been a change.

On 4/26/24 the Director of Nursing began in-servicing for all full-time, part-time and PRN (as needed) registered nurses, licensed practical nurses, and medication aides including agency nursing staff on the Narcotic Process policy. This training included: Misappropriation of Resident Property and the Narcotic Process Policy. The Narcotic Process policy includes ordering, receipt, storage and record keeping of narcotics, this policy also includes systems to assist with prevention and recognition of diversion and what to do once diversion was suspected and corrective actions to take. On-going education of the new process would be included in the new hire orientation for any newly hired staff. The education was implemented on 4/28/24.

On 4/29/24 audits for controlled medications in the Capsa medication machine(medication dispenser) was initiated. The audits would ensure the facility had adequate back up narcotics to provide pain control for residents. The audits were done weekly for a minimum of two quality assurance cycles or until sufficient compliance.

On 4/30/24 the Director of Nursing and Social Worker followed -up with Resident #2 to give her the resolution of the abuse investigation. Resident #2 was able to confirm that she had continued to have no issue with pain control. Medical Director was also notified of the investigation.

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On 5/3/24 the Director of Nursing and Clinical Coordinator began a new audit of narcotic logs on each neighborhood. This was to ensure that the new form and process was being carried out appropriately. Controlled substances in each cart were verified against the count sheet in real time during the audit to confirm accuracy. The audits would be done on a weekly basis for two quality assurance cycles or until sufficient compliance.

Date of Compliance: 5/03/2024

The facility's corrective action plan with a correction date of 5/3/24 was validated onsite on 08/06/24-8/7/24 by record review, observations, and interviews with nursing staff, director of nursing, and the Administrator.
Medication Administration observations were conducted from 08/06/24 at 1:30 PM with the Clinical Coordinator and Director of Nursing who demonstrated the process for medication control count process. The Clinical Coordinator reviewed the narcotic sheet for resident demographic information and reconciled with the medication card prior to count with the Director of Nursing. The medication consisted of 76 medications and 12 different residents. Controlled medication was pulled from the double-locked compartment in the medication cart during the medication pass observation. The nurse documented the retrieval of controlled medication in the controlled medication count sheet properly. Random samples of 4 controlled medications were pulled from each medication cart to verify accuracy and the controlled medication counts were consistent with the records in the count sheets.
An observation was conducted on 8/6/24 at 3:30 PM during a shift transition. The arriving Nurse #5

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F 602	Continued From page 10 and the departing Nurse #6 #started the process by counting the total number of blister cards containing controlled medication in the double-locked compartment to verify the total number of controlled medications in the count sheet. Then, they counted each blister card of controlled medication to ensure the quantity listed in the count sheet was consistent with the actual counts. Nurse #6 read out the number of pills for each blister card from the controlled medication count sheets and the arriving nurse pulled the blister card to verify the quantity. After all the counts were completed without any discrepancies, Nurse #5 signed the controlled medication count sheet before the departing nurse passed the medication cart key to her. The nursing staff confirmed during the interviews that they had received in-service training related to "Abuse, neglect, misappropriation, reporting, code of ethics, and diversion" and "The Control Substance Process". They were assigned to review the handouts for the in-service prior to the training. The training was conducted in-person by director of nursing, and it included multiple examples and scenarios. A review of the in-service log revealed a total of 35 nursing staff had completed the training and signed in the in-service records. The training was completed on 5/1/24-5/5/24. A review of the audit records revealed the Director of Nursing and Clinical Coordinator began a new audit of narcotic logs for each of the facility neighborhoods of residents receiving controlled medications were randomly audited once per week for 4 weeks by comparing controlled medication count sheets, MAR, and the	F 602		

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controlled medication return sheets. This would ensure that the new form and process were being carried out appropriately. Controlled substances in each cart were verified against the count sheet in real-time during audit to confirm accuracy. This will be audited on weekly basis for a minimum of two quality assurance cycles or until sufficient compliance. This would monitor ongoing in the quality assurance performance process until such that consistent substantial compliance has been achieved as determined by the committee. Corrective action compliance date 5/3/24 with ongoing monitoring and auditing.

An interview on 8/7/24 at 2:30 PM, with the Administrator and Director of Nursing revealed the in-services and education related to controlled medication process and accountability immediately after the incident to re-educate all the licensed nurses and medication aides. The Administrator stated the interventions were successful as the facility did not have any similar drug diversion issues since then.

