STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing and Rehabilitation Center	1930 West Sugar Creek Road Charlotte, NC 28262

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 20934 Based on observations, record review, resident, physician, and staff interview the facility failed to protect a severely cognitively impaired resident from the right to be free from physical abuse (Resident #5). Resident #5 experienced physical abuse twice on [DATE] when before bingo Resident #4 placed her arm around the Resident #5's neck, and pulled her forward, and then on the same day, placed Resident #5 in a chokehold with her arm while she was seated in her wheelchair. Resident #5 was held in the chokehold position which caused the resident to gasp and her face to become red. In addition, the facility failed to protect a severely cognitively impaired resident from the right to be free from sexual abuse (Resident #3). Resident #3 experienced sexual abuse on [DATE] when Resident #2 touched and rubbed her pubic area. Based on the reasonable person concept, being placed in a chokehold and non-consensual sexual contact would cause a reasonable person to experience psychosocial harm, trauma and fear from physical or sexual abuse. Abuse occurred for 2 of 4 sampled residents reviewed for protection from abuse (Resident #5 and Resident #3). The findings included: 1. Resident #4 readmitted to the facility on [DATE]. Diagnoses included recurrent major depressive disorder, post-traumatic stress disorder (PTSD), and anxiety disorder. A [DATE] quarterly Minimum Data Set (MDS) assessment evaluated Resident #4 with adequate hearing and vision (with corrective lenses), clear speech, made herself understood, able to understand others, intact cognition, no behaviors, used a motorized wheelchair for mobility and independent or required supervision with activities of daily living (ADL). Review of the care plan for Resident #4 revised [DATE] revealed she did not have a comprehensive person-centered behavior care plan. The care plan did document that Resident #4 required staff assistance with ADL due to her history of PTSD. Staff interventions included allowing rest breaks between tasks, encouraging participation in small tasks, and allowing adequate time to complete tasks. A [DATE] skin audit conducted by the Director of Nursing (DON) recorded no injuries noted for Resident #4. Resident #5 readmitted to the facility on [DATE] and expired in the facility with hospice services on [DATE]. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Diagnoses included dementia with agitation, anxiety disorder, mood affective disorder, psychosis, and major depressive disorder. A care plan revised [DATE] recorded Resident #5 cursed at a resident and at staff. Interventions included referral for psych services as needed, provide psych medications as ordered, involve the Responsible Party (RP), if possible, redirect her when she is noted with agitation/aggression, and educate her that cursing others is not acceptable. A [DATE] quarterly MDS assessment evaluated Resident #5 with adequate hearing, impaired vision, clear speech, made self-understood, able to understand others, severely impaired cognition, no behaviors, no functional limitation in upper extremity range of motion (ROM), impaired function limitation in lower extremity ROM on both sides, wheelchair use for mobility and dependent on staff for ADL. A [DATE] skin audit conducted by the DON recorded no injuries noted for Resident #5. 1a. Medical record review for Resident #4 and Resident #5 revealed there was no documentation in either medical record that Resident #4 placed her arms around the neck of Resident #5 on [DATE] and pulled the Resident forward. An interview with the Activity Director (AD) and the Activity Assistant occurred on [DATE] at 5:37 PM. During the interview, the AD stated that on [DATE], she did not know the exact time, but sometime before bingo which was scheduled at 2:30 PM, she was in her office, which was adjacent to the dining room, and she heard Resident #5 talking loudly in the dining room and using profanity. Resident #4 told Resident #5 nobody wants to hear that. During the interview, the Activity Assistant stated that before the 2:30 PM bingo activity, she was not sure of the exact time, she was in/out of the dining room setting up bingo, and she told Resident #5 to calm down. The Activity Assistant stated that Resident #5 got upset, continued using profanity and yelled at Resident #4 b**** I will f*** you up. The Activity Assistant stated she called the AD to come and help her when she saw Resident #5 propel in her wheelchair towards Resident #4, Resident #4 put her arms around the neck/shoulders of Resident #5 and pulled her forward. The Activity Assistant stated she separated the Residents, directed Resident #4 to go to her room while the AD took Resident #5 to the Nurse. The Activity Assistant said she returned to setting up bingo and that she did not report to the administration that she had to separate the two Residents. The interview continued and the AD stated that the Activity Assistant asked for her help. The AD stated that when she came out of her office into the dining room, she saw the Activity Assistant pulling the two residents apart. The AD said that the Activity Assistant told her what occurred, the AD took Resident #5 to her Nurse (Nurse #1), reported the incident to Nurse #1 and returned to the dining room for bingo. The AD stated that she did not report the incident to the administration, but rather took Resident #5 to her Nurse. Both the AD and the Activity Assistant stated they were unaware that a second incident occurred between Resident #4 and Resident #5 on the same day ([DATE]) in the hallway. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Nurse #1 was interviewed via phone on [DATE] at 3:35 PM. He stated that he was the assigned Nurse on the South Unit for the 7A - 3P shift on [DATE]. He stated that close to the end of the shift on [DATE] he heard staff stating that Resident #5 said something to Resident #4 that got her upset and caused her to hit Resident #5. He stated that no one reported the incident to him directly. Nurse #1 said he was told that an incident report had been made, but he could not recall who told him that, so he did not make a report about the incident because he did not witness it and he was not asked to do any follow up. Nurse #1 said after he heard about the incident, he did recall seeing Resident #5 in her wheelchair at the end of the hall near her room, but that she did not mention what occurred. Nurse #1 said he was not made aware that there were two incidents between Resident #4 and Resident #5 that day. Nurse #1 stated that if staff had reported the incident directly to him, he would have contacted the DON and Administrator to get the police involved if a resident was assaulted and followed the facility's abuse policy. Nurse #1 described Resident #5 as confused intermittently and heard staff say she made racial comments and cursed staff/resident, but that he was not aware that Resident #5 ever physically hit another resident. Nurse #1 described that Resident #4 seemed like the sweetest person, but that she could be aggressive at times and made verbal threats of what she would do in different circumstances if she were provoked. He stated that he never reported the behavior of Resident #4 because these were comments that he heard in passing. 