STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graham Healthcare and Rehabilitation Center	811 Snowbird Road Robbinsville, NC 28771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Visitor, Police Sergeant, and Nurse Practitioner interviews, the facility failed to protect a cognitively impaired resident's right to be free from staff to resident physical and verbal abuse when Agency Nurse #1 yelled at Resident #1 loudly in a common area of the facility utilizing language that was vulgar and demeaning in a volume that was loud enough for a visitor in a nearby room to hear. Agency Nurse #1 also pushed Resident #1 down into her wheelchair when she attempted to stand up, shook the wheelchair violently, propelled the resident down the hall in her wheelchair in an aggressive manner, and hit Resident #1 in the back with a closed fist multiple times. Resident #1 was crying following the incident and stated to staff that she was afraid. Agency Nurse #1 was charged with assault on a handicapped person. The language utilized by Agency Nurse #1 would have humiliated a reasonable person. This deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included dementia, major depressive disorder, right eye glaucoma (eye condition that damages the optic nerve and can cause vision loss or blindness) secondary to other eye disorders, right eye age-related cataract Morgagnian (advanced and severe type of a cataract that typically results in vision loss such as only being able to see hand movements or light), and left eye cortical age-related cataract (clouding of the eye's natural lens that typically causes increased glare, halos and blurred vision). The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #1 with severe cognitive impairment. Resident #1 required substantial/maximum assistance with sit-to-stand, chair/bed-to-chair transfers and was independent with wheelchair mobility. Resident #1 received anticoagulant medication and displayed no physical, verbal or other behaviors during the MDS assessment look-back period.Review of the facility's initial allegation report (24-hour report) completed by the Administrator revealed on [DATE] at 6:00 AM the facility became aware of an incident of staff-to-resident abuse involving Agency Nurse #1 and Resident #1 that occurred on [DATE]. Resident #1 had no injuries or signs of mental distress.A Nurse Practitioner (NP) progress note dated [DATE] revealed the NP was asked to come to the facility to evaluate Resident #1 urgently due to an incident of abuse. The NP noted the facility was informed by a witness that Agency Nurse #1 had struck Resident #1 in the back of the head the previous night ([DATE]), law enforcement was notified, and the abuser had been incarcerated per staff reports. The NP's exam revealed Resident #1 had normal range of motion to all extremities, no edema (swelling) or bony abnormalities, and no complaints of pain during palpation (use of hands or fingers to feel the surface of the body) to any bone, joint or muscle. Resident #1 had ecchymosis (bruising) to the lateral right fifth digit (pinky finger), right lateral wrist, right forearm, and right elbow. In addition, Resident #1 had a small one centimeter scratch to the left neck. Resident #1 complained of no pain during the exam but did report feeling swimmy headed. The NP noted that prior to the incident on [DATE], Resident #1 had a fall the evening of [DATE] and complained of right wrist pain. The on-call provider was notified and ordered a 2-view right wrist x-ray which resulted on [DATE] at 8:35 PM. The x-ray results showed demineralization and degenerative changes and suspicion of fracture with recommendations (continued on next page)

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.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	to consider a more complete assessment with Computed Tomography (CT, medical imaging test that combines a series of x-rays taken from different angles to create detailed images of internal structures, including bones, that standard x-rays cannot show) and Magnetic Resonance Imaging (MRI, medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in the body). Under Assessment and Plan, the NP noted a diagnosis of Victim of Elder Abuse with no apparent injuries; however, given Resident #1 reported feeling swimmy headed and received Pradaxa (anticoagulant), the decision was made to send Resident #1 to the Emergency Department (ED) for an evaluation. ED records dated [DATE] revealed Resident #1 was evaluated following a fall the day prior and x-rays obtained at the facility showed a possible fracture to the right wrist. The ED noted x-rays and imaging obtained at the hospital revealed no acute findings. Resident #1 was discharged back to the facility in stable condition on [DATE]. A police report dated [DATE] revealed the Police Sergeant arrived to the facility in reference to a report of abuse that occurred on [DATE] at 7:05 PM. The police report indicated Agency Nurse #2 was interviewed and reported that near shift change Resident #1 approached and entered the nurses' station to request water. Resident #1 suffers from dementia, she is also blind and in a wheelchair. Resident #1 was removed from the nurses' station by Agency Nurse Aide (NA) #1 and told to wait in the hallway for the water. Resident #1 entered the nurses station again. Agency Nurse #1 was at the end of her shift and made angry comments to and about Resident #1 as she violently removed Resident #1 and the wheelchair from the nurses' station. While removing Resident #1, Agency Nurse #1 exclaimed that she is sick of this b***h's s**t and pulled Resident #1 out of the nurses' station in an aggressive manner, shaking her wheelchair violently, while cursing at Resident #1. Agency Nurse #2 separated the two (Agency Nurse #1 and Resident #1) and finished the nurse report with Agency Nurse #1 while Agency NA #1 took Resident #1 to the courtyard. Agency Nurse #1 completed the nurse report then left to go home. Agency NA #1 was interviewed and reported she saw Resident #1 trying to get a cup of water from the medication cart and Agency Nurse #1 began to yell mean things at [Resident #1], so she wheeled Resident #1 back into the hallway and gave her some water. Agency NA #1 then went to a room to assist other residents, heard yelling and cursing and returned to see Agency Nurse #1 pushing Resident #1 in an aggressive manner in the wheelchair and yelling go to hell you ugly b***h. Agency NA #1 then saw Agency Nurse #1 hit [Resident #1] on the back. The only other witness to the incident was a visitor who reported she did not see the incident but she heard a loud commotion while she was at the facility visiting a family member. The visitor reported she heard Resident #1 arguing with someone and that person was being very ugly to [Resident #1] with the language that she was using.Continued review of the police report (dated [DATE]) revealed Agency Nurse #1 was interviewed by the Police Sergeant at her place of residence. Agency Nurse #1 reported Resident #1 had been involved in a fight with another resident because