F 603 SS=E Free from Involuntary Seclusion
CFR(s): 483.12(a)(1) F 603

§483.12
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

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F 603	Continued From page 12 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents, staff, and physician, the facility failed to protect residents' rights to be free from involuntary seclusion for 1 of 3 resident (Resident #1) reviewed for abuse. The findings included: The facility's Abuse, Neglect, or Misappropriation of Resident property policy, last revised in August 2024, revealed in part the facility would ensure all residents to remain free from involuntary seclusion. Resident #1 was admitted to the facility on 1/15/19. The diagnoses included vascular dementia, cerebral vascular accident, restless leg syndrome and atrial fibrillation. The significant change Minimum Data Set(MDS) dated 7/10/24 indicated Resident #1's cognition was severely impaired. Resident's #1's mode of transportation was the wheelchair. Resident#1 required one-person assistance with transfer. The care plan dated 7/16/24 read in part: Resident #1's focus area revealed Resident #1 demonstrated behaviors related to dementia and required additional observation and support. Behaviors demonstrated included but are not limited to refusing care and medications; increased anxiety/agitation, socially inappropriate behaviors; yelling at staff members and her spouse; cursing at staff members; impaired safety awareness. She also throws away briefs and clothing in the trash can and reports it	F 603	Past noncompliance: no plan of correction required.	

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missing. Resident #1wis difficult to redirect at times and has increased anxiety and inability to state needs & wants. When she requests an item, she then has another need immediately. The goal included Resident #1 would have a reduction in behaviors. The interventions included provide consistent caregiver when possible. Assist resident with mobility/transfers/toileting. Explain care before starting care. Ensure resident understands next processes.

The initial allegation report dated 7/11/24 revealed the facility became aware of the seclusion of Resident #1 in a room on 7/11/24 at 2:30 PM when Resident #1 was overheard yelling and found in the bathroom in the shower with the wheelchair stuck on the lip of the shower by therapy staff. Resident #1 was unable to move the wheelchair or exit the bathroom.
A review of the 5-day investigation report dated 7/12/24 revealed the facility review of video footage revealed Nurse Aide #2 took Resident #2 into her bathroom and trapped her wheelchair on the lip pf the shower and closed her bathroom door and room door. Resident #1 was in a position that she was unable to free herself and leave her room. Nurse Aide #2 was not assigned to Resident #1. On 7/11/24 Nurse Aide #2 was on Resident#1's unit to socialize. Additional review of video footage on 7/4/24 revealed Nurse Aide #2 was observed on Resident#1's unit although he was not assigned. Skin checks were completed on Resident #1 on 7/11/24-7/12/24 and there were no abnormal bruising or areas of concerns. Nurse Aide #2 was interviewed via telephone on 7/11/24 and terminated on 7/12/24. Education was provided to nursing staff and care givers on the abuse policy to include seclusion, abuse and managing difficult behaviors.

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F 603	Continued From page 14 A telephone interview was conducted on 8/6/24 at 10:45 AM, with the Social Worker who stated the Occupational Therapy staff reported she was working in another residents' room adjacent to Resident#1's room when she overheard Resident #1 yelling through the bathroom wall and the sounds were of an unusual tone different from Resident#1's normal yelling. The therapy staff reported when she entered the room the bathroom door was closed. Resident #1's wheelchair was positioned in the shower over the lip of the shower floor. The therapy staff did not report Resident #1 was injured. She indicated an immediate investigation was initiated which included assessment of the resident, staff interviews and review of the facility cameras on 7/11/24. The physician and responsible person was informed of the incident. Resident #1 was interviewed but was unable to respond any questions related to the incident due to poor cognition. Staff and other resident interviewed and educated on abuse and involuntary seclusion. An interview was conducted on 8/6/24 at 11:27 AM, with the Occupational Therapy staff who stated she was working with another resident in a room that was adjacent to Resident #1 when she heard through the bathroom wall Resident #1 yelling and screaming at a tone louder than normal which made her uncomfortable. When she entered Resident #1's room the room door and bathroom door was closed. She entered the bathroom door and Resident #1 was still in her wheelchair, but the wheels of the chair were wedged over the shower lip and Resident#1 was facing the back of the shower. The Occupational therapy staff stated she removed the resident	F 603		

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from the bathroom and there were no visible injuries noted. She further stated she reported her observation to Nurse #2 and Nurse #3.

