| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255297 | A. BUILDING _____ B. WING _____ | C 09/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BEDFORD CARE CTR-MONROE HALL | 300 CAHAL STREET HATTIESBURG, MS 39401 |

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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted a complaint survey, MS Complaint #18085, at the facility from 09/21/21 through 09/22/21. During the survey, The SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate the complaint for verbal and physical abuse, but cited other related deficiencies at F609 and F610.<br><br>At the time of survey, the facility had a census of 71 and held a license for 80 beds. | F 000 | | |
| F 609 SS=E | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all | F 609 | | 10/21/21 |

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

Electronically Signed | 10/22/2021

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| F 609 | Continued From page 1<br>investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interview, staff interview and facility policy review, the facility failed to report an allegation of physical abuse and/or verbal abuse for two (2) of 4 sampled residents investigated for abuse of 20 residents screened for abuse. Resident #1 and Resident #2.<br><br>Findings Include:<br><br>A review of the facility's policy titled "Abuse Prevention Program", with a revision date of December 2017 and review date of July 2019, revealed administration was to identify, assess, investigate, and report any allegation of abuse within timeframes as required by federal requirements.<br><br>A review of the facility's policy titled "Abuse Investigation and Reporting" with a revision date of July 2017 and a review date of July 2019 revealed "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ('Abuse") shall be promptly reported to local, state, federal agencies (as defined by current regulations) ...An alleged violation of abuse, neglect, exploitation or mistreatment ...will be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse ..." | F 609 | Disclaimer:<br><br>Bedford Care Center-Monroe Hall, LLC acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of the findings is factually correct and in order to maintain compliance with applicable rules and regulations. Please accept this Plan of Correction as our allegation of compliance. Bedford Care Center-Monroe Hall, LLC's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that any deficiency is accurate.<br><br>Resident#1 was assessed by the Director of Nursing on 9/17/2021, and Resident #2 was assessed by the Staff Development Nurse and the Nurse Unit Manager on 9/17/2021, and both residents were not found to have any physical or psychosocial harm nor did they state any | |

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| F 609 | Continued From page 2<br><br>Resident #1<br><br>A review of the facility's Face Sheet for Resident #1 revealed the facility admitted the resident on 6/4/21 with diagnoses including Hemiplegia, Hemiparesis, Aphasia, and Dysphagia all following Nontraumatic Intracerebral Hemorrhage (Stroke), and Dementia.<br><br>A review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/25/21, revealed Resident #1 had no Brief Interview for Mental Status (BIMS)score, which indicated the resident had significant cognitive impairment.<br><br>A review of Resident #1's Medical Record revealed no documentation related to an allegation of abuse, and no notification to the physician, practitioner, or Responsible Party (RP) regarding an allegation of abuse.<br><br>An interview on 9/21/21 at 11:10 AM with the Administrator and the Director of Nurses (DON) revealed they had not had any recent complaints or incidents reported to them.<br><br>In an interview on 9/21/21 at 12:51 PM with the DON she stated "There was a thing between two staff not getting along. Certified Nurse Assistant (CNA) #2 wrote a note and gave it to someone but not me. As soon as I found out I did an investigation." The SA requested a copy of the investigation.<br><br>A review of the facility's investigation revealed a note written by CNA#2 alleging verbal and | F 609 | problems related to the alleged deficient practice.<br><br>All residents have the potential to be affected by the alleged deficient practice.<br><br>An inservice was conducted by the Corporate Compliance Officer for the Administrator and the Director of Nursing on 10/7/21 regarding the Policies and Procedures for abuse prevention, investigation and reporting that include, but not limited to " all allegations of abuse, including injury of unknown origin, will be investigated and reported according the the facilty's policy and within the timeframes as required by federal requirements." An inservice was also, conducted for all the staff by the Staff Development Nurse on 9/21/2021 regarding the policies and procedures for reporting of the alleged abuse, neglect exploitation of a vulnerable adult and on the policies on Abuse Prevention, Investigation and Reporting.<br><br>Daily, beginning October 8, 2021, the Clinical Interdisciplinary Team along with the Administrator will monitor its effectiveness by discussing any reports of alleged abuse with the required reporting documentation related to the facility policies and procedures during the Standards of Care daily meetings Monday through Friday, for maintaining | |

