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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 04/23/25 through 04/24/25. Additional information was obtained offsite on 04/25/25. Therefore, the exit date was changed to 04/25/25. Event ID# 5SQM11. The following intakes were investigated: NC00229219, NC00229250 and NC00229578. 3 of the 10 complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of video footage, resident and staff interviews, the facility failed to protect a resident's right to be free from physical abuse when a moderately cognitively impaired resident (Resident #3) used a closed fist and punched a severely cognitively impaired resident (Resident #4) in the face. Resident #4 fell	F 600	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	5/15/25

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

Electronically Signed | 05/15/2025

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F 600	Continued From page 1 backwards, hit her head on the floor and was sent to the emergency room for further evaluation. A computed tomography (CT) scan of the head identified a small intraventricular hemorrhage (a small amount of bleeding inside the ventricles that produce fluid to protect and cushion the brain in the skull) and a scalp hematoma (a collection of blood between the skull the scalp). Neurosurgery was consulted and considered the intraventricular hemorrhage stable, and no further treatment was required, and Resident #4 returned to the facility. Additionally, the facility failed to protect a residents' right to be free from physical abuse when Resident #3 shoved a severely cognitive impaired resident (Resident #12) causing her to fall to the floor. Resident #12 was not injured as a result of the fall. A reasonable person would experience feelings of fear, pain, and anxiety as a result of being physically abused in their home. The deficient practice occurred for 2 of 4 residents (Resident #4 and Resident #12) reviewed for abuse. Findings included: a) Resident #3 was admitted to the facility on 3/23/24 with diagnoses including dementia, traumatic brain injury (a disruption of normal brain activity), manic depression/bipolar disorder (a mental health condition causing extreme mood changes), unspecified impulse disorder, and seizures related to diffuse traumatic brain injury. The annual Minimum Data Set (MDS) assessment dated 3/16/25 revealed Resident #3's speech was clear, hearing and vision were adequate, he had the ability to be understood and understand others, and his cognition was	F 600	regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. • Corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/16/25-3/28/25 Resident #12 was placed on 1:1 supervision due to provoking behaviors toward Resident #3. Resident # 12 was diagnosed and treated for a UTI during that time frame. Resident #3 was moved to the ground floor on 3/18/25. Resident #4 was readmitted to the facility on 4/22/25 with a diagnosis of small intraventricular hemorrhage. On 5/1/25 another CT scan was performed, and the hemorrhage has resolved. Residents #4 and #12 reside on a different floor than Resident #3. On 5/13/25, Resident #3 was placed on 24 hour 1:1 supervision. Social Services Director sent a referral on 5/13/2025 to seek an alternate placement for Resident #3 where resident's behaviors and anxiety cannot be triggered or can be avoided by absence of wandering and pacing residents. • Identification of residents having the	

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F 600	Continued From page 2 moderately impaired. No physical or other behaviors had occurred during the MDS lookback period. Resident #3 was independent with transfers and walking. Manic depression/(bipolar disease) was an active diagnosis and Resident #3 was currently taking antipsychotic and antidepressant medication. A review of Resident #3's current medication orders included valproic acid 250 milligrams (mg) give one capsule three times a day for bipolar disorder, olanzapine (antipsychotic) 5 mg give one tablet twice a day related to bipolar disorder and unspecified impulse disorder, phenytoin sodium (anticonvulsant) 100 mg extended release give 3 capsules at bedtime for seizures related to diffuse traumatic brain injury. A review of a monitoring tool document dated 3/16/25 revealed Resident #3 was being monitored every 15 minutes after he shoved Resident #12 causing her to fall. The tool was initialed by staff to indicate monitoring of Resident #3 had continued from 3/16/25 and was currently ongoing. The care plan last revised on 3/21/25 revealed Resident #3 had the potential to be verbally aggressive related to a diagnoses of traumatic brain injury, depression, neurocognitive disorder with impulse control disorder. The care plan revealed Resident #3's behaviors were triggered related to his personal belongings and personal space. Interventions included frequent observation, administer medications as ordered and monitor/document for side effects and effectiveness, analyze key times, places, circumstances, triggers, and what de-escalates behavior and document.	F 600	potential to be affected by the same deficient practice: On 5/13/25, the Director of Clinical Services audited all current residents' diagnosis to identify other residents with a diagnosis of “poor impulse control” or “impulse disorders” for potential harm toward others. No other residents were identified. • Measures / systemic changes made to ensure that the deficient practice will not recur: On 5/14/25, the Director of Nursing and Unit Managers were educated by the Administrator on reviewing newly admitted residents' diagnosis for “poor impulse control” or “impulse disorder”, implementing intervention immediately and educating the staff on residents identified trigger. This education will be included in the new hire process for the Director of Nursing and Unit Manager positions. On 5/13/25, education was initiated with the licensed clinical staff and certified nursing assistants on the duties and responsibilities of providing 1:1 supervision and the identified trigger for Resident #3. No clinical staff, including contract personnel, will be allowed to work after 5/15/25 until they receive this training by the Director of Nursing or designee. This information will be included in the standard new hire orientation training and required refresher course for the clinical staff.	