Resident #1 couldn't see and she goes along the side of the hallway and kicks at any one that gets in her way. Agency Nurse #1 did put Resident #1 back into her wheelchair when she tried to stand up because she did not want Resident #1 to fall. A follow-up call was made to the facility to validate Agency Nurse #1's claim of breaking up a fight and it was reported by the facility that there was no fight. The Police Sergeant noted that based on the statements from Agency Nurse #1, Agency NA #1, and the Visitor, there was sufficient evidence to charge Agency Nurse #1 with assault on a handicapped person, she was advised of her [NAME] Rights and transported to the County Detention Center. Agency Nurse #1 was no longer employed at the facility. A phone interview was attempted with Agency Nurse #1 on [DATE] at 11:55 AM. Agency Nurse #1 refused to discuss the incident involving Resident #1 and abruptly disconnected the phone call.An undated witness statement from Agency Nurse #2 revealed, on [DATE] at 7:05 PM during shift change, Agency Nurse #1 was giving report to Agency Nurse #2 when Resident #1 came behind the nurses' station in her wheelchair asking for water. Agency NA #1 removed Resident #1 from behind the nurses' station and told Resident #1 to wait in the hallway while she got her some water. While waiting for Agency NA #1 to bring her some (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	water, Resident #1 went back behind the nurses' station again asking for water. Agency Nurse #1 walked toward Resident #1 stating, I'm so tired of this b***h's s**t and pulled Resident #1 in her wheelchair out from behind the nurses' station into the hallway in a backwards motion with Agency Nurse #2 following them. Agency Nurse #1 continued to curse at Resident #1 while pulling her wheelchair backwards aggressively in a zig-zag pattern from the right to left causing Resident #1 to almost fall out of the wheelchair. Resident #1 yelled at Agency Nurse #1 to stop and tried to stand up from the wheelchair. Agency Nurse #1 placed her right hand around the right side of Resident #1's throat, pushed Resident #1 back down in the wheelchair and told Resident #1 don't f---in fall out. Agency Nurse #1 then started punching Resident #1 in the back with her left hand in a closed fist while Resident #1 was leaning forward in the wheelchair scratching at Agency Nurse #1's forearms and yelling for Agency Nurse #1 to let her go. Agency Nurse #1 then told Resident #1 go to hell you f***in b***h and started walking back toward the nurses' station telling Agency Nurse #2 that she wanted to give report so that she (Agency Nurse #1) could leave. Agency Nurse #2 went to assess Resident #1 but Resident #1 cursed at Agency Nurse #2 and told her to leave her alone. Agency Nurse #2 asked Agency NA #1 to take Resident #1 outside and stay with her. Agency Nurse #1 was angry in her demeanor while trying to give Agency Nurse #2 report, stated she (Agency Nurse #1) was sick of this place and her ass too. Agency Nurse #2 told Agency Nurse #1 to just leave and go home because she (Agency Nurse #2) did not want her around anyone else. Agency Nurse #1 grabbed her belongings and exited the facility. Agency Nurse #2 looked out the door into the courtyard and Agency NA #1 was sitting with Resident #1. Approximately, two hours later, Agency NA #1 brought Resident #1 back into the facility and told Agency Nurse #2 that Resident #1 had been crying while out in the courtyard and was scared to return back inside the facility. When Resident #1 came back into the facility, she was no longer crying and Agency NA #1 assisted Resident #1 to bed for assessment. Upon assessment, Agency Nurse #2 noted Resident #1 had a scratch on the right side of her neck approximately 1 to 2 centimeters in length, two bruises near the inside bend of the right forearm each approximately the size of a quarter, four smaller areas that were scattered down the forearm toward the hand and bruising around both the right pinky and middle fingers. Resident #1 complained of pain all over but refused pain medication and slept throughout the remainder of the shift. Agency Nurse #2 notified the Director of Nursing (DON) of the incident on [DATE] at approximately 6:00 AM. Agency Nurse #2 was no longer employed at the facility. Telephone attempts made on [DATE] at 11:25 AM, [DATE] at 8:52 AM, and [DATE] at 10:21 AM for an interview with Agency Nurse #2 were unsuccessful.A witness statement from Agency NA #1 dated [DATE] revealed that she went to the nurses' station after arriving to work on [DATE] at approximately 7:03 PM. Resident #1 was behind the nurses' station at the medication cart, trying to stand up from the wheelchair and get some water. Agency NA #1 assisted Resident #1 with getting water from the medication cart. Agency Nurse #1 was giving report to Agency Nurse #2 at the time and Agency Nurse #1 yelled at Resident #1 stating, I am not dealing with this s**t, I've dealt with this all day. Sit your g**damn ass down. I hate dealing with her. Resident #1 told Agency Nurse #1 that she just wanted some water and stated, I know, I know, I am sitting down. Agency NA #1 assisted Resident #1 out into the hallway and Resident #1 calmed down. Agency NA #1 then went down the hall and into another resident's room to provide care. Approximately 2 to 4 minutes later, Agency NA #1 heard Agency Nurse #1 yelling, screaming and cussing. Agency NA #1 heard Agency Nurse #1 state get off me, go to hell you ugly old b***h as she was coming out into the hall to see what was going on. As she walked up the hall, Resident #1 was seated in her wheelchair with her back toward Agency NA #1 and Agency Nurse #1 was standing on the left side of Resident #1's wheelchair. Agency Nurse #1 was shaking Resident #1's wheelchair trying to get Resident #1 turned around and used both her hands to grab Resident #1's shirt. Agency Nurse #1 then held Resident #1's left hand with her left hand while hitting Resident #1 on the right side of her back with a closed fist at least three times very fast and heard Resident #1 tell Agency Nurse #1 you are ringing my neck. Agency NA #1 ran to Resident #1 and heard Agency Nurse #2 tell (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Agency Nurse #1 to leave. Agency NA #1 moved Resident #1 to the dayroom and sat with Resident #1 because she was crying. Agency NA #1 observed that Resident #1 had a red mark on the right side of her neck approximately 2-3 inches long. Agency NA #1 took Resident #1 out into the courtyard and stayed with her for approximately 2 hours because Resident #1 stated she was afraid to go back inside. Agency NA #1 told Resident #1 she would be taking care of her and assured Resident #1 she would be safe. At approximately 9:30 PM, Agency NA #1 brought Resident #1 back inside the facility and assisted her to bed. Agency NA #1 was no longer employed at the facility. Telephone attempts made on [DATE] at 11:27 AM, [DATE] at 8:53 AM, and [DATE] at 10:21 AM for an interview with Agency NA #1 were unsuccessful.During a phone interview on [DATE] at 4:23 PM, a Visitor reported