1b. A Resident Incident Report for Resident #4 completed by the DON recorded that on [DATE] at 1:45 PM, Resident #4 and Resident #5 were both in the dining room when Resident #5 began to harass the kitchen staff. The report recorded that when Resident #4 told Resident #5 to stop harassing the staff, Resident #5 turned to Resident #4 and cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a chokehold because Resident #5 had been harassing her for weeks. The report recorded that staff heard the commotion, separated the Residents, and both Residents were assessed by the DON without injury. The report recorded that the Physician (MD), RP for Resident #5, law enforcement and Adult Protective Services (APS), were notified of the incident. Review of a Facility Reported Incident, completed by the DON, dated [DATE] at 1:45 PM indicated Resident #4 put Resident #5 in a headlock. The Summary of Facility Investigation recorded, Resident #4 and Resident #5 were both in the dining room when Resident #5 shouted to dietary staff that she was hungry. The DON recorded Resident #5 received a sandwich and juice but continued to shout for more food. Resident #4 asked Resident #5 to stop harassing the dietary staff at which time Resident #5 turned to Resident #4 and responded with expletives. The DON documented that Resident #4 stated that she became extremely frustrated because Resident #5 had been harassing her for weeks, and that this incident made her so angry that she rolled up behind Resident #5 and put her in a headlock from behind. A police report dated [DATE] at 2:08 PM recorded that Resident #4 verbally threatened Resident #5 with bodily injury. Resident #5 alleged that Resident #4 threatened to choke her to death. Multiple attempts to interview the police officer were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Nursing General Note for Resident #5 dated [DATE] at 8:38 AM by the DON recorded that on [DATE] at approximately 1:45 PM, Resident #5 and Resident #4 were in the dining room. The DON recorded that Resident #4 reported that Resident #5 started harassing kitchen staff and when Resident #4 asked Resident #5 to stop harassing the kitchen staff, Resident #5 cursed at her. At this, the DON recorded that Resident #4 stated that she got upset and put Resident #5 in a chokehold because Resident #5 had been harassing her for weeks. The DON recorded that staff heard the commotion and separated the Residents. The RP for Resident #5 was made aware of the incident and the incident was recorded in the MD communication book. During an interview with Resident #4 on [DATE] at 10:30 AM, and a follow-up interview on [DATE] at 9:15 AM, she stated that on [DATE], she remembered that she and Resident #5 were in the dining room. Resident #4 said she recalled Resident #5 kept messing with staff in the kitchen saying she was hungry. Resident #4 said she told Resident #5 to leave the kitchen staff alone and to eat the food she had been given. At that time, Resident #5 turned to her, got in her face, and said f*** you. Resident #4 said she got so tired of Resident #5 talking to her that way, so she knocked on the activity door, which was a room in the dining room, but then decided she would go find a staff member. Resident #4 stated that as Resident #5 was leaving the dining room Resident #4 stated, she rolled up behind her (Resident #5) in the hallway and stated, that's when I blacked out and then the next thing I knew staff told me that I grabbed her around her neck and was pulling her hair. Resident #4 stated that staff had to tell her what she did when she blacked out because she did not remember that she grabbed Resident #5 around her neck and pulled her hair. She stated staff also told her that on the same day, [DATE], there was another incident between the two Residents that occurred before she grabbed Resident #5 around her neck. Resident #4 said the Activity Assistant told her that while the two Residents were in the dining room before bingo, the Activity Assistant had to separate them because Resident #4 placed her arms around the neck of Resident #5 and pulled her forward. Resident #4 stated she did not recall putting her arms around the neck of Resident #5 and pulling her forward, but that Resident #5 must have continued to curse at her in order for her to physically assault Resident #5 twice. Resident #4 stated this was not her usual behavior, she stated I don't put my hands on people, and I asked God to forgive me for what I did. She stated that she did not have a chance to apologize to Resident #5 before she passed away and that she felt bad about that, but that Resident #5 should not have gotten in her face and cursed at her. Resident #4 stated that she talked to a Mental Health Nurse Practitioner after these incidents, who adjusted her medications for depression, which has helped. The Human Resources (HR) Director was interviewed on [DATE] at 1:20 PM and stated that on [DATE] she was in the DON's office sometime after lunch, she did not recall the exact time, when she heard Resident #4 say I told you not to f*** with me no more. When she went into the hallway, she saw Resident #4 and Resident #5 in the hallway in front of the dining room. The HR Director described that Resident #4's arm was around the neck of Resident #5, in a headlock, Resident #5's face was red, and she was gasping. The HR Director stated she told Resident #4 to let go of Resident #5, but she did not, so the HR Director had to physically separate them. The HR Director stated that the DON came into the hallway after the incident, so she reported to the DON what happened and called the Administrator to report to him what occurred. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on [DATE] at 5:30 PM occurred with the DON. She stated that she was notified on [DATE] by the HR Director that at around 1:45 PM, the HR Director overheard commotion coming from the hallway near the dining room. The HR Director said she went to the hallway and saw Resident #4 holding Resident #5 in a headlock. The HR Director said she separated the Residents, and Resident #5 was taken to her room. The DON stated she notified the Administrator, started an investigation, contacted law enforcement, and the RP for Resident #5. The DON said she assessed and interviewed both Residents. Resident #4 was assessed without injury and when she was interviewed, she explained she was tired of Resident #5 picking on her and this is what she gets. The DON said that about an hour later, Resident #4 came to her office, very remorseful and said she should not have choked Resident #5 but reported her concerns regarding Resident #5 to staff instead. She said that she just lost it. Resident #4 said that Resident #5 picked on her for weeks and she was tired of it. She stated that while the Residents were in the dining room, Resident #5 started banging on the kitchen door, asking for food. The kitchen staff gave her a sandwich and juice, but Resident #5 continued to yell out for more food. Resident #4 said she told Resident #5 to stop shouting and to eat the food she had. That's when Resident #5 cursed at her, so Resident #4 went up to Resident #5 and put her in a headlock. The DON stated that Resident #5 was assessed without injury, but during the assessment, she was still upset and cursing, so the DON had to allow her time to calm down. When Resident #5 was interviewed, she said that Resident #4 tried to choke her, but that she was fine. The DON said that both Residents were monitored every 15 minutes for two hours and then hourly for the next 24 hours. During the interview, the DON was asked by the Surveyor if she was aware that on [DATE] sometime before bingo, the Activity Assistant separated Resident #4 from Resident #5 in the dining room when she put her arms around the neck of Resident #5 and pulled her forward. The DON stated that she was not notified by staff that both Residents were separated earlier that day on [DATE] due to another physical altercation that occurred in the dining room. She said that if she had been made aware of the first physical altercation that occurred between the two Residents in the dining room, she would have separated the Residents then which would have prevented the