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F 600	Continued From page 3 Resident #4 was admitted to the facility on 3/19/25 with diagnoses including dementia, metabolic encephalopathy (impaired brain dysfunction causing increased confusion) pneumonia, and respiratory failure. A review of Resident #4's current physician orders revealed no order in place for administration of anticoagulant (increase the time it takes blood to clot) or antiplatelet (reduces the ability of the blood to form a clot) medications. The admission MDS assessment dated 3/24/25 revealed Resident #4's hearing was highly impaired, speech was unclear, her cognition was severely impaired and sometimes she understood. During the MDS lookback period Resident #4 had demonstrated physical behaviors directed towards others and other behaviors not directed towards others for 1 to 3 days and had rejected care 1 to 3 days. Resident #4 was independent with walking and received no anticoagulant or antiplatelet medications. Resident #4's care plan last revised on 4/14/25 identified she was at risk of falls due to poor safety awareness. Interventions included physical therapy to evaluate and treat as ordered and as needed. The care plan identified Resident #4's behaviors of yelling out, resisting care, refusing medications, impaired cognitive function and communication problems related to dementia and metabolic encephalopathy. Interventions included anticipate and meet the resident's needs, cue, reorient and supervise as needed. Be conscious when Resident #4 was in groups, activities, or the dining room to promote proper communication with others.	F 600	• Facility plans to monitor performance to make sure solutions are sustained: All new admission diagnosis will be reviewed daily (Monday-Friday) to identify residents with a diagnosis of “poor impulse control” or “impulse disorder,” to ensure intervention are immediately implemented and education of the staff regarding the residents identified trigger. This monitoring process will take place daily Monday to Friday for 2 weeks, weekly for 2 weeks, then monthly for 2 months. The Administrator, DON, or designee will report the findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. Date of compliance 5/15/25	

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A review of the video camera footage on 4/24/25 at 12:46 PM revealed on 4/6/25 at 6:30 PM Resident #3 was sitting in a wheelchair in the hallway approximately six feet away from the nurse station on the upper unit. Several nurse and Nurse Aide (NA) staff were around the area and Resident #3 was calm and did not attempt to hit or grab others when they passed. At 6:54 PM Resident #4 came from a room and pointed her finger at Resident #3 and continued to walk pass the nurse station towards Resident #3. As Resident #4 got closer Resident #3 used both arms to create a circular space in front of his chest. Resident #4 continued towards Resident #3 until she stood approximately two feet away facing the left side of Resident #3's wheelchair. Resident #3 extended his left arm and pointed his finger at Resident #4's face. NA #1 stood in front of the nurse station approximately five or six feet away from Resident #3 and #4 and looked up and started to walk towards them. Resident #4 leaned forward to get closer to Resident #3 and without hesitation Resident #3 extended his left arm, used his fist, and hit Resident #4 in the mouth. Resident #4's body fell backwards causing her head to hit the floor.

A progress note dated on 4/6/25 at 7:41 PM written by Nurse #1 read in part, "Resident #4 was standing next to Resident #3 and as staff tried to redirect Resident #3 punched Resident #4 in the mouth. Resident #4 fell backwards and hit her head on the floor." The note revealed Resident #4 had swelling and bleeding to mid lip, a bump (hematoma) on the back of the head, and a quarter size skin tear on the left elbow.

A review of the emergency room report revealed

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on 4/7/25 a diagnostic CT scan of Resident #4's head identified a small volume, right lateral intraventricular hemorrhage, and scalp hematoma. After neurosurgery consult it was noted the brain bleed was stable and Resident #4 was safe to return to the facility. Discharge instructions recommended Resident #4 to return to the neurosurgery clinic and have a repeat CT scan in 3 to 4 weeks.

A review the current physician orders revealed Resident #4's repeat CT scan was scheduled on 5/1/25 at 10:00 AM.