that on the evening of [DATE] she was visiting her family member who was a resident at the facility. The Visitor stated she and her family member were in the resident's room with the door of the room partially opened when around 7:00 PM, the Visitor heard a heated discussion out in the hall. The Visitor stated she did not go out into the hall and only heard bits and pieces of the conversation. She recognized Resident #1's voice but did not recognize the other person's voice who was speaking to Resident #1 loudly. The Visitor reported the other person called Resident #1 a b***h and that she was a mean old lady. The Visitor expressed there was no way of her knowing who the other person was that was speaking to Resident #1 but what was said by the other person was not a proper way to speak to anyone.During a phone interview on [DATE] at 10:31 AM, the Police Sergeant confirmed he responded to the facility on [DATE] to investigate the incident involving Resident #1 and Agency Nurse #1. The Police Sergeant stated he interviewed Agency Nurse #1, Agency Nurse #2, Agency NA #1, and a Visitor and the documentation of their interviews included in his police report was an accurate account of their statements. When he spoke to the Visitor, she reported she did not witness anything but did hear the commotion out in the hall and recognized Resident #1's voice. She expressed not recognizing the voice of the other person but stated the other person was speaking to Resident #1 in a very bad manner. He did not interview Resident #1 due to her dementia but stated when he saw her at the facility, she did have a scratch on her neck. He stated he drove to Agency Nurse #1's home to talk with her about the incident. When he asked her what had happened at the facility and gave her some of the details of what was alleged, she denied the allegation and stated she did not assault Resident #1. He recalled Agency Nurse #1 reported to him that Resident #1 was fighting with another resident, she separated the two residents and when Resident #1 tried to stand, she pushed her back down in the wheelchair. The Police Sergeant stated Agency Nurse #1's statements of the events did not coincide with other witnesses statements. The Police Sergeant expressed that based on the statements he received from Agency Nurse #2, Agency NA #1 and the Visitor, he took what information he had to the Magistrate's office and the decision was made to charge Agency Nurse #1 and she was placed under arrest.During an interview on [DATE] at 5:54 PM, the DON stated she received a call from Agency Nurse #2 on [DATE] at approximately 6:00 AM to let her know that Agency Nurse #1 had called out of work for the 7:00 AM to 7:00 PM shift for [DATE]. Agency Nurse #2 then proceeded to inform the DON of the incident related to Agency Nurse #1 and Resident #1 that occurred during shift change (7:00 PM) on [DATE]. The DON stated she was with the Police Sergeant when they assessed Resident #1 the morning of [DATE] and she had a slight red mark on her neck, bruising around the pinky finger of her left hand and bruising approximately the size of a dime at the palm of the thumb of her right hand with no bruising noted to her back. The DON stated she felt all over Resident #1's head with no lumps or bumps noted and Resident #1 complained of no pain. Resident #1 was also evaluated by the NP on [DATE] who sent Resident #1 to the hospital for evaluation and x-rays obtained at the hospital were negative for fractures. The DON stated that prior to the incident on [DATE], she had not received any reports about Agency Nurse #1's interactions with residents at the facility and was not sure what prompted her to act the way she did toward Resident #1. Following the incident, the DON stated she has had no further communication with Agency Nurse #1.During an interview on [DATE] at 5:26 PM, the Administrator revealed Agency (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Nurse #1 had only worked at the facility since [DATE] and prior to the incident on [DATE], she had received no reports of any issues with Agency Nurse #1's interactions with residents. The Administrator stated at approximately 6:00 AM on [DATE], she received a call from the DON informing her of the incident involving Resident #1 and Agency Nurse #1 and she came straight to the facility to start an investigation. When the Administrator talked to Resident #1 the morning of [DATE], Resident #1 appeared to be her normal self, sweet and talkative but not making a lot of sense, and when the Administrator asked if she could look at her neck, Resident #1 stated she whopped me good but could not recall the name of the staff member or further details. The Administrator stated she observed a small, red scratch on the right side of Resident #1's neck that was very faint in color and there was no bruising on her back but she did have some bruising on her hands/arms that could have been from the fall she had on [DATE]. The Administrator stated the contracts for Agency Nurse #1, Agency Nurse #2 and Agency NA #1 were terminated as of [DATE] and they were not allowed to return to the facility. She stated a QA meeting was held to discuss the incident and they immediately started implementing a corrective action plan that included in-service education with quizzes and scenarios to ensure staff understood the education provided and conducted observations of staff interactions with residents during care. During a phone interview on [DATE] at 9:00 AM, the NP revealed she received a call from the facility on [DATE] informing her of the incident involving Resident #1 the evening prior ([DATE]) and was asked if she could come to the facility to evaluate Resident #1. The NP stated when she arrived to the facility, Resident #1 was sitting up in her wheelchair finishing lunch. She was her at her normal baseline, not tearful or distressed, and unable to recall the incident on [DATE] due to her advanced dementia. The NP stated she conducted a complete head-to-toe assessment of Resident #1 and from what she could recall, Resident #1 had bruising to the right wrist, elbow and forearm and a small scratch to the neck with no injuries or bruising to her back or other areas. She stated Resident #1 had hurt her wrist when she fell on [DATE] and the facility x-rays showed suspicion for a fracture with recommendation to obtain additional imaging. Resident #1 denied pain until the NP started palpating the back of her head and she then reported having a swimmy head. The NP stated that given Resident #1's report of having a swimmy head along with the initial x-ray results, the decision was made to send Resident #1 to the hospital for an evaluation and x-rays obtained at the hospital showed no acute findings or fractures. The NP stated she re-evaluated Resident #1 on [DATE], completed another head-to-toe examination and there were no latent injuries identified. The NP stated she had seen Resident #1 several times following the incident and had she had been at her normal baseline, pleasantly confused with no memory of the incident. The NP stated she felt the facility