second incident from occurring later in the hallway. The Administrator stated in an interview on [DATE] at 5:45 PM that he was notified on [DATE] that Resident #4 physically assaulted Resident #5 in the hallway after an argument occurred in the dining room. He stated that he told the staff to separate the Residents, assess them for injury, place the Residents on monitoring every 15 minutes for the first two hours and then hourly checks thereafter. He also informed staff to notify law enforcement, the MD, the RP for Resident #5, and APS. The Administrator stated that when he returned to work on [DATE], he spoke to Resident #4 about her behavior and advised her that she should have reported her previous concerns with Resident #5 to the DON, that her behavior was unacceptable and that he expected to see improvement. Resident #4 stated that she understood what she did wrong and that her behavior needed to improve. He stated that at the time of the incident, Resident #4 was being followed weekly by mental health services for depression and after the physical abuse toward Resident #5, she was referred for psych services. He said that he was not notified of a prior incident involving physical abuse by Resident #4 to Resident #5 on the same day. He stated that he expected residents to be protected from abuse and if he had been notified of the first incident of physical abuse by Resident #4 that occurred in the dining room, he would have strategized a plan to prevent further interactions between the two Residents and protected Resident #5 from further abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A phone interview with the MD occurred on [DATE] at 9:06 AM. The MD stated that she was notified that Resident #4 physically assaulted Resident #5 on [DATE] and that she remembered the incident vaguely. The MD stated she recalled Resident #4, physically assaulting other residents was not her history and such an incident had not occurred before with Resident #4. The MD stated both Residents were separated, both Residents were assessed without injury and assessed for any contributing factors that attributed to the events of [DATE]. The MD stated that Resident #4 was already followed by mental health services for a history of depression and when this occurred, she was referred for psych services. The MD stated that to her knowledge, Resident #4 had no further incidents of physical assault. The facility put ongoing monitoring into place for both Residents and the family of Resident #5 did not want to press charges. MD stated that the facility had a responsibility to protect all residents in the facility and due to the facility's high-risk population of residents with a mental health/behavior history, that made managing behaviors difficult. The MD stated that she was no longer the MD at the facility, but while she was the MD, the facility met the mental health needs of the residents by making mental health services readily available. 2. Resident #2 was admitted to the facility on [DATE] from a previous nursing home with diagnoses that included other sexual dysfunction not due to a substance or known physiological condition, dementia, mild with other behavioral disturbance, cerebrovascular accident with hemiplegia affecting the left non-dominant side, anxiety disorder, depression, and adjustment disorder with depressed mood. The February 2024 Medication Administration Record (MAR) for Resident #2 recorded a Physician (MD) order for Fluoxetine Hydrochloride (Prozac) 20 milligrams (mg) to give one tablet once daily for depression. The medication start date was [DATE]. A [DATE] Psychotherapy Diagnostic Assessment written by the Licensed Clinical Social Worker (LCSW) recorded Resident #2 displayed inappropriate sexual behaviors as noted in a previous assessment completed by the Psych Mental Health Nurse Practitioner (PMHNP) in a previous nursing home. The assessment also noted that Resident #2 met the criteria for adjustment disorder due to impulsivity and inappropriate sexual behaviors. A phone interview with the LCSW occurred on [DATE] at 11:08 AM. She stated that her initial visit with Resident #2 occurred on [DATE] for Psychotherapy Talk Services. She stated that he was referred to mental health services regarding his diagnoses of adjustment disorder and mild dementia with other behavioral disturbance. The LCSW said during her initial assessment on [DATE], he did not seem oriented and appropriate for services due to some confusion. The LCSW said she reviewed the progress notes of his history from the psych services he received while he was a Resident at the previous nursing home. The LCSW said she saw in the notes that he was accused by two female residents of inappropriately touching them, presented with mild cognitive impairment during his stay at the previous nursing home and received Prozac 20 mg daily to assist with sexual behaviors by decreasing his libido (sexual desire). The LCSW said she communicated to the Administrator that Resident #2 had a history of inappropriate touching while he was a Resident at the previous nursing home and that the electronic psych records from the previous nursing home were faxed to the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A [DATE] psychiatric initial consult progress note written by the Doctor of Nurse Practitioner, (DNP) recorded that Resident #2 was referred for mild dementia with other behavioral disturbance and other sexual dysfunction not due to a substance or known physiological condition. The DNP documented that she reviewed the prior psych records from the previous nursing home which indicated Resident #2 displayed inappropriate sexual behaviors when he was noted touching another female resident, but that he had not been noted to display any current sexual behaviors at the facility. The DNP documented that the Administrator informed her of a conversation he had with Resident #2 regarding his behaviors at the previous nursing home and advised that those types of behaviors were not allowed in the facility under any circumstances. The DNP recommended to continue Prozac 20 mg daily. The DNP was interviewed by phone on [DATE] at 8:07 AM. She stated that Resident #2 was admitted to the facility from the previous nursing home where he received psych services with the same provider group. The DNP said she had access to his prior psych records because the psych services were from the same provider group. She stated that when she reviewed his previous psych records she noted his history of inappropriate sexual behavior, which she spoke to the Administrator about on [DATE]. The DNP said Resident #2 was placed on Prozac 20 mg when he exhibited inappropriate sexual behaviors at the previous nursing home. The DNP said she had a very candid conversation with Resident #2 on her first visit with him on [DATE], regarding his behavior at the previous nursing home and he was informed that inappropriate sexual behavior was not going to be tolerated at the facility. A [DATE] admission Minimum Data Set assessed Resident #2 with adequate hearing, adequate vision, clear speech, understood by others, and understands others, intact cognition, no mood disorders, no behaviors, no functional limitation in upper/lower extremity range of motion (ROM), and he independently used a manual wheelchair for ambulation. Review of the [DATE] care plan for Resident #2 revealed he did not have a behavior symptoms care plan. During an interview on [DATE] at 3:00 PM, Resident #2 said a few days after he came to the facility, he told the Administrator and Director of Nursing (DON) about the time he touched (named Resident) at the previous nursing home. Resident #2 said They asked me if I had touched anyone inappropriate at (the previous nursing home) and I told them I touched her breast, she said I could, but the Administrator told