A review of the emergency room discharge report revealed Resident #3 was evaluated on 4/6/25 for aggressive behaviors noted as punching another resident. The note revealed Resident #3 denied any physical altercation occurred. A urinalysis identified a moderate amount of leukocyte esterase (white blood cells associated with a urinary tract infection). A physician's order was included for cefuroxime (antibiotic) 500 mg give one tablet twice a day for 7 days (14 doses) to treat or prevent infection and recommended Resident #3 follow up with his primary physician. Resident #3 was discharged back to the facility on 4/7/25.

A review of Resident #3's electronic Medication Administration Record (MAR) revealed the physician's order for cefuroxime 500 mg give one tablet twice a day for 7 days was scheduled to be administered at 9:00 AM and 9:00 PM. Nurses initialed the first dose was administered on 4/8/25 at 9:00 PM and continued to be administered as ordered with the last dose given on 4/15/25 at 9:00 AM (14 doses).

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A phone interview was conducted on 4/25/25 at 1:46 PM with NA #1. NA #1 confirmed she had worked on the upper unit from 7:00 AM through 7:00 PM on 4/6/25. NA #1 revealed she was at the nurse station giving report when she heard someone call out, "grab her." NA #1 revealed when she turned around she saw Resident #3 use his fist to punch Resident #4 in the face causing Resident #4 to fall backwards onto the floor.

During a phone interview on 4/24/25 at 9:27 AM Nurse #1 revealed the altercation between Resident #3 and Resident #4 occurred on the upstairs unit during shift changed around 7:00 PM on 4/6/25 when she was giving report and counting medications with the oncoming nurse. Nurse #1 described Resident #4 had walked around most of the day and was known to exhibit wandering behaviors including getting into others personal space but, "meant no harm." Nurse #1 revealed Resident #3 was sitting in his wheelchair in the hallway near the nurse station and Resident #4 had walked towards him. Nurse #1 stated she heard someone yell out, "get her" and before anyone did Resident #3 reached up and punched Resident #4 in the mouth causing Resident #4 to "fall straight back hitting her head hard on the floor." Nurse #1 revealed after the altercation she checked Resident #4 for injury and her mouth was bleeding and swollen, there was a "pump knot" on the back of her head, and a skin tear on the left elbow. Nurse #1 revealed Resident #4 was sent to the emergency room after the fall and Resident #3 was sent within approximately an hour afterwards for evaluation of aggressive behaviors. Nurse #1 revealed Resident #3 had a history of aggressive behaviors, but she had not witnessed him hit

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another resident before the altercation on 4/6/25. Nurse #1 revealed Resident #4's room was relocated to the downstairs unit and Resident #3's room remained upstairs. Nurse #1 revealed she was educated to monitor Resident #3's whereabouts and redirect other residents and keep them away. Nurse #1 described Resident #3's behaviors as impulsive and not being able to understand how to interact with other residents with dementia.

During a phone interview on 4/25/25 at 11:50 AM Nurse #2 revealed the altercation between Resident #3 and Resident #4 occurred on the upstairs unit on 4/6/25 at shift change when she was getting report and counting medications with the previous shift nurse. Nurse #2 stated she heard someone tell a NA, "pull Resident #4 away from Resident #3" and when she looked up saw Resident #3 punch Resident #4 in the face causing her to fall backwards onto the floor. Nurse #2 described Resident #3 usually stayed to himself, did not like anyone touching him, and mostly stayed in either his room or the main dining room. Nurse #2 revealed she had not witnessed Resident #3 do anything like that before. Nurse #2 stated she had previously received education to separate residents in attempt to prevent resident-to-resident abuse and she tried to keep other residents away from Resident #3 to ensure they were not standing over him or got close and she did not leave other residents alone with Resident #3. Nurse #2 described Resident #4 like to "roam" and after the altercation a sitter was placed with her to observe for behaviors or a change of condition.

A review of the facility's initial 24 hour report revealed it was completed by the previous

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Director of Nursing (DON) and dated 4/6/25 at 7:00 PM to indicate the time the facility became aware. The details revealed a resident was wandering and got in the face of another resident and was pushed hard causing a fall. The report indicated both residents were sent to the hospital.

A review of the 5-day investigation completed by the previous DON indicated Resident #4's diagnosis of dementia and Resident #3's diagnosis of traumatic brain injury and newly identified acute urinary tract infection were contributing factors that lead to their altercation and unsubstantiated the allegation.