acted quickly and appropriately to address the issue once the facility was made aware of the incident involving Agency Nurse #1 and Resident #1. The facility provided the following corrective action plan with a completion date of [DATE]:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:Resident #1 had diagnoses including dementia, hypertensive heart disease with heart failure, atrial fibrillation, type 2 diabetes mellitus, hyperlipidemia, major depressive order, and congestive heart failure.On [DATE] at approximately 7:00 PM, Resident #1 entered the area behind the nurses station requesting water. During this encounter, Agency Nurse #1 spoke to Resident #1 in an inappropriate and unprofessional manner. Agency Nurse Aide (NA) #1 redirected Resident #1 away from the nurses station; however, Resident #1 later returned to the area. The interaction between Agency Nurse #1 and Resident #1 then escalated. As Agency Nurse #1 removed Resident #1 from behind the nurses station, Agency Nurse #1 continued speaking in an inappropriate manner and transported Resident #1 down the hallway in the wheelchair in an erratic and aggressive manner. The oncoming nurse, Agency Nurse #2, who was witnessing the interaction, was walking behind them. Agency NA #1 heard the commotion and came out of a room to inquire what was going on. Both Agency Nurse #2 and Agency NA #1 reported that they witnessed the interaction escalating further. According to Agency Nurse #2, she observed Agency Nurse #1 place her right hand around the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	right side of Resident #1's throat and pushed the resident back toward the wheelchair while the resident was attempting to stand. Agency Nurse #2 further reported that Agency Nurse #1 then struck Resident #1 in the back multiple times with her left hand clinched in a closed fist. Agency NA #1 stated that she observed Agency Nurse #1 grab the top of Resident #1's shirt. She further stated that Agency Nurse #1 held Resident #1's left hand with her left hand and struck the upper right side of the resident's back with a closed fist at least three times.Agency Nurse #2 informed Agency Nurse #1 to leave the premises and observed Agency Nurse #1 exit the premises. Simultaneously, Resident #1 was then removed from the day room and taken outside to the courtyard by Agency NA #1 for approximately 2 hours to provide emotional support, reassurance, and psychosocial comfort following the incident. Resident #1 initially refused an assessment. After returning inside the facility, Resident #1 allowed Agency Nurse #2 to complete an assessment. The assessment revealed a small scratch to the right side of the neck, discoloration to the right forearm, the 5th digit of the right hand and middle finger of the right hand, bruising to the right anterior wrist, along with complaints of generalized pain. Resident #1 refused pain medication and repositioning. Staff continued to monitor Resident #1 throughout the night.On [DATE] at approximately 5:55 AM, Agency Nurse #2 notified the Director of Nursing (DON) of the incident. At approximately 6:00 AM the DON notified the Administrator of the incident and the Administrator immediately initiated an investigation. Agency Nurse #1 was immediately removed from the schedule pending investigation. At approximately 6:51 AM, the Administrator notified the police. Notifications were made to Adult Protective Services (APS), Health Care Personnel Investigations/Registry (HCPI/HCPR), Board of Nursing, and Resident #1's representative regarding the allegation and inappropriate staff to resident interaction. Law enforcement and APS responded to the facility and initiated an investigation. The facility was later informed that Agency Nurse #1 had been arrested and charged in relation to the incident. Agency Nurse #1 refused to give a statement to the facility. Per law enforcement, Agency Nurse #1 denied the incident and stated that following an interaction with another resident and Resident #1 attempted to stand and Agency Nurse #1 assisted her back into her wheelchair because she did not want Resident #1 to fall.At approximately 10:15 AM on [DATE], the Administrator implemented 1:1 with Resident #1 for psychosocial support and well-being. Resident #1 remains on 1:1 observation.On [DATE], the Nurse Practitioner was notified and assessed Resident #1. While being assessed by the Nurse Practitioner, Resident #1 reported feeling swimmy headed. This complaint was determined to be related to low blood pressure and not this incident. On [DATE], Resident #1 was transferred to the emergency department for further evaluation with agreement from Resident #1's representative. On [DATE], hospital evaluation included diagnostic imaging consisting of CT scans of the brain and cervical spine, as well as a right wrist x-ray, with no fractures or acute abnormalities identified. Resident #1 returned to the facility with no new treatment orders or recommendations.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:On [DATE], 100% skin checks were initiated on all residents with a Brief Interview of Mental Status (BIMS) score of 12 or less (including Resident #1) who are unable to report signs/symptoms of abuse, by Facility Floor Nurses. A skin check assessment tool will be utilized with documentation in the electronic medical record. The skin checks were completed by [DATE]. There were no concerns related to abuse identified during the audit.On [DATE],100% of all alert and oriented residents with a BIMS score of 13 and above were interviewed by a sister facility ADON regarding: Do you know what it means to be abused? Are there any instances that you felt you were abused that has not been reported and/or addressed? Are there any instances that you witnessed abuse that has not been reported and/or addressed? Do you feel safe in the facility? There were no concerns regarding abuse verbalized during the interviews. During the interviews, education was completed regarding abuse to include the definitions, resident rights, what to do in an abusive situation, and how to report abuse. The education was completed by [DATE].On [DATE], all abuse allegations for the last three months were reviewed for trends and patterns by the Administrator. There were no trends and patterns (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	identified during this timeframe.On [DATE], all employee files were audited by the sister facility Administrator to ensure the files had background checks, reference checks, Health Care Personnel Registry (HCPR) checks and abuse education on hire, with no concerns noted.On [DATE], an audit of incident reports from the previous three months was conducted by the Facility Consultant to identify any incidents that may have involved concerns related to staff-to-resident interactions or potential abuse. Any identified concerns will be reviewed and addressed promptly through the facility's investigation and abuse process, as appropriate. No concerns were identified.Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur:On [DATE], an in-service was initiated, in person, by the sister facility DON with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, DON, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding (1) abuse, including policy and definition, (2) burnout, including signs and symptoms, (3) dementia and de-escalation/communication for residents with dementia, and (4) the abuse allegation action checklist. The education emphasized (A) the importance of immediately intervening during inappropriate staff-to-resident interactions, (B) immediately reporting all allegations, concerns, observations, involving possible abuse, mistreatment or inappropriate conduct to the Administrator, DON or supervisor, (C) timely documentation of incidents, observations, actions taken, and notifications completed, (D) expectations related to maintaining resident dignity and safety, (E) appropriate dementia communication techniques and use of de-escalation strategies during resident care, and (F) the potential disciplinary action associated with failure to appropriately intervene, report, or respond to allegations involving resident abuse or mistreatment. The in-services were completed by [DATE] for all staff who worked. After [DATE], any staff that has not worked and not received the in-service will complete it before the start of their next scheduled shift. The DON and ADON will monitor the staff's completion. All newly hired staff, including agency staff, will be in-serviced by the Staff Development Coordinator (SDC) during orientation regarding (1) abuse, (2) burn out, (3) dementia and de-escalation, and (4) the abuse allegation action checklist.On [DATE], Abuse/Burn out Quizzes were initiated, in person, by the sister facility DON with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, DON, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist. The purpose of the quizzes is to ensure that all staff successfully validate knowledge and understanding of the abuse/burn out in-services. Any employee who does not successfully pass the quiz will be required to retake the quiz unital a successful passing score is achieved. The quizzes were completed by [DATE] for all staff who worked. After [DATE], any staff that has not worked and completed the quiz will complete it before the start of their next scheduled shift. The DON and ADON will monitor the staff's completion. The DON and ADON were notified of this responsibility by the Administrator on [DATE].Effective [DATE], all newly hired staff, including agency, will receive an abuse\burnout quiz by the Staff Development Coordinator to validate knowledge and understanding. Newly hired staff and agency staff will not be permitted to independently assume resident care assignments until successful completion of the required quiz. The ADON who is also the Staff Development Coordinator was notified of this responsibility by the Administrator on [DATE].On [DATE], local law enforcement and the Long-Term Care Ombudsman were contacted by the Administrator to coordinate and schedule abuse education for staff related to resident protection, immediate reporting, intervention expectations, and potential criminal implications. Training is scheduled for [DATE].Effective [DATE], the Social Worker will discuss resident rights including abuse during the monthly resident council meeting to ensure understanding of the definition of abuse and importance of immediately reporting. During the discussion, residents will be encouraged to discuss any concerns of potential abuse that may not have previously been reported. The Social W[TRUNCATED]

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	345355	A. Building B. Wing	05/28/2026

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Graham Healthcare and Rehabilitation Center	811 Snowbird Road Robbinsville, NC 28771

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure staff implemented their abuse policy in the areas of protecting and reporting for 1 of 3 residents reviewed (Resident #1) for abuse. On [DATE] at approximately 7:05 PM, Agency Nurse #2 and Agency Nurse Aide #1 witnessed Agency Nurse #1 use inappropriate language to speak to Resident #1, aggressively push Resident #1 down the hall in her wheelchair in an erratic and aggressive manner, hit Resident #1 in the back with a closed fist multiple times, and did not effectively intervene and immediately report the incident to the Administrator. On [DATE] at approximately 6:00 AM, Agency Nurse #2 reported the incident to the Director of Nursing. This failure resulted in a delay in implementing protection for a resident being abused, reporting the allegation to the State Agency, law enforcement and the Adult Protective Services, and the facility investigating the allegation.Findings included:The facility's policy titled, Abuse, Neglect or Misappropriation of Resident Property last revised on [DATE] revealed in part, any employee who witnesses or suspects that abuse, neglect, exploitation, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor who will immediately report the incident to the Administrator. The facility shall take whatever steps are necessary to prevent further acts of abuse, neglect, misappropriation while the investigation is in progress.the employee(s) accused of being directly involved will be suspended immediately pending the outcome of the investigation. The resident will be examined for any sign of injury as appropriate and emotional support will be provided as needed.Resident #1 was admitted to the facility on [DATE] with diagnoses that included dementia and major depressive disorder.The facility's initial allegation report (24-hour report) completed by the Administrator revealed on [DATE] at 6:00 AM the facility became aware of an incident of staff-to-resident abuse involving Agency Nurse #1 and Resident #1 that occurred on [DATE]. Resident #1 had no injuries or signs of mental distress.An undated witness statement from Agency Nurse #2 revealed in part, on [DATE] at 7:05 PM during shift change, Agency Nurse #1 was giving report to Agency Nurse #2 when Resident #1 came behind the nurses' station in her wheelchair asking for water. Agency Nurse Aide (NA) #1 removed Resident #1 from behind the nurses' station and told Resident #1 to wait in the hallway while she got her some water. While waiting for NA #1 to bring her some water, Resident #1 went back behind the nurses' station again asking for water. Agency Nurse #1 walked toward Resident #1 stating I'm so tired of this b***h's s**t and pulled Resident #1 in her wheelchair out from behind the nurses' station into the hallway in a backwards motion with Agency Nurse #2 following them. Agency Nurse #1 continued to curse at Resident #1 while pulling her wheelchair backwards aggressively in a zig-zag pattern from the right to left causing Resident #1 to almost fall out of the wheelchair. Resident #1 yelled at Agency Nurse #1 to stop and tried to stand up from the wheelchair. Agency Nurse #1 placed her right hand around the right side of Resident #1's throat, pushed Resident #1 back down in the wheelchair and told Resident #1 don't f---in fall out. Agency Nurse #1 then started