me not to do that here, I told him that I would try to be good here, he said I had to behave and that I could not touch anyone here. During an interview with the Administrator and DON on [DATE] at 1:45 PM, the Administrator said the LCSW notified him after her first session with Resident #2 on [DATE] that she had access to the psych progress notes for Resident #2 from the previous nursing home since Resident #2 was seen by a Practitioner from the same provider group. Per the Administrator, the LCSW said when she reviewed the psych progress notes from the previous nursing home, she saw documentation that Resident #2 had poor, inappropriate behaviors at the previous nursing home that required one-to-one monitoring. The Administrator stated that the LCSW was not specific about the behaviors, and that he did not ask specifics, but that the Administrator and the DON went to Resident #2 and asked him what happened. The DON said when interviewed, Resident #2 said that he tried to fist bump two residents and accidentally contacted their shoulder, and then he said, I did not touch anyone. The Administrator stated he advised Resident #2 of the expectation to have appropriate behavior while he was a Resident at the facility, Resident #2 expressed understanding. The Administrator stated that he did not request the psych notes from the previous nursing home at that time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #3 was readmitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, major depressive disorder, and dementia without behavioral disturbance. A [DATE] quarterly MDS assessed Resident #3 with severely impaired cognition, dependent on staff for all activities of daily living (ADL) and used a wheelchair for ambulation. Resident #1 was admitted to the facility on [DATE] and discharged home on [DATE]. A [DATE] quarterly MDS assessment indicated Resident #1's cognition was intact. A [DATE] Facility Reported Investigation for resident abuse recorded that on [DATE] at 4:40 PM, staff notified nurse leadership of poor resident interaction that was witnessed by Resident #1. The Summary of Investigative Findings recorded that on [DATE], Resident #1 witnessed Resident #2 touch Resident #3 on the leg while the Residents were seated in the commons area of the [NAME] Unit. Resident #1 yelled for Resident #2 to stop touching the leg of Resident #3 which prompted staff to separate Resident #2 from Resident #3. Resident #2 was placed on one-to-one monitoring ongoing, Resident #3 was assessed without injury, and notifications were made to the Administrator, law enforcement, Adult Protective Services (APS), the Responsible Party (RP) for Resident #3, the Emergency Contact for Resident #2, and the MD. The Summary of Findings included a written statement from Resident #1 which recorded I, (Name of Resident), saw the young man put his hands between a resident's legs, the resident was trying to move his hands, but he continued to rub her between her legs or crotch; I saw it and approached him telling him to stop because it was wrong. A [DATE] police report noted that law enforcement was notified at 5:03 PM on [DATE] that the listed suspect (name withheld) sexually assaulted the victim (name withheld) at the facility on [DATE] at approximately 5:00 PM. The North Carolina Offense Category was listed as adult sex offense/assault/sexual battery, and the classification was listed as forcible fondling. Attempts to interview law enforcement were unsuccessful. A [DATE] 11:34 AM Triage Note from the DON to DNP recorded that on [DATE], Resident #2 was caught fondling a female resident who was oriented to self only due to dementia, the Resident (Resident #2) was placed on one-to-one since then, he is on Prozac for depression, please advise. The DNP responded on [DATE] to the Triage Note from the DON that Resident #2 was not on Prozac for depression, but for his history of inappropriate sexual behavior, to refer to the DNP progress note of [DATE], increase Prozac to 40 mg daily and under no circumstances leave Resident #2 alone with Resident #3. A [DATE] Resident Incident Report for Resident #3 recorded that on [DATE] at 5:00 PM, Resident #3 was seated in her wheelchair when Resident #1 screamed get away from her when she saw Resident #2 put his hands between the legs of Resident #3. The report recorded that Resident #3 began moving the hands of Resident #2, but Resident #2 continued rubbing the Resident's leg. The report described Resident #3 as alert to person only, the Immediate Action Taken as staff separated and monitored the two Residents, and the MD and RP for Resident #3 were notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A [DATE] Resident Incident Report for Resident #2 recorded that on [DATE] at 5:38 PM, Resident #1 yelled What are you doing at Resident #2 and accused him of rubbing Resident #3 between her legs. The Resident Incident Report described Resident #2 as alert, oriented to person, place, and time. The Immediate Action Taken recorded Resident #2 was sent to the emergency room (ER) for a psych evaluation and returned to the facility before midnight with no new orders. The Administrator, MD and Emergency Contact for Resident #2 were notified of the incident. During review of the [DATE] Resident Incident Report for Resident #2, with the Administrator on [DATE] at 12:30 PM, he stated that the date of [DATE] was an error and should have been [DATE]. The medical record for Resident #2 included progress notes from the previous nursing home faxed to the facility on [DATE] at 10:02 AM which included the following: - A Triage Note dated [DATE] recorded Resident #2 inappropriately touched another resident's breast and the staff requested medication management. - A Physician Assistant (PA) progress note dated [DATE], recorded the PA was asked to assess Resident #2 for sexual behavior issues due to complaints by staff of inappropriate gestures and touching. The progress note recorded a MD order was written for a psych referral and for Prozac 20 mg daily. - A Psych Mental Health Nurse Practitioner (PMHNP) progress note dated [DATE], recorded Resident #2 was seen for an urgent Telehealth psych evaluation for the diagnoses of mild dementia, with other behavioral disturbance and other sexual dysfunction not due to a substance or known physiological condition after accusations from two female residents of inappropriately touching them. The progress note recorded that Resident #2 reported to the PMHNP when interviewed that he accidently touched a female resident. The progress note recorded that the Resident was placed on Prozac 20 mg daily after this incident to assist with sexual behaviors by reducing his libido. A [DATE] psychotherapy progress note written by the LCSW recorded that staff reported that on [DATE], Resident #2 displayed inappropriate sexual behaviors. The progress note recorded that Resident #2 acknowledged during the [DATE] psychotherapy session that he inappropriately touched a resident, made hand motions towards his private area when asked where he touched the resident and stated that the resident said he could. The note also recorded that Resident #2 stated that he was being kept in his room, but that he did not want to stay there when he referred to the one-on-one support provided by the facility because of his inappropriate behavior. The progress note recorded that he expressed he understood that he should not ask other peers to be touched inappropriately as some residents may not have the cognition to consent appropriately. The progress note recorded Resident #2 received Prozac 40 mg daily to decrease libido and manage his sexual behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing and Rehabilitation Center	1930 West Sugar Creek Road Charlotte, NC 28262