During a phone interview on 4/23/25 at 4:46 PM the previous Director of Nursing (DON) confirmed she completed the initial 24 hour report and investigation that involved Resident #3 and Resident #4. She described Resident #3 had a history of traumatic brain injury and did not like others in his space and Resident #4 had wandering behaviors and on 4/6/25 got in Resident #3's face. She had watched the video camera and saw Resident #3 use hand gestures to redirect Resident #4 to move away and when Resident #4 did not she was pushed hard and fell on her back and hit head on the ground. The DON revealed both Resident #3 and #4 were sent to the hospital after the altercation and the hospital was asked to complete a psychiatric evaluation of Resident #3 for aggressive behaviors. She revealed Resident #3 returned with antibiotic treatment for a urinary tract infection. She revealed Resident #4 had small brain bleed the hospital said would resolve without treatment and to follow up with neurosurgery. The DON revealed Resident #4 had no changes in her level of consciousness or

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mobility after the altercation and room changes were made to prevent future interactions with Resident #3. She revealed facility staff were already educated on what triggered Resident #3's behaviors and to watch his hand gestures, and when another resident was around to move them away.

During an interview on 4/24/25 at 3:32 PM the current DON revealed she started her position on 4/12/25 and on 4/6/25 she was the Assistant DON. She revealed Resident #3's location was being monitored prior to 4/6/25 and it was expected he was within eyesight of staff when up and out of his room. She described Resident #4 ambulated without assistance, had dementia, and might not understand hand gestures made by Resident #3 and after the altercation Resident #4 was relocated to a room on the downstairs unit.

During an interview on 4/24/25 at 2:32 PM and 3:57 PM the Administrator revealed Resident #3's location on the unit was being monitored every hour prior to the altercation on 4/6/25. The Administrator revealed she did not think Resident #3's reaction was willful or that he intended to hurt Resident #4 because of his diagnosis of traumatic brain injury. The Administrator revealed Resident #3's hourly monitoring of location on the unit was ongoing and he was already on psychiatric caseload and the next scheduled visit was a tele-health visit on 4/28/25.

Observations and interviews of Resident #3 were conducted on 4/23/25 at 5:00 PM and 4/24/25 at 7:45 AM. Resident #3's room was located on the upper unit. He was observed in the main dining room/common area sitting in his wheelchair alone at a table or with the wheelchair placed directly in

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front of the television. He was calm with no signs of increased agitation. When asked if he recalled hitting someone in the face with his fist Resident #3 denied he had hit anyone.

Attempts to interview Resident #4 were unsuccessful.

Observations of Resident #4 were conducted on 4/23/25 at 5:21PM and 4/24/25 at 8:08 AM. Resident #4's room was located on the lower unit. She was observed to ambulate without assistance. Nurse and NA Staff were observed to provide reassurance and cues for redirection. Resident #4 was not observed to wander.

b) Resident #3 was admitted to the facility on 3/23/24 with diagnoses including dementia, traumatic brain injury (a disruption of normal brain activity), manic depression/bipolar disorder (a mental health condition causing extreme mood changes), unspecified impulse disorder, and seizures related to diffuse traumatic brain injury.

The annual Minimum Data Set (MDS) assessment dated 3/16/25 revealed Resident #3's speech was clear, hearing and vision were adequate, he had the ability to be understood and understand others, and his cognition was moderately impaired. No physical or other behaviors had occurred during the MDS lookback period. Resident #3 was independent with transfers and walking. Manic depression/(bipolar disease) was an active diagnosis and Resident #3 was currently taking antipsychotic and antidepressant medication.

The care plan last revised on 3/21/25 identified Resident #3 had the potential to be verbally

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aggressive related to a diagnoses of traumatic brain injury, depression, and neurocognitive disorder with impulse control disorder. The care plan revealed Resident #3's behaviors were triggered related to his personal belongings and personal space. Interventions included frequent observation, administer medications as ordered and monitor/document for side effects and effectiveness, analyze key times, places, circumstances, triggers, and what de-escalates behavior and document.

A review of Resident #3's current medication orders included valproic acid 250 mg give one capsule three times a day for bipolar disorder, olanzapine 5 mg give one tablet twice a day related to bipolar disorder and unspecified impulse disorder, phenytoin sodium 100 mg extended release give 3 capsules at bedtime for seizures related to traumatic brain injury.

Resident #12 was admitted to the facility on 1/9/25 with diagnoses including dementia and cognitive communication deficit.

The quarterly MDS assessment dated 2/15/25 revealed Resident #12's cognition was severely impaired and had demonstrated wandering behaviors that occurred 1 to 3 days during the lookback period. The MDS revealed Resident #12 was able to walk independently without assistance and did not take anticoagulant or antiplatelet medications.