An interview was conducted on 8/6/24 at 1:45 PM, Nurse #2 stated the Occupational Therapy staff who stated that Resident #1 was heard yelling from the bathroom while she was providing service to another resident whose room was adjacent to Resident #1's room. When she entered the bathroom Resident#1's wheelchair was wedged over the shower lip and the resident was unable to move. Nurse #2 reported Resident #1 was able to propel herself in the wheelchair and had a history of being found in awkward positions or location while in the wheelchair. She had assumed Resident #1 had propelled herself into the bathroom and got stuck. Nurse #2 indicated a head-to-toe assessment was done and the resident did not have any injuries.

An interview was conducted on 8/6/24 at 2:00 PM with Nurse Aide #1 who stated she was preparing to go to Resident #1's room with Nurse #3 when the therapy staff pulled Nurse #2 and Nurse #3 aside to discuss her observation of Resident #1 having been found in the bathroom with the door closed and in the corner with the wheelchair wedged on the shower lip of the floor. Nurse Aide #1 reported Resident #1 had a similar incident on 7/4/24. Nurse Aide #1 reported she had observed Resident #1 in her wheelchair in the shower eating ice cream. The resident was in no distress, nor did she appear upset. She reported Resident #1 was able to propel herself throughout the facility and had been found in awkward positions and situations on other occasion. Nurse Aide #1 further stated when she and Nurse #1 entered the room the therapy staff had already removed the

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resident from the shower area and was doing therapy services. Nurse #2 did a physical assessment of the resident and there were no visible injuries. The Administrator, Director of Nursing and Social Worker asked her about her observations on 7/4/24 which prompted an investigation. Nurse Aide #1 stated she did not think anything about the incident due to the resident was able to propel self and get around on her own.
An interview was conducted on 8/6/24 at 2: 20 PM, with Nurse #3 who stated the Occupational Therapy staff reported to her and Nurse #2 she heard Resident #1 yelling from the bathroom in her room, when she went in to check on Resident #1, the resident wheelchair was found caddy corner in the shower and the wheels of the chair was wedged on shower lip of the floor. The Occupational Therapy staff was very concerned about Resident #1's positioning in wheelchair in the bathroom. She indicated there was no report of any injuries. Nurse #3 stated reported the observation to the Administrator and Director of Nursing who began reviewing the camera footage of Resident #1 on 7/11/24.

A telephone interview was conducted on 8/6/24 at 7:30 PM, with Nurse Aide #2 who stated he was not assigned to the hall where Resident #1 resided. He was ending his shift, and he was walking down the hall when he observed Resident #1 in the doorway of her room and requested to be taken to the nurses' station. He did not recall the exact conversation but knew that Resident #1 would often request to go to the nurses' station and once taken within a few minutes would request to be returned to her room. Nurse Aide #2 reported Resident #1 had the capability to propel herself throughout the

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F 603	Continued From page 17 facility independently. Nurse Aide #2 stated since his shift was ending , he did take the resident to her room and placed her in front of her television and left the room within a few seconds. Nurse Aide #2 stated he did not take the resident to the bathroom prior to leaving the room. He reported the bathroom had a sensor which could be heard at the nursing station. He indicated as he entered the nursing station to clock out, the sensor to the room could be heard by anyone around the area. He stated he received a call on Thursday 7/11/24 from the Director of Nursing and the Administrator informed him an investigation of abuse and resident seclusion was being conducted against him based on video footage of his interaction with Resident #1. Nurse Aide #2 stated he had been told that Resident #1 was found in the bathroom shower wedged in a corner and could be heard through camera footage requesting for help and screaming. He further stated he was told he was under investigation for secluding the resident in a room when she requested to be taken another location. Nurse #2 stated he had worked with Resident #1 for awhile and would not have secluded the resident at any time because she did have the ability to propel herself to any location of choice. He placed the resident in her room and immediately left and closed the door. Resident #1 normally yells and screams throughout the day which was her normal behavior. Nurse Aide #2 stated he did not seclude the resident or place the resident in a compromising position prior to leaving the room. He was called on 7/12/24 and told her was terminated. A telephone interview was conducted on 8/7/24 at 9:33 AM with the Physician who stated she was made aware of the alleged seclusion of Resident	F 603		