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #2 was interviewed on [DATE] at 1:00 PM. He stated that he was recently admitted to the facility and that since his admission, staff spoke to him about touching a resident. Resident #2 said he touched a resident on her vagina while she was clothed. When asked to show the surveyor where he touched the Resident, he touched the center of his pubic area and said, I touched her here, I asked her if I could touch her, and she said yes. He said they were in the TV area watching TV near the nurse's station when he touched Resident #3. Then he said, But then (named Resident #1) yelled at me to stop, I told her what is it to you, nobody is touching you, but she told on me, so I am supposed to be going to court so [NAME] can get guardianship of me. A [AGE] year-old with a guardian, what do I need a guardian for? Now I have a sitter with me all the time. It's like I am a chap. When asked if anything like this happened before he said yeah, I had a sitter while I was at a (previous nursing home), I touched a lady there, I asked her too and she said I could, but then I got in trouble and had to be watched. Resident #3 was interviewed on [DATE] at 1:19 PM and did not recall the sexual abuse that occurred on [DATE]. The Medication Aide (MA) was interviewed on [DATE] at 4:22 PM and stated she was the assigned MA on [DATE] on the [NAME] Unit. The MA s [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety 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** 20934 Based on a resident interview, staff interviews and record review, the facility failed to report an incidence of physical abuse to facility administration to protect a resident from further physical abuse. Resident #5 experienced physical abuse twice on 12/27/23. Both incidents occurred on 12/27/23 before 2:30 PM. Resident #4 first physically assaulted Resident #5 in the dining room. This occurrence of physical abuse was not reported to the facility administration. As a result, Resident #4 physically assaulted Resident #5 again in the hallway. The deficient practice occurred for 1 of 4 sampled residents reviewed for abuse (Resident #5). The findings included: The facility's policy, Abuse Prevention, Intervention, Reporting and Investigation, effective November 2016, recorded in part, The facility will ensure the protection, prompt reporting, and interventions in response to alleged, suspected, or witnessed abuse of any resident. It is the responsibility of employees to promptly report to facility management any incident or suspected incident of abuse from other residents, staff, family, or visitors. Residents are to be protected during incident investigations by ensuring the administrator is immediately informed. A resident who is allegedly mistreated by another resident is removed from contact with that resident during the investigation. It is the facility policy that residents will be protected from alleged offender(s). Resident #5 readmitted to the facility on [DATE]. Diagnoses included dementia with agitation, anxiety disorder, mood affective disorder, psychosis, and major depressive disorder. Resident #4 readmitted to the facility on [DATE]. Resident #4 was her own responsible party (RP). Diagnoses included recurrent major depressive disorder, post-traumatic stress disorder, and anxiety disorder. Review of a Facility Reported Incident completed by the Director of Nursing (DON) and dated 12/27/23 at 1:45 PM indicated Resident #4 and Resident #5 were both in the dining room when Resident #5 shouted to dietary staff that she was hungry. Resident #5 received a sandwich and juice but continued to shout for more food. Resident #4 asked Resident #5 to stop harassing the dietary staff at which time Resident #5 turned to Resident #4 and responded with expletives. Resident #4 stated that she became extremely frustrated because Resident #5 had been harassing her for weeks, and that this incident made her so angry that she rolled up behind Resident #5 in the hallway and put her in a headlock from behind. A Resident Incident Report for Resident #5 completed by the DON recorded that on 12/27/23 at 1:45 PM, Resident #4 and Resident #5 were both in the dining room when Resident #5 began to harass the kitchen staff. When Resident #4 told Resident #5 to stop harassing the staff, Resident #5 turned to Resident #4 and cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a chokehold in the hallway, witnessed by the Human Resources (HR) Director, because Resident #5 had been harassing her for weeks. The Resident Incident Report documented that Resident #5 was assessed by the DON without injury. The Resident Incident Report did not record that a second incident of physical abuse by Resident #4 against Resident #5 also occurred on 12/27/23 before 2:30 PM. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing General Note dated 12/28/23 at 8:38 AM by the DON recorded that on 12/27/23 at approximately 1:45 PM, Resident #5 and Resident #4 were in the dining room. Resident #4 reported that Resident #5 started harassing kitchen staff and when Resident #4 asked Resident #5 to stop harassing the kitchen staff, Resident #5 cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a chokehold because Resident #5 had been harassing her for weeks. Staff heard the commotion and separated the Residents. The Nursing General Note recorded that Resident #5 was assessed without injury. The Nursing General Note dated 12/28/23 did not record that a second incident of physical abuse by Resident #4 against Resident #5 also occurred on 12/27/23 before 2:30 PM. During an interview with Resident #4 on 4/11/24 at 10:30 AM, and a follow-up interview on 4/12/24 at 9:15 AM, she stated that on 12/27/23, she remembered that she and Resident #5 were in the dining room sometime before bingo which was scheduled for 2:30 PM, when Resident #5 kept messing with staff in the kitchen saying she was hungry. Resident #4 said she told Resident #5 to leave the kitchen staff alone and to eat the food she had been given. At that time, Resident #5 turned to her, got in her face, and said f*** you. Resident #4 said she got so tired of Resident #5 talking to her that way, so she knocked on the activity door, which was an office inside the dining room, but then decided she would go find a staff member. Resident #4 stated that as Resident #5 was leaving the dining room Resident #4 stated, she rolled up behind her (Resident #5) in the hallway and stated, that's when I blacked out and then the next thing I knew staff told me that I grabbed her around her neck and was pulling her hair. Resident #4 stated that staff had to tell her what she did when she blacked out because she did not remember that she grabbed Resident #5 around her neck and pulled her hair. She stated staff also told her that on the same day, 12/27/23, there was another incident between the two Residents that occurred before she grabbed Resident #5 around her neck. Resident #4 said the activity assistant told her that while the two Residents were in the dining room before bingo, the activity assistant had to separate them because Resident #4 placed her arms around the neck of Resident #5 and pulled her forward. Resident #4 stated she did not recall putting her arms around the neck of Resident #5 and pulling her forward, but that Resident #5 must have continued to curse at her in order for her to physically assault Resident #5 twice. Resident #4 stated this was not her usual behavior, she stated I don't put my hands on people, and I asked God to forgive me for what I did. She stated that she did not have a chance to apologize to Resident #5 before she passed away and that she felt bad about that, but that Resident #5 should not have gotten in her face and cursed at her. Resident #4 stated that she talked to a mental health nurse practitioner after these incidents, who adjusted her medications for depression, which has helped. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Activity Director (AD) and the Activity Assistant occurred on 4/11/24 at 5:37 PM. During the interview, the AD stated that on 12/27/23, she did not know the exact time, but sometime before bingo which was scheduled at 2:30 PM, she was in her office, which was a room inside the dining room, and she heard Resident #5 talking loudly in the dining room and using profanity. Resident #4 told Resident #5 nobody wants to hear that. During the interview, the Activity Assistant stated that before the 2:30 PM bingo activity, she was not sure of the exact time, she was in/out of the dining room setting up bingo, and she told Resident #5 to calm down. The Activity Assistant stated that Resident #5 got upset, continued using profanity and yelled at Resident #4 b**** I will f*** you up. The Activity Assistant stated she called the AD to come and help her when she saw Resident #5 propel in her wheelchair towards Resident #4, Resident #4 put her arms around the neck/shoulders of Resident #5 and pulled her forward. The Activity Assistant stated she separated the Residents, directed Resident #4 to go to her room while the AD took Resident #5 to her room. The Activity Assistant said she returned to setting up bingo and that she did not report to administration that she had to separate the two Residents. The interview continued and the AD stated that the Activity Assistant asked for her help. The AD stated that when she came out of her office into the dining room, she saw the Activity Assistant pulling the two residents apart. The AD said that the Activity Assistant told her what occurred, the AD took Resident #5 to her nurse (Nurse #1), reported the incident to Nurse #1 and returned to the dining room for bingo. The AD stated that she did not report the incident to the administration, but rather took Resident #5 to her Nurse. Nurse #1 was interviewed via phone on 4/12/24 at 3:35 PM. He stated that he was the assigned Nurse on the South Unit for the 7A - 3P shift on 12/27/23. He stated that close to the end of the shift on 12/27/23 he heard staff stating that Resident #5 said something to Resident #4 that got her upset and caused her to hit Resident #5. Nurse #1 said he was told that an incident report had been made, but he could not recall who told him that, so he did not make a report about the incident because he did not witness it and he was not asked to do any follow up. Nurse #1 said after he heard about the incident, he did recall seeing Resident #5 in her wheelchair at the end of the hall near her room, but that she did not mention what occurred. Nurse #1 said he was not made aware that there were two incidents between Resident #4 and Resident #5 that day. Nurse #1 stated that if staff had reported the first incident directly to him, he would have contacted the DON and administrator to get the police involved if a resident was assaulted and followed the facility's abuse policy to protect Resident #5 from further physical abuse. The Human Resources (HR) Director was interviewed on 4/11/24 at 1:20 PM and stated that on 12/27/23 she was in the DON's office sometime after lunch, she did not recall the exact time, when she heard Resident #4 say I told you not to f*** with me no more. When she went into the hallway, she saw Resident #4 and Resident #5 in the hallway in front of the dining room. The HR Director described that Resident #4's arm was around the neck of Resident #5, in a headlock, Resident #5's face was red, and she was gasping. The HR Director stated she told Resident #4 to let go of Resident #5, but she did not, so the HR Director had to physically separate them. The HR Director stated that the DON came into the hallway after the incident, so she reported to the DON what happened and called the administrator to report to him what occurred. The HR Director stated that she was not aware of a second incident of physical abuse by Resident #4 towards Resident #5 that occurred in the dining room. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 4/11/24 at 5:30 PM occurred with the DON. She stated that she was notified on 12/27/23 by the HR Director that at around 1:45 PM, the HR Director overheard commotion coming from the hallway near the dining room. The HR Director said she went to the hallway and saw Resident #4 holding Resident #5 in a headlock. The HR Director said she separated the Residents, and Resident #5 was taken to her room. The DON stated she notified the administrator and started an investigation. The DON said that both Residents were monitored every 15 minutes for two hours and then hourly for the next 24 hours. During the interview, the DON was asked by the surveyor if she was aware that on 12/27/23 sometime before bingo, the activity assistant separated Resident #4 from Resident #5 in the dining room when she put her arms around the neck of Resident #5 and pulled her forward. The DON stated that she was not notified by staff that both Residents were separated earlier that day on 12/27/23 due to another physical altercation that occurred in the dining room before bingo. She said that if she had been made aware of the first physical altercation that occurred between the two Residents in the dining room, she would have separated the Residents then which would have prevented the second incident from occurring later in the hallway. The Administrator stated in an interview on 4/11/24 at 5:45 PM that he was notified on 12/27/23 by the DON that Resident #4 physically assaulted Resident #5 in the hallway after an argument occurred in the dining room. He stated he did not recall the exact time he was notified. He stated that he told the staff to separate the Residents, assess them for injury, place the Residents on monitoring every 15 minutes for the first two hours and then hourly checks thereafter. When asked by the Surveyor if he was aware that two incidents of physical abuse occurred on 12/27/23 between the two Residents, he said that he was not notified of a prior incident involving physical abuse by Resident #4 to Resident #5 on the same day. He stated that he was only aware of the physical abuse by Resident #4 that occurred in the hallway. He stated that he expected residents to be protected from abuse and if he had been notified of the first incident of physical abuse by Resident #4 that occurred in the dining room, he would have strategized a plan to prevent further interactions between the two residents and protected Resident #5 from further abuse that occurred in the hallway. The Administrator and the DON were notified of immediate jeopardy on 4/12/24 at 2:05 PM. The facility provided the following corrective action plan with a completion date of 12/29/23. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/27/23 during the 7a - 3p shift, the Activity Director reported to nursing that Resident #4 placed both arms around the neck/shoulder area of Resident #5, a confused resident, and pulled Resident #5 towards her when she was approached by Resident #5 in the dining room after a verbal altercation between the two Residents. This resident-to-resident altercation was not reported to the administration, and therefore protection was not put into place or implemented. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/27/2023, at approximately 1:45pm, Resident # 4 was sitting in the facility's dining room in her wheelchair when a staff member brought Resident #5 into the dining room. Resident # 5 proceeded to shout that she was hungry to get the attention of the kitchen staff. A sandwich and juice were brought to the resident, but the resident continued to shout out after the kitchen staff went back into the kitchen and closed the door. Resident #4 then asked Resident #5 to stop harassing the kitchen staff and eat the food that was brought to her. On hearing what Resident #4 stated, Resident #5 turned around and uttered expletives to Resident #4. Resident #4 explained that when she heard the expletives, she was extremely frustrated because Resident #5 has been harassing her for weeks and this incident made her get so angry that she rolled up to Resident #5 and put her in a headlock from behind. Staff members outside the dining room heard the commotion and ran in to separate the two residents. The residents were separated by the Human Resources (HR) Manager. Resident #5 was examined by the Director of Nursing for any injuries. No injuries were noted, and the resident was taken to her room while Resident #4 was allowed to remain in the dining room. The facility's Nurse Practitioner was informed of the incident on 12/27/2023. Law Enforcement was notified on 12/27/2023 and Adult Protective Services (APS) was notified on 12/27/2023. Resident #4 is her own Responsible Party. Resident #5's Responsible Party was notified. Resident # 4 was placed on Q15mins every 15 minutes) checks for 2hrs (hours) and then Q1hr for the next 24 hrs on 12/27/2023. No aggressive behavior was observed during the observation period. Resident #4's next psych visit was 1/9/2024. No changes were made to the medications. Progress notes states that the resident will have follow up in one month. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 12/27/2023 abuse questionnaires were completed by the facility's Social Worker on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses to determine if any other residents had any unidentified allegations of abuse that had not been reported. The questions included with Social Worker Assistant's interviews with residents were the following: 1. Have you had inappropriate interactions with others that was uncomfortable? i.e. personal space was crossed with another resident. If so, describe specifically your encounter in detail. 2. Have you observed poor interactions from residents on your unit toward others, if so, describe your observation. Based on resident interviews there were no other reported incidents of abuse from any residents. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing educated current facility staff on the facility abuse policy. Education was completed on 12/27/2023. Education included but not limited to the various types of abuse such as physical, mental, sexual, neglect, misappropriation of property, and involuntary seclusion. Education is also inclusive of the procedure for reporting any observed or suspected events of abuse. Education also included the importance of protecting residents following an allegation of abuse. Staff will not be permitted to work until education is completed. The Director of Nursing will verify completion of education. Education will be included in new hires orientation by Human Resources as of 12/28/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing/Unit Managers will audit progress notes and incident reports during clinical meetings beginning on 12/27/23 to ensure any behaviors or altercations between residents were reported to administrator and/or Director of Nursing. Auditing will be completed 5 x per week for 4 weeks then weekly for 4 weeks starting on 12/27/2023. The Director of Nursing will report all findings of audits to the Quality Assurance Performance Improvement committee monthly until substantial compliance is obtained. Facility completed AdHoc QAPI to review investigation and current action plan to ensure all components were done and followed on 12/27/2023. IJ removal date: 12/29/2023 On 4/29/24 the facility's credible allegation of immediate jeopardy removal date of 12/29/23 was validated. The validation was evidenced by interviews with staff and residents, record review, and review of in-service agendas and staff attendance records. In-service agendas and staff attendance records revealed staff were in-serviced on the facility's Abuse, Prevention, Intervention, Reporting, and Investigation policy, effective November 2016, One on One Monitoring and updating the care guide. Interviews conducted with staff from all shifts and all disciplines, and interviews conducted with residents indicated knowledge of the in-services provided. Review of QA records, monitoring tools and audits revealed ongoing monitoring systems were in place by the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on record review and staff interviews the facility failed to develop a comprehensive person-centered individualized care plan for a resident with behaviors for 1 of 3 sampled residents (Resident #4). The findings included: Resident #4 readmitted to the facility on [DATE] with diagnoses that included recurrent major depressive disorder, post- traumatic stress disorder, and anxiety disorder, among others. A review of the 8/4/23 care plan for Resident #4 revealed it did not include a behavior symptoms care plan. A 12/4/23 quarterly Minimum Data Set (MDS) assessment evaluated Resident #4 with adequate hearing and vision (with corrective lenses), clear speech, made self-understood, able to understand others, intact cognition, and no behavior symptoms. A Nursing General Note dated 12/28/23 at 8:38 AM written by the Director of Nursing (DON) recorded that on 12/27/23 at approximately 1:45 PM, Resident #5 and Resident #4 were in the dining room. Resident #4 reported that Resident #5 started harassing kitchen staff and when Resident #4 asked Resident #5 to stop harassing the kitchen staff, Resident #5 cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a chokehold because Resident #5 had been harassing her for weeks. A 1/4/24 quarterly MDS assessment evaluated Resident #4 with adequate hearing and vision (with corrective lenses), clear speech, makes self-understood, able to understand others, intact cognition, and physical behavior symptoms directed towards others for 1 to 3 days of the assessment period. A review of the care plan on 4/10/24 revealed Resident #4 did not have a behavior symptom care plan. A phone interview on 4/18/24 at 2:30 PM with the Social Services Director (SSD) revealed she was not the SSD at the facility in December 2023, but that her department was responsible for completing the cognition section of the MDS and behavior care plans. She stated that if a resident displayed a new behavior symptom that occurred more than once, a care plan for behavior symptoms should be developed to monitor the resident and to see if the resident continued to exhibit the behavior. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/18/24 at 1:22 PM with the MDS Nurse, she reviewed the medical record for Resident #4. The MDS Nurse stated that the 12/4/23 quarterly MDS assessed Resident #3 without behaviors symptoms, but the 1/4/24 quarterly MDS assessed Resident #4 with physical behavior symptoms directed towards others, due to the 12/28/23 Nursing General Note that documented physical behavior symptoms. The MDS Nurse stated that the care plan for Resident #4 did not have a behavior symptoms care plan until she added it on 4/15/24 at the direction of the Administrator. The MDS Nurse stated that the behavior symptoms care plan for Resident #4 should have been developed by Social Worker (SW #1) at the time she displayed behavior symptoms on 12/27/23. During a phone interview on 4/19/24 at 9:03 AM, SW #1 stated that she ended her employment at the facility on 1/12/24. She stated that she was notified of a new behavior for Resident #4 on 12/27/23 and witnessed an interview with Resident #4 regarding physically assaulting Resident #5. SW #1 said when interviewed, Resident #4 stated that Resident #5 was going off at the mouth and because of that, Resident #4 said she put Resident #5 in a chokehold. SW #1 stated she educated Resident #4 that her behavior was inappropriate, and that she knew that she could not put her hands on residents. Resident #4 expressed understanding. SW #1 stated that she was responsible for the completion of the behavior section of the MDS and for developing behavior symptom care plans. SW #1 stated that she did not develop a behavior symptom care plan for Resident #4 regarding physical abuse directed toward others, because it was an oversight and that the care plan should have been developed. During an interview on 4/12/24 at 1:45 PM with the Administrator and the DON, they both stated that a behavior symptoms care plan should have been developed for Resident #4 related to her physical behavior that occurred twice with Resident #5 on 12/27/23. The administrator stated that at the time of the incident, developing a behavior symptoms care plan was not discussed with the interdisciplinary team or considered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing and Rehabilitation Center	1930 West Sugar Creek Road Charlotte, NC 28262