punching Resident #1 in the back with her left hand in a closed fist while Resident #1 was leaning forward in the wheelchair scratching at Agency Nurse #1 forearms and yelling for Agency Nurse #1 to let her go. Agency Nurse #1 then told Resident #1 go to hell you f***in b***h and started walking back toward the nurses' station telling Agency Nurse #2 that she wanted to give report so that she (Agency Nurse #1) could leave. Agency Nurse #2 went to assess Resident #1 but Resident #1 cursed at Agency Nurse #2 and told her to leave her alone. Agency Nurse #2 asked Agency NA #1 to take Resident #1 outside and stay with her. Agency Nurse #1 was angry in her demeanor while trying to give Agency Nurse #2 report and stated she (Agency Nurse #1) was sick of this place and her ass too. Agency Nurse #2 told Agency Nurse #1 to just leave and go home because she (Agency Nurse #2) did not want her around anyone else. Agency Nurse #1 grabbed her belongings and exited the facility. Agency Nurse #2 notified the Director of Nursing (DON) of the incident on [DATE] at approximately 6:00 AM. A witness statement from Agency NA #1 dated (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] revealed in part, she went to the nurses' station after arriving to work on [DATE] at approximately 7:03 PM. Resident #1 was behind the nurses' station at the medication cart, trying to stand up from the wheelchair and get some water. Agency NA #1 assisted Resident #1 with getting water from the medication cart. Agency Nurse #1 was giving report to Agency Nurse #2 at the time and Agency Nurse #1 yelled at Resident #2 stating I am not dealing with this s**t, I've dealt with this all day. Sit your g**damn ass down. I hate dealing with her. Resident #1 told Agency Nurse #1 that she just wanted some water and stated, I know, I know, I am sitting down. Agency NA #1 assisted Resident #1 out into the hallway and Resident #1 calmed down. Agency NA #1 then went down the hall and into another resident's room to provide care. Approximately 2-4 minutes later, Agency NA #1 heard Agency Nurse #1 yelling, screaming and cussing. Agency NA #1 heard Agency Nurse #1 state get off me, go to hell you ugly old b***h as she was coming out into the hall to see what was going on. As she walked up the hall, Resident #1 was seated in her wheelchair with her back toward Agency NA #1 and Agency Nurse #1 was standing on the left side of Resident #1's wheelchair. Agency Nurse #1 was shaking Resident #1's wheelchair trying to get Resident #1 turned around and used both her hands to grab Resident #1's shirt. Agency Nurse #1 then held Resident #1's left hand with her left hand while hitting Resident #1 on the right side of her back with a closed fist at least three times very fast and heard Resident #1 tell Agency Nurse #1 you are ringing my neck. Agency NA #1 ran to Resident #1 and heard Agency Nurse #2 tell Agency Nurse #1 to leave. Agency NA #1 moved Resident #1 to the dayroom and sat with Resident #1 because she was crying. Agency NA #1 did not notify anyone of the incident because she thought Agency Nurse #2 had.The facility's investigation report completed by the Administrator on [DATE] revealed Resident #1 had skin alteration to the neck, discoloration to the right forearm, the fifth digit (pinky finger) of the right hand, middle finger of the right hand, and complaints of generalized pain. Resident #1 had no signs of mental distress. The allegation of staff-to-resident abuse was substantiated and Agency Nurse #1's employment was terminated effective [DATE].Agency Nurse #1 was no longer employed at the facility. A phone interview was attempted with Agency Nurse #1 on [DATE] at 11:55 AM. Agency Nurse #1 refused to discuss the incident involving Resident #1 and abruptly disconnected the phone call.Agency Nurse #2 was no longer employed at the facility. Telephone attempts made on [DATE] at 11:25 AM, [DATE] at 8:52 AM, and [DATE] at 10:21 AM for an interview with Agency Nurse #2 were unsuccessful.Agency NA #1 was no longer employed at the facility. Telephone attempts made on [DATE] at 11:27 AM, [DATE] at 8:53 AM, and [DATE] at 10:21 AM for an interview with Agency NA #1 were unsuccessful.During an interview on [DATE] at 5:54 PM, the DON stated she received a call from Agency Nurse #2 on [DATE] at approximately 6:00 AM to let her know that Agency Nurse #1 had called out of work for the 7:00 AM to 7:00 PM shift for [DATE]. Agency Nurse #2 then proceeded to inform the DON that during shift change (7:00 PM) on [DATE], Agency Nurse #1 was giving report to Agency Nurse #2 when Resident #1 entered the nurses' station for water. She stated Agency NA #1 gave Resident #1 some water and then assisted her back out into the hallway. Shortly after being assisted back out into the hall, Resident #1 came back behind the nurses' station while Agency Nurse #1 was still giving report which upset Agency Nurse #1 and Agency Nurse #2 took Resident #1 back out into the hall with Agency Nurse #1 following behind them. Agency Nurse #1 grabbed Resident #1's wheelchair and aggressively pushed her down the hall, describing it as moving the wheelchair rapidly left-to-right in a zig-zag pattern, and using foul language to Resident #1 as she pushed her down the hall. Agency Nurse #2 told the DON that Agency Nurse #1 appeared to choak Resident #1 and hit her in the back with a closed fist but did not say how many times. Agency Nurse #2 stated she immediately intervened and told Agency Nurse #1 to leave. The DON stated she asked Agency Nurse #2 if Resident #1 was safe and if Agency Nurse #1 was gone and she reported yes; however, the DON stated once she arrived to the facility she found out that Agency Nurse #1 had stayed to finish shift report with Agency Nurse #2 after the incident and then left the facility. During the phone conversation with Agency Nurse #2, the DON stated she reviewed the abuse policy with Agency Nurse #2 and reminded (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her that staff had been instructed to report abuse immediately. When asked why she didn't report the incident sooner, Agency Nurse #2 stated it was a busy night and she felt that she and Agency NA #1 had handled the situation. The DON stated when Agency NA #2 was asked why she didn't report the incident, Agency NA #1 stated she thought that Agency Nurse #2 had.During an interview on [DATE] at 5:26 PM, The Administrator stated at approximately 6:00 AM on [DATE], she received a call from the DON informing her of the incident involving Resident #1 and Agency Nurse #1 and she came straight to the facility to start an investigation. She immediately started interviewing the staff, students and instructor who were at the facility during the evening shift (7:00 PM to 7:00 AM) and no one reported witnessing the incident or overhearing any commotion except for Agency Nurse #2 and Agency NA #1. She stated Agency Nurse #2 reported she was getting shift report from Agency Nurse #1 when Resident #1 came behind the nurses' station wanting water, which was her normal behavior, Agency NA #1 gave Resident #1 some water and assisted her