Resident #12's care plan last revised on 3/16/25 identified she was an elopement risk/wanderer related to poor safety awareness. Interventions included distract from wandering by offering activities, food, identify wandering patterns and

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intervene as appropriate and provide structured activities. The care plan identified Resident #12's cognitive/thought process was impaired related to dementia and included interventions to anticipate needs and allow adequate time to respond.

A review of the nurse progress note dated 3/16/25 at 9:15 AM revealed Resident #12 was demonstrating behaviors that included going in resident rooms and taking tables, wheelchairs, and walkers and putting them in the hallway, pacing back and forth and was unable to redirect.

A review of the incident report for Resident #12 revealed on 3/16/25 in the common area located on the upper unit Resident #12 started moving Resident #3's belongings and got in his personal space and was pushed that resulted in Resident #12 falling to the ground. No injuries were observed and 1:1 monitoring was initiated to ensure Resident #12's safety and implement redirection. The previous DON completed the report.

A review of Resident #12's weekly skin assessment dated 3/16/25 noted normal skin color that was intact with no redness or bruising.

A review of the facility's initial 24 hour report revealed the facility was made aware of an allegation of resident abuse on 3/16/25 at 12:50 PM. The details of incident revealed Resident #12 touched Resident #3's face and when Resident #3 asked Resident #12 to stop Resident #12 did not and was pushed causing her to fall. The previous DON completed the report.

A review of a monitoring tool dated 3/16/25 at 2:00 PM revealed staff initialed Resident #3 was

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being monitored every 15 minutes after shoving Resident #12 causing her to fall. The monitoring times increased to every 30 to 45 minutes to every hour and was currently ongoing.

A review of the facility's 5-day investigation revealed the altercation did not result in physical injury, harm or mental anguish and the allegation was unsubstantiated. The facility indicated the root cause of the abuse was Resident #12's insomnia and being newly diagnosed with a urinary tract infection contributed to increased wandering and an invasion of others personal space. The report was completed by the previous DON and included witness statements from NA #2 and a Speech Therapist.

A review of Resident #12's MAR revealed cephalexin (antibiotic) 500 mg give one tablet every 12 hours was scheduled to be administered at 9:00 AM and 9:00 PM. Nurses initialed the first dose was given on 3/18/25 at 9:00 PM and continued every 12 hours until the last dose given on 3/25/25 at 9:00 AM to equal 14 doses. Melatonin 5 mg give one tablet at bedtime for insomnia was started on 3/24/25.

During a phone interview on 4/25/25 at 12:57 PM, NA #2 confirmed she wrote the witness statement involving a physical altercation between Resident #3 and Resident #12 that happened on 3/16/25. NA #2 stated she saw was Resident #12 falling to the floor but did not see Resident #3 shove or push Resident #12. NA #2 revealed she was talking with the Speech Therapist who was standing in front of her and had a better view of what happened. NA #2 revealed she moved Resident #3 away from the area and obtained Resident #12's vital signs. NA #2 revealed she

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had not observed Resident #3 hit or push another resident prior to the incident on 3/16/25 and stated, "he usually did not bother others." NA #2 described Resident #12 walked independently and wandered and stated, "we try to redirect wanderers from getting into other residents' personal space and rooms." She described Resident #12 as unable to cognitively understand to stay away from Resident #3 including if he gestured for her to go away.

During a phone interview on 4/25/25 at 2:40 PM, the Speech Therapist confirmed she wrote the witness statement involving a physical altercation between Resident #3 and Resident #12. The Speech Therapist stated she would refer to what was written on her statement was correct and Resident #3 shoved Resident #12 causing her to fall. The Speech Therapist revealed after the incident nursing took over. The Speech Therapist stated she had not observed Resident #3 be aggressive towards another resident and did not recall observing a prior physical altercation between residents.

During a phone interview on 4/24/25 at 5:06 PM the previous DON stated after the altercation on 3/16/25 Resident #3's location was being monitored and was ongoing every hour to protect other residents. The DON stated Resident #3 did not typically bother others unless they got in his personal space or face. The DON revealed Resident #12 was not injured and she educated staff about what triggered Resident #3's behaviors and to redirect residents when they got close and in his personal space.

A Nurse Practitioner (NP) progress note dated 3/18/25 revealed the NP saw Resident #3 for an

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angry outburst. The NP noted Resident #3's diagnoses of bipolar, impulse disorder, and traumatic brain disorder and was taking phenytoin. The NP considered the use of phenytoin was for bipolar disorder and made no changes to Resident #3's medications.