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F 603	Continued From page 18 #1. The Director of Nursing and Administrator informed her of the events leading up to Resident #1 observed in her wheelchair wedged on the lip of the shower floor. She reported nursing had done a head-to-toe assessment of the resident and did not find any injuries. The Physician reported she had come to the facility on 7/12/24 and assessed the resident's condition and confirmed there were no visible injuries on the resident. Nursing had notified the family of the situation as well. The Physician was aware of Resident #1's ability to propel self throughout the facility and have been found in unusual and awkward positions/situations. The primary concern was when the resident requested to be taken to another location and was refused the assistance, only to be found in the bathroom shower with the inability to get herself out without staff assistance. The Physician reported the facility interdisciplinary team took appropriate action to assess the resident and review facility footage and decided to terminate the employee. The resident had some health changes during this period which would have contributed to her decline and ability to get herself out of the shower or the room. An interview was conducted on 8/7/24 at 10:30 AM with the Director of Nursing who stated when the therapy staff, Nurse #2 and Nurse #3 brought the concern to her attention, she and the Administrator began reviewing the video footage of events on 7/11/24 and initiated an investigation. She reported during the investigation Nurse Aide #2 was observed conversing with Resident #1 in her doorway and made a request to be taken to the nursing station and the Nurse Aide #2 telling the resident no and eventually taking resident back into her room. In	F 603		

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the review of the video, auditory conversations of the resident yelling and screaming "no, no, help me, help me" the team was concerned with the tone of the auditory sounds. Nurse Aide #2 was observed leaving the room and closing the door, however, there was no visuals of the bathroom door being closed or the position of the resident in the room once Nurse Aide #2 left. The Director of Nursing reported based on the report provided by the therapy staff of Resident #1 position in the shower and the resident's inability to remove herself from the location, the team felt as though Nurse Aide #2 secluded the resident in the room when a request to be taken to another location was made. She reported during the investigation all staff who had contact with the resident during the day of 7/11/24 were interviewed and in-service education on the abuse policy with inclusion of involuntary seclusion was provided to all staff and new hires. Each of the employees were provided with a hard copy of the policy to ensure everyone was aware of the facility expectation of the prevention of seclusion for residents. The Social Worker and Nurse #3 began resident interviews on abuse and resident safety. The Director of Nursing reported the incident to the Department of Health and Human Services (DHHS), law enforcement agent, Health Care Personnel Registry and the Adult Protective Services. In addition, the Medical Director, Resident #1's family all was notified.

An interview was conducted on 8/7/24 at 2:30 PM with the Administrator stated she reviewed the video footage and determined that Nurse Aide #2 would be terminated for involuntary seclusion of Resident #1 She further stated during the investigation process and an ongoing staff education would include the abuse policy with

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emphasis on involuntary seclusion, recognizing abuse and managing difficult behaviors to be done by the staff development coordinator and/or designee. The Director of Nursing or designee would interview 4 employees weekly for 4 weeks and then 4 employees monthly for 2 months to verify understanding of current policy for reporting allegation of abuse and involuntary seclusion.

The facility implemented the following corrective action plan:

Immediate action(s) taken for the resident(s) found to have been affected include:
On 7/11/2024 the Occupational staff reported to the Social Worker that she heard Resident #1 yelling from her bathroom. She states that she went into Resident #1's room and noted that her bathroom door and door to her room were both closed. Upon entering bathroom, therapy staff observed Resident #1's wheelchair wheel over the lip of the shower and that she was unable to move her wheelchair. Staff member reported the incident to the Nurse# #2 and Nurse #3. Nurse #3 immediately reported the incident to the Social Worker and Administrator.

Video was reviewed and Nurse Aide #2 was observed taking Resident #1 in her room and closing the door. Nurse Aide #2 was suspended pending the abuse investigation on Thursday 7/11/24.

Review of the timeline of events revealed on 7/11/24 at 1:51 PM Resident #1 came to her doorway in her wheelchair.

On 7/11/24 at 1:52 PM, Nurse Aide #2 walks down the hallway. Resident #1 could be heard

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asking Nurse Aide #2 to go "out there." Nurse Aide #2 stated "No, you have everything you need." Nurse aide #2 then pushes Resident #1 into her room. You can hear the bathroom motion sensor go off at the nurses' station, Resident #1 could be heard yelling out loudly.