back out into the hall. Agency Nurse #1 and Agency Nurse #2 continued on with shift report and at some point, Resident #1 came back behind the nurses' station asking for more water which upset Agency Nurse #1. Agency Nurse #2 stated when she started pushing Resident #1 back out into the hall, Agency Nurse #1 grabbed Resident #1's wheelchair, said a few unchoice words and pushed Resident #1 aggressively down the hall. Agency Nurse #2 reported observing Agency Nurse #1 hitting Resident #1 in the lower mid-back with a closed fist and at some point, when Resident #1 started to stand up from the wheelchair, Agency Nurse #1 placed her hands on Resident #1's shoulders next to her neck and roughly pushed Resident #1 back down into the wheelchair which was how they determined Resident #1 likely sustained the scratch to her neck. Agency Nurse #2 reported she then intervened, told Agency NA #1 to take Resident #1 out into the courtyard and told Agency Nurse #1 to leave but Agency Nurse #1 stated she wasn't leaving until they finished shift report and once that was done, Agency Nurse #1 left the building. She stated Agency NA #1 also reported witnessing Agency Nurse #1 hit Resident #1 in the back. The Administrator stated all staff had received abuse education and instructed to report any abuse concerns to her immediately. When she asked Agency Nurse #2 why she didn't call her when the incident happened or report the incident sooner, Agency Nurse #2 stated she thought that she and Agency NA #1 had handled the situation which was why she felt she didn't need to report it right away. When Agency NA #1 was asked why she didn't report the incident to her (Administrator), she stated she thought Agency Nurse #2 had. The Administrator stated the contracts for Agency Nurse #1, Agency Nurse #2 and Agency NA #1 were terminated as of [DATE] and they were not allowed to return to the facility. She stated a QA meeting was held to discuss the incident and they immediately started implementing a corrective action plan that included in-service education with quizzes and scenarios to ensure staff understood the education provided and conducted observations of staff interactions with residents during care. The facility provided the following corrective action plan with a completion date of [DATE]:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:Resident #1 is a [AGE] year old with diagnoses including dementia, hypertensive heart disease with heart failure, atrial fibrillation, type 2 diabetes mellitus, hyperlipidemia, major depressive order, and congestive heart failure.On [DATE] at approximately 7:00 PM, Resident #1 entered the area behind the nurses station requesting water. During this encounter, Agency Nurse #1 spoke to Resident #1 in an inappropriate and unprofessional manner. Agency Nurse Aide (NA) #1 redirected Resident #1 away from the nurses station and Agency NA #1 did not report the initial inappropriate exchange to Agency Nurse #2. Resident #1 later returned to the area and the interaction between Agency Nurse #1 and Resident #1 then escalated. As Agency Nurse #1 removed Resident #1 from behind the nurses station, Agency Nurse #1 continued speaking in an inappropriate manner and transported Resident #1 down the hallway in the wheelchair in an erratic and aggressive manner and became physically aggressive toward Resident #1 by striking Resident #1 in the back with a closed fist. This interaction was observed by Agency NA #1 and Agency Nurse #2. Agency NA #1 did not report the inappropriate verbal exchange to the Director of Nursing (DON) or (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator as she thought Agency Nurse #2 had reported it. Agency Nurse #2 did not immediately intervene and/or report the continued inappropriate verbal exchange, erratic movements of the resident in her wheelchair or the physical abuse to the DON or Administrator as she believed Resident #1 was protected due to Agency Nurse #1 removing herself from the situation as Agency Nurse #2 informed Agency Nurse #1 to leave the premises and observed Agency Nurse #1 exit the premises. Simultaneously, Resident #1 was then removed from the dayroom and taken outside to the courtyard by Agency NA #1. Staff continued to monitor Resident #1 throughout the night. On [DATE] at approximately 5:55 AM, Nurse #2 notified the DON of the incident. At approximately 6:00 AM the DON notified the Administrator of the incident and the Administrator immediately initiated an investigation. Agency Nurse #1 was immediately removed from the schedule pending investigation. Approximately at 6:51 AM, the Administrator notified the police. Notifications were made to Adult Protective Services (APS), Health Care Personnel Investigations/Registry (HCPI/HCPR), Board of Nursing, and Resident #1's representative regarding the allegation and inappropriate staff-to-resident interaction. Law enforcement and APS responded to the facility and initiated an investigation. The facility was later informed that Agency Nurse #1 had been arrested and charged in relation to the incident. Agency Nurse #1 refused to give a statement to the facility. Per law enforcement, Agency Nurse #1 denied the incident and stated that following an interaction with another resident and Resident #1 attempted to stand and Agency Nurse #1 assisted her back into her wheelchair because she did not want Resident #1 to fall.Approximately at 10:15 AM on [DATE], the Administrator implemented a 1:1 with Resident #1 for psychosocial support and wellbeing. Resident #1 remains on 1:1 observation.Effective [DATE], employment contracts for Agency Nurse #1, Agency Nurse #2 and Agency NA #1 were terminated.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:On [DATE], reportable investigation folders from the past 30 days were reviewed by the Administrator to ensure all previous allegations or concerns involving potential abuse were appropriately reported, investigated, and addressed. There were no other reportable allegations identified.On [DATE], local law enforcement and the Long-Term Care Ombudsman were contacted by the Administrator to coordinate and schedule abuse education for staff related to resident protection, immediate reporting, intervention expectations, and potential criminal implications. Training is scheduled for [DATE].Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur:On [DATE], the Administrator developed and posted an Abuse Allegation Action Checklist on brightly colored paper at the nurses station, time clock, and break room to serve as a readily accessible reference for staff regarding intervening, responding, and immediately reporting to the Administrator and DON for allegations or concerns involving potential abuse. This action checklist steps to be taken in the case of any allegations of abuse. The checklist includes that staff are to immediately ensure the resident is removed from harm, immediate removal of the perpetrator, immediate notification of the Administrator and DON.On [DATE], the Administrator made the decision to implement a badge buddy (laminated card worn behind an employee's ID badge) to provide staff with a simple, consistent, and easily accessible reference to reinforce expectations related to abuse recognition, intervention, immediately reporting, and response responsibilities. On [DATE], the badge buddies were ordered by the Administrator. The badge buddies indicate that staff are to tell nurse, supervisor, DON and/or Administrator immediately related to any potential allegation of abuse. The badge buddies were distributed to staff upon receipt prior to the start of their next scheduled shift.On [DATE], an in-service was initiated, in person, by the sister facility DON with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, DON, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding abuse, including policy and definition. The education emphasized immediately reporting all allegations, concerns, observations, involving possible abuse, mistreatment, or inappropriate conduct to the Administrator, DON or supervisor. The in-services were completed by (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] for all staff who worked. After [DATE], any staff that has not worked and not received the in-service will complete it before the start of their next scheduled shift. The DON and ADON will monitor the staff's completion. The DON and ADON were notified of this responsibility by the Administrator on [DATE]. All newly hired staff, including agencies, will be in-serviced by the Staff Development Coordinator during orientation regarding abuse and the abuse allegation action checklist.On [DATE], Abuse Quizzes was initiated, in person, by the sister facility DON with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, DON, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist. The purpose of the quizzes is to ensure that all staff successfully validate knowledge and understanding of when to report abuse and the importance of reporting abuse. Any employee who does not successfully pass the quiz will be required to retake the quiz until a successful passing score is achieved. The quizzes were completed by [DATE] for all staff who worked. After [DATE], any staff that has not worked and completed the quiz will complete it before the start of their next scheduled shift. The DON and ADON will monitor the staff's completion. The DON and ADON were notified of this responsibility by the Administrator on [DATE].Effective [DATE], the facility implemented an Abuse Response Competency Validation Program requiring all staff, including agency, to demonstrate competency related to abuse recognition, intervention, immediate reporting, and resident protection measures upon hire. All newly hired staff, including agency, will receive an abuse\burnout quiz and complete the abuse scenario by the Staff Development Coordinator to validate knowledge and understanding of how to respond to staff inappropriate interactions with residents, including immediately intervening. Newly hired staff and agency staff will not be permitted to independently assume resident care assignments until successful completion of the required quiz and abuse response serious scenario competency validation. The ADON who is also the Staff Development Coordinator was notified of this responsibility are the administrator on [DATE].Effective [DATE], the Social Worker will discuss resident rights including abuse during the monthly resident council meeting to ensure understanding of the definition of abuse and importance of immediately reporting. During the discussion, residents will be encouraged to discuss any concerns of potential abuse that may not have previously been reported. The Social Worker will immediately notify the Administrator of all potential abuse concerns voiced and document on the resident concern form. The Administrator will ensure timely reporting and investigation of concerns of potential abuse per protocol. The Administrator will notify newly hired Social Workers of this responsibility during orientation.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:10 Abuse Quizzes will be completed by the DON, ADON, SDC, or supervisor with staff weekly x 4 weeks then monthly x 1 month. The quizzes are to ensure staff maintain knowledge and understanding of immediately reporting abuse. These quizzes will be conducted on all shifts and weekends. Staff will be immediately retrained during the quiz for any identified areas of concern. The DON will review and initial the abuse quizzes weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concerns are addressed. The Director of Nursing was notified of this responsibility by the Administrator on [DATE].Progress notes and incident reports will be reviewed by the DON, ADON, SDC, or Supervisor 5 x per week x 4 weeks then monthly x 1 month for all residents to include Resident #1. This audit is to identify any events of potential abuse to ensure it was immediately reported and investigated per facility protocol. All newly identified potential abuse allegations will be documented on the (Interdisciplinary) IDT meeting minutes form. All identified areas of concerns will be immediately addressed by the Administrator to include reporting and retraining of staff as necessary.A Quality Assurance Meeting was held to include the Administrator, DON, admission Coordinator, Medical Records, Minimum Data Set Nurse, Accounts Payable, Nurse Practitioner, and Maintenance Director on [DATE] to discuss the action items related to abuse reporting. The committee made the decision to implement the action plan with monitoring on (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE].Date corrective actions completed: [DATE].On [DATE] and [DATE], the facility's corrective action plan was validated by the following: Staff interviews revealed they had received education related to abuse which included immediately intervening and removing the resident from the situation and immediately reporting any concerns of abuse to their immediate supervisor, DON, and/or Administrator, signs/symptoms of burnout, and communication/deescalation for residents with dementia. In addition, staff also reported taking quizzes to ensure they understood the education and receiving a buddy badge to remind them of what to do if they had concerns or witnessed abuse. Alert and oriented residents were interviewed who all reported they felt safe at the facility, had no concerns of abuse and verified they knew how/who to report any concerns. Review of the attendance sign-in sheets and quizzes completed by staff revealed in-service education was initiated for all staff/departments on [DATE]. Skin assessments were completed on all cognitively impaired residents and interviews were conducted with all alert and oriented residents on [DATE] with no concerns reported or identified. Staff interviews were conducted with staff in all departments on [DATE] with no concerns of abuse reported. Audits and Monitoring tools were reviewed for the period [DATE] through [DATE] with no identified concerns noted and were completed as outlined in the facility's corrective action plan. The corrective action plan's completion date of [DATE] was validated.