A NP progress note dated 3/24/25 revealed Resident #3 medications were reviewed. Resident #3 continued to receive divalproex sodium 250 mg three times a day for seizures and behaviors related to bipolar and was followed by psychiatry. The NP noted a neurology consult was scheduled in June and during the exam Resident #3 was calm and cooperative with no behaviors and made no changes to his medications.

During an interview on 4/24/25 at 3:32 PM the current DON revealed she started her position on 4/12/25 and previously was the Assistant DON. She revealed Resident #3 typically stayed to himself or near staff. She revealed Resident #3's location was being monitored, and it was expected he was within eyesight of staff when up and out of his room. She revealed Resident #3's room was relocated after the altercation with Resident #12 to prevent further interactions between the two.

During an interview on 4/24/25 at 2:32 PM and 3:57 PM the Administrator revealed staff continued to monitor Resident #3's location on the unit every hour. The Administrator revealed she did not think Resident #3's actions were willful because of his diagnosis of traumatic brain injury and his room was relocated downstairs to separate him from Resident #12. The Administrator revealed Resident #3 was already

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F 600	Continued From page 16 on psychiatric caseload and the next scheduled visit was a tele-health visit on 4/28/25. Attempts to interview Resident #12 were unsuccessful. An observations of Resident #12 on 4/24/25 at 8:16 AM revealed her room was located on the lower unit. Resident #12 was asleep in bed and not observed to wander on the unit.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		5/16/25

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F 607	Continued From page 17 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with the Responsible Party (RP), and staff, the facility failed to implement their abuse policy and procedures for reporting and protecting residents after a resident (Resident #2) reported a male Nurse Aide (NA) attacked and cursed at her. After the allegation of abuse was reported the male NA assigned to the unit remained at the facility for the rest of his shift with access to other residents. Additionally, the facility failed to report Resident #2 alleged sexual abuse to Adult Protective Services. The deficient practice occurred for 1 of 4 residents reviewed for abuse (Resident #2). Findings included: A review of the facility's Abuse, Neglect and Exploitation Policy dated 9/1/24 revealed it was the facility's policy to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. For "Reporting/Response" the facility's policy was to report all alleged violations to the Administrator and Adult Protective Services. For "Protection of Resident" the facility's policy indicated they would respond immediately to protect the alleged victim and integrity of the investigation and remove the alleged perpetrator or suspension of employee. Resident #2 was admitted to the facility on 2/21/25 with diagnoses including viral pneumonia, COVID, sepsis due to streptococcus pneumonia,	F 607	FTAG 607 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. " Corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing completed a directed in-service training on 5/14/25 to NA #3 and Medication Aide # 1 related to facility policy and procedure related to reporting of abuse including timeliness of reporting of allegation of resident abuse. A report was made to Adult Protective Services on 3/13/2025 by the Social Services Director. " Identification of residents having the	

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F 607	Continued From page 18 anxiety disorder, and depression. Resident #2 was discharged from the facility on 3/15/25. The admission Minimum Data Set assessment dated 2/26/25 revealed Resident #2's cognition was intact and no physical, verbal, rejection of care or other behaviors had occurred during the lookback period. a) A review of the document entitled, "Acknowledgement of Receipt of Training of the Facility's Freedom from Resident Abuse, Neglect, and Exploitation Policy and Procedure" revealed NA #3 signed the document on 1/2/24. By signing the document NA #3 acknowledged she had received training of the facility's abuse policy and procedures that read in part, "I understand that I should report any concerns of resident abuse to either the Compliance and Ethics Officer or any other Department Head and agree to abide by the requirements." A review of NA #3's statement dated 3/3/25 revealed around 2:30 AM she was asked to take over Resident #2's care because the resident preferred a woman. The statement revealed when assisted to the bathroom Resident #2 told NA #3 a black man attacked her and cursed at her. During a phone interview on 4/24/25 at 10:28 AM, NA #3 stated around 2:30 AM or 3:00 AM on 3/3/25 while assisting Resident #2 to the bathroom Resident #2 told her what she wrote on her statement, "the NA was a black man, and he attacked her and cursed at her." NA #3 stated she immediately reported what Resident #2 told her to Medication Aide #1. NA #3 stated she did not report the allegation of abuse to the nurse,	F 607	potential to be affected by the same deficient practice: On 5/14/25 the Social Worker Director and Unit Managers completed interviews for abuse monitoring with interviewable residents with a BIMS of 13 and above. No concerns were identified On 5/14/25 the Unit Managers completed head to toe body audits of current residents with a BIMS of 12 and below for observable signs of abuse for residents that were non-interviewable. No concerns were identified. " Measures / systemic changes made to ensure that the deficient practice will not recur: On 5/12/25 the Administrator educated all the Department Leaders (Dietary Manager, Housekeeping Director, Rehab Director) on the abuse policy and procedures. On 5/12/25, education was initiated with all staff including contract agency staff on 5/12/25 by the Director of Nursing and the respective Department Leaders for all staff on abuse policy including procedure for timely reporting of allegations of resident abuse, neglect, and resident rights. This was completed on 5/15/25. No employees, including contract personnel, will be allowed to work after 5/15/25 until they receive this training by the Director of Nursing or designee. This information is included in the standard new hire orientation training and required refresher course for all staff.	