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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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 20934 Based on staff interviews and record review, the facility failed to have an accurate facility assessment that recorded the current Medical Director and changes to administrative personnel. This failure occurred for a facility census of 99 residents. The findings included: The facility assessment was reviewed and recorded the last update and review by the facility's quality assurance, performance, and improvement (QAPI) committee occurred in January 2024. Page one of the facility assessment recorded the name of the former Medical Director. Pages 14 and 15 recorded the facility's Staffing Plan and the number of staff available to meet resident needs. The facility's Staffing Plan recorded that the Assistant Director of Health Services (Assistant to the Director of Nursing (DON)) provided 0.5 full-time equivalent hours and the Staff Development Coordinator (SDC) provided 0.5 full-time equivalent hours. During an interview on 4/10/24 at 1:30 PM the DON stated that she started her role at the facility at the end of May 2023 and that since she started, she did not have an assistant and the facility did not currently have a SDC. The DON stated that the unit managers reported directly to her and that she was responsible for providing staff education unless otherwise delegated. The DON stated that she was responsible for managing the nursing department, unit managers and that she educated staff. The Administrator was interviewed by phone on 4/18/24 at 2:02 PM. He stated that he updated the facility assessment in January 2024 and at the time the facility's Medical Director was not the current Medical Director. He stated that the current Medical Director started at the facility on 4/1/24. The Administrator stated that at the time he updated the facility assessment in January 2024, the DON did not have an assistant and the facility did not have a SDC. He stated that at the time, he included in the facility assessment a budget for these positions, an anticipation of what the facility could afford, but that he did not have anyone in those roles at the time the facility assessment was updated in January 2024. He stated that the Unit Managers reported directly to the DON and that either the DON, the Administrator or a designee provided staff education. He stated that he was aware that the facility assessment should reflect a current facility status, but that he included these roles as part of his anticipated budget. He stated that the facility assessment did not reflect these changes due to prioritizing other responsibilities. He stated that the changes to the facility assessment would likely occur during the next quarterly QAPI meeting scheduled for April 2024.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 20934 Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 08/13/21, the complaint investigation survey of 09/29/22 and the current complaint investigation survey of 4/29/24. This failure occurred for three repeat deficiencies originally cited in the areas of freedom from abuse and neglect, develop and implement abuse and neglect policies, and comprehensive resident centered care plans that was subsequently recited on the current complaint investigation survey of 4/29/24. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F600: Based on observations, record review, resident, physician, and staff interview the facility failed to protect a severely cognitively impaired resident from the right to be free from physical abuse (Resident #5). Resident #5 experienced physical abuse twice on 12/27/23 before bingo when Resident #4 placed her arm around the Resident's neck, and pulled her forward, and then on the same day, placed Resident #5 in a chokehold with her arm. Resident #5 was held in that position which caused the resident to gasp and her face to become red. The facility failed to protect a severely cognitively impaired resident from the right to be free from sexual abuse (Resident #3). Resident #3 experienced sexual abuse on 2/26/24 when Resident #2 touched and rubbed her pubic area. Based on the reasonable person concept, being placed in a chokehold and non-consensual sexual contact would cause a reasonable person to experience psychosocial harm, trauma and fear from physical or sexual abuse. Abuse occurred for 2 of 4 sampled residents reviewed for protection from abuse. During the complaint investigation survey of 09/29/22, the facility failed protect four residents from verbal and physical abuse when the same resident shook a resident, pushed a resident to the ground, grabbed a resident by the wrist causing a bruise, punched another resident in the chest and caused a resident to be fearful when the resident was threatened verbally with physical harm. F607: Based on a resident interview, staff interviews and record review, the facility failed to report an incidence of physical abuse to facility administration to protect a resident from further physical abuse. Resident #5 experienced physical abuse twice on 12/27/23. Both incidents occurred on 12/27/23 before 2:30 PM. Resident #4 first physically assaulted Resident #5 in the dining room. This occurrence of physical abuse was not reported to the facility administration. As a result, Resident #4 physically assaulted Resident #5 again in the hallway. The deficient practice occurred for 2 of 4 sampled residents reviewed for abuse (Resident #5). During the complaint investigation survey of 09/29/22, the facility failed to implement their abuse policy to report an allegation of verbal abuse to the state agency. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F656: Based on record review and staff interviews the facility failed to develop a comprehensive person-centered individualized care plan for a resident with behaviors for 1 of 3 sampled residents (Resident #4). During a recertification and complaint investigation survey of 8/13/21, the facility failed to develop care plans for three residents in the areas of Pre-Admission Screening and Resident Review, pressure ulcers and smoking. The Administrator stated in a phone interview on 4/18/24 at 2:09 PM that the facility's QAPI committee met quarterly with the department managers, the Medical Director, and the pharmacist to review corporate directives and the outcome of prior surveys. He stated the continued non-compliance in the areas of abuse and care plans was attributed to staff turnover, and staff communication. He stated that the current facility staff were not the same staff in the facility during the surveys of 2021 and 2022 and that although staff education was included in orientation regarding abuse and care plans, the facility would need to engage in staff education on abuse and care plans outside of resident incidents that occurred.