On 7/11//24 at 1:53 PM, Nurse Aide was observed closing the door to Resident #1's room as he exited the room.

On 7/11/24 at 2:05 PM, the Occupational Therapist, enters Resident #1's room after hearing her yelling while in the room next door.

On 7/11/2024: A skin assessment was completed by nurse #3 and Nurse #8. No bruising or harm was noted. The Social Worker interviewed the resident and was unable to state if an event had occurred due to progressed dementia. Resident #1 was not in any emotional distress at the time of the interview.

On 7/11/2024, Nurse Aide #2 was interviewed by the Administrator and Social Worker. He denied any wrongdoing and said he put the resident in the bedroom and not the bathroom. He also stated that Resident #1 did not yell out while he was in the room. Nurse Aide #2 stated he did not shut the door.

On 7/12/2024, a skin assessment was completed by nurse #3, with no new findings of bruising or harm.

On 7/12/2024, Staff and resident interviews were completed. One interview offered additional information.

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On 7/12/2024 the video footage was reviewed and found Nurse Aide #2 entered the room in that case as well.

On 7/12/2024: Nurse Aide #2 was terminated due to suspected Involuntary Seclusion.

No adverse effects or harm to resident have been identified.

Identification of other residents having the potential to be affected was accomplished by:

Social Worker and Director of Nursing interviewed residents on 7/12/24 who were alert and oriented on the Outer bank's neighborhood, as this was the neighborhood of the incident as well as Nurse Aide #'2 assigned neighborhood. All residents interviewed denied having issues or concerns regarding abuse or involuntary seclusion. Staff interviewed had no other concerns.
However, all residents have the potential to be affected.

Actions taken/systems put into place to reduce the risk of future occurrence include:

On 7/12/2024 Education and a copy of our Abuse policy and procedures including Involuntary Seclusion was provided to all TLC Coble Creek nursing and caregivers. Education on recognizing abuse and education on managing difficult behaviors was completed with staff on the Outer Banks.

On 7/19/24 all staff was assigned to complete training/quiz on preventing, Recognizing and Reporting Abuse and involuntary seclusion. The

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training/quiz was to be completed by the date of 7/31/2024. This was assigned on the online training forum by Human Resources and was monitored by the Director of Nursing for compliance.

On 7/11/24 it was determined to review the identified deficient practice of involuntary seclusion in the facility's next QA (Quality Assurance) meeting.

All new hires will continue to receive resident rights training and a review of Abuse policies including the definition and examples of each type of abuse. Involuntary seclusion will be included in the training.

How the corrective action(s) will be monitored to ensure the practice will not recur:

On 7/12/24 it was determined the Director of Nursing, or designee, will interview four (4) employees weekly for four (4) consecutive weeks then (4) employees monthly for 2 months to verify understanding of current policy for identifying, reporting allegations of abuse and involuntary seclusion, such as putting a confused resident room in their room against their will and closing the door, and that involuntary seclusion was not an acceptable action for resident care because it was a form of abuse. Re-education will be provided at the time of the interview, if needed.

Results of interviews will she shared with the QAPI (Quality Assurance and Performance Improvement) committee for further review and recommendations.

This Corrective Action will be completed

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F 603	Continued From page 24 8/1/2024. The validation of the facility's corrective action plan was completed on 8/7/24 and it was discovered education and a copy of the facility's abuse policy and procedures including Involuntary Seclusion was provided to all resident neighborhood nursing staff and caregivers on 7/12/24. Education on recognizing abuse and managing difficult behaviors was completed with staff on the unit where Resident #1 resided. The Director of Nursing and Staff Development Coordinator were found to have ensured all staff were assigned and completed the training/quiz preventing, recognizing and reporting abuse/involuntary seclusion with a completion date of 7/31/2024. Interviews were conducted with staff regarding the in-service on the abuse policy and involuntary seclusion, and all interviewed staff were able to explain the training they had received. The facility staff roster was validated against the attendance record of skills and training log, and it was found all facility staff received the training about abuse/involuntary seclusion. The facility was found to be in compliance as of their alleged date of compliance of 8/1/24.	F 603		