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F 607	Continued From page 19 Director of Nursing (DON) or Administrator and received abuse education that included to report by following the chain of command and report to the supervisor and that was what she did. She stated Medication Aide #1 was her supervisor on 3/3/25 between 2:30 AM and 3:00 AM and she reported Resident #2's allegation of abuse to her. A review of Medication Aide #1's written statement dated 3/4/25 revealed she was informed Resident #2 wanted to speak with her and both her and NA #4 went to the room. NA #4 asked Resident #2 if she needed help to bathroom and she stated "no." NA #4 left the room. Medication Aide #1 stayed with Resident #2 and asked if she was okay or needed anything. Resident #2 asked who NA #4 was and gave his name. Resident #2 stated NA #4 startled her, and she had nothing against him. Resident #2 was asked if she preferred not have NA #4 and she kept saying "she was nervous." Medication Aide #1 stayed with Resident #2 until she calmed down and asked NA #4 to switch residents. A phone interview was conducted on 4/24/25 at 9:58 AM with Medication Aide #1. Medication Aide #1 confirmed she worked on 3/2/25 from 7:00 PM to 7:00 AM and the person NA #4 reported Resident #2 did not want him doing anything. Medication Aide #1 revealed Resident #2 told her she was afraid of NA #4 and when asked why Resident #2 stated "NA #4 was black, and she did not want him back in the room." She revealed NA #3, and #4 switched residents and NA #4 did not go back into the room. Medication Aide #1 stated Resident #2 did not share any type of abuse with her nor did NA #3. Medication Aide #1 stated NA #3 did not report to her Resident #2 stated she	F 607	" Facility plans to monitor performance to make sure solutions are sustained: The Director of Nursing or designee will complete 5 random resident interviews for abuse monitoring and timely reporting twice a week x 4 weeks, then monthly X 2 months until compliance is achieved. The Quality Assurance and Performance Committee will review interview findings to make recommendations to ensure compliance is sustained ongoing and determine the need for further monitoring. Date of compliance 5/16/25	

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was attacked and cursed at by male NA.

A review of NA #4's written statement dated 3/3/25 revealed he went into Resident #2's room to check on her. He offered to help when Resident #2 stated she wanted to talk to the Administrator. The statement indicated he got the nurse, and the nurse then told him Resident #2 does not want a male NA. He switched residents with NA #3. He was told by NA #3 Resident #2 stated he cursed at her. The statement indicate NA #4 did not curse at Resident #2, just asked if he could help with anything and then got the nurse.

During a phone interview on 4/23/25 at 12:42 PM, NA #4 revealed it was sometime around 12:00 AM on 3/3/25 during his rounds when he entered the room to check on Resident #2 and she asked to speak to the Administrator. He told Resident #2 he could get the nurse. NA #4 revealed he did not get nurse but did get Medication Aide #1, and she went into the room. He further revealed Medication Aide #1 told him Resident #2 requested no male NA could take care of her and he switched residents with a female NA (NA #3). He revealed NA #3 told him Resident #2 stated he cursed at her but did not say he had attacked her. NA #4 denied he attacked or cursed at Resident #2 and stated after they switched residents he did not go back into her room, did his shift and was taken off the scheduled after he finished on 3/3/25. NA #4 revealed he was taken off the schedule because of the abuse allegation made by Resident #2 and he was educated to ask female residents if they were okay with a male NA providing care.

A review of the timecard detail report revealed on

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3/2/25 NA #4 clocked in at 7:09 PM and out on 3/3/25 at 7:08 AM. NA #4 did not clock in again until 3/6/25 at 6:56 PM.

A phone interview was conducted on 4/23/25 at 3:08 PM with Resident #2 and her RP. Resident #2 was difficult to understand, and her RP spoke for her. The RP revealed the morning of 3/3/25 she went to the facility for a visit, and Resident #2 told her "this fellow came in her room when she was asleep, and she woke up to him feeling her and she was wet down there and asked what he was doing." The RP stated Resident #2 could easily see the clock in her room and knew exactly what time the person was in her room and had stated it was 12:00 AM midnight on 3/3/25. The RP revealed Resident #2 described a tall thin white male was the perpetrator. The RP stated she reported the allegation to the Administrator on 3/3/25 the morning of her visit.

A statement signed by the current Director of Nursing (DON) revealed she spoke with the nurse assigned on the unit Resident #2's room was located on 3/2/25 from 7:00 PM through 7:00 AM. The nurse was asked if she was aware of or witnessed any reportable situation that had occurred. The nurse responded she was not.

An interview was conducted on 4/24/25 at 2:51 PM with the current DON. The DON revealed she recently started her position as the DON on 4/12/25. She was the previous Assistant DON and helped with the abuse investigation of Resident #2. She spoke with NA #3 on phone and did not recall her saying Resident #2 reported a black male attacked her. She did recall NA #3 said Resident #2 told her she was cursed at and asked NA #3 to write a statement. The DON

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revealed she had spoken with the assigned night shift nurse working on the unit on 3/2/25 from 7:00 PM to 7:00 AM and asked if she had any knowledge of an allegation of abuse and was told nothing was reported. The DON revealed she expected either the NA #3 or Medication Aide #1 to report what Resident #2 told NA #3 to the nurse. The DON revealed based on NA #3's written statement she expected that was reported to nurse so the nurse could assess Resident #2 for injury and notify the Administrator. The DON revealed she became aware of the abuse allegation on 3/3/25 during their morning meeting with the Administrator.

During a phone interview on 4/24/25 at 5:06 PM the previous Director of Nursing (DON) revealed she assisted with the abuse investigation of Resident #2. The DON revealed she was made aware Resident #2 alleged sexual abuse during their morning meeting with the Administrator after the RP reported it on 3/3/25 at approximately 9:00 AM or 9:30 AM. The DON stated she was not aware Resident #2 had reported she was attacked by a male NA earlier that morning on 3/3/25 during the night shift. The DON stated NA #3 had not reported Resident #2 alleged she was attacked and cursed at her by a male NA. The DON revealed staff were trained to immediately report abuse and she expected NA #3 to report an allegation of abuse to the nurse and the nurse to immediately report to her or the Administrator. She revealed her and the Administrator's contact phone numbers were provided for Nurse and NA staff to call and report abuse.

A phone interview was conducted on 4/25/25 at 2:07 PM with the Administrator. The Administrator stated the date and time she was notified was

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when RP reported Resident #2 alleged sexual abuse on 3/3/25 at 9:20 AM during their morning meeting. The Administrator stated she was not aware Resident #2 had previously reported to NA #3 she was attacked by a male NA earlier that morning on 3/3/25 on the night shift. She revealed if she had known Resident #2 alleged abuse and had reported to it NA #3 she expected to be notified at the time the allegation was made and would have sent NA #4 home to protect other residents.

A review of the initial 24-hour report revealed the facility became aware of an allegation of resident abuse on 3/3/25 at 9:20 AM. The details of the allegation revealed the Responsible Party (RP) reported she was informed by Resident #2 that around midnight Nurse #3 allegedly came into her room, sat in her bed and attempted to fondle her and engaged in sexual activity. The report was completed by the Administrator.

Review of the 5-day investigation dated 3/6/25 revealed after review of video footage NA #4 (a male NA) was seen leaving Resident #2's room and suspended pending the investigation. The investigation included staff interviews and written statements and after several interviews Resident #2 gave different scenarios of the incident, and the allegation of abuse was unsubstantiated. The report was completed by the Administrator.

b) A review of the initial 24-hour and 5-day investigation reports revealed other agencies notified did not include Adult Protective Services after the facility was made aware Resident #2 alleged sexual abuse on 3/3/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND HEALTH AND REHABILITATION	213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 24 During an interview on 4/24/25 at 5:06 PM the previous DON revealed she thought the allegation of sexual abuse made by Resident #2 was reported to Adult Protective Services. The DON stated she did not report Resident #2's allegation of sexual abuse to Adult Protective Services. A joint interview was conducted on 4/24/25 at 5:53 PM with the Administrator and SW. The Administrator revealed she had received a text from her Supervisor/Boss on 3/11/25 at 3:16 PM informing her to make sure the Department of Social Services were notified. The Administrator thought the previous DON had spoken to the Department of Health and Human Services about reporting but was unsure. The SW stated he called the Department of Social Services on 3/13/25, to report the alleged abuse incident. Both the Administrator and SW stated the incident should be reported to the Department of Social Services before 3/13/25.	F 607		