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| F 609 | Continued From page 3<br>physical abuse of Resident #1 by CNA#1.<br><br>On 9/21/21 at 12:55 PM an interview with the Director of Nursing (DON) revealed she did not report the written allegation of verbal and physical abuse to the State Agency (SA) or any other entity as she determined the allegation to be false based on her investigation.<br><br>An observation on 9/21/21 at 12:59 PM revealed Resident #1 in the common area seated in a Geri chair. The resident responded when spoken to but was unable to engage in conversation beyond her immediate self. Resident responded she felt "ok" and responded "no" when asked if she was hurting anywhere. When asked other questions she had no response.<br><br>An observation on 9/21/21 at 2:15 PM of Resident #1 revealed her resting quietly in her bed in her room with her eyes open. Resident #1 was able to respond when spoken to and when asked if she was comfortable responded "We're alright". She did not answer any other questions. She appeared comfortable with no indication of distress.<br><br>On 9/21/21 at 2:18 PM an interview with CNA #1 revealed she had been called in to the DON's office on the afternoon of 9/17/21 regarding an allegation of abuse against her related to Resident #1. CNA #1 stated she had written and submitted a statement denying all allegations. CNA #1 stated she worked fast but was not abusive and denied verbally or physically abusing Resident #1.<br><br>On 9/21/21 at 2:40 PM an interview with CNA #2 revealed she had worked at the facility "a little | F 609 | compliance. The Administrator and Director of Nursing will give an oral report monthly, beginning October 20, 2021, to the Quality Assurance and Assessment Committee along with the Quality Assurance Performance Improvement Committee, that includes the Medical Director on all "Allegations, Abuse and Any reports to the MS State Department of Health" and will show the documents as required in the policies and procedures if any allegations of abuse are reported. Any concerns or issues will addressed immediately and reported to the corporate ompliance Officer in order to maintain and sustain compliance. | |

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| F 609 | Continued From page 4 | F 609 | | |

over a year". She confirmed she had worked Friday 9/17/21. She stated she went into the room with Resident #1 and CNA #1 at approximately 10:00 AM to help get the resident dressed for a visit. CNA #2 stated she had witnessed what she considered an act of verbal and physical abuse against Resident #1 by CNA #1. CNA #2 stated she spoke to the MDS Nurse and told her what happened. CNA #2 stated she was advised to write a statement and give it to her (the MDS Nurse), and it would be given to the DON. CNA #2 stated she followed the instructions of the MDS Nurse immediately and wrote a statement and gave it to the MDS Nurse "around lunch time". CNA #2 stated that she also learned there had been another incident involving CNA #2 on 9/17/21 in which Resident #2 had reported CNA #2 for "being rough with her".

An interview on 9/21/21 at 3:00 PM with the MDS nurse revealed on the morning of 9/17/21 CNA #2 reported an incident that morning at approximately 11:00 AM involving CNA #1 being "rough" with Resident #1 and "saying things she shouldn't in front of the resident". The MDS Nurse stated her instructions to CNA #2 were to write a statement and give it to the DON, in accordance with facility policy and procedure. The MDS Nurse stated CNA #2 did write a statement and gave it to her, (the MDS Nurse) and she in turn gave the statement to the DON "around lunch time".

Resident #2

A review Resident #2's Face Sheet revealed Resident #2 was admitted by the facility on 8/27/21 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction (Stroke) Affecting Right Dominant Side.

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| F 609 | Continued From page 5 | F 609 | | |

A review of Resident #2's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/3/21 revealed the resident had a Brief Interview for Mental Status (BIMS) indicated moderate cognitive impairment.

An interview on 9/21/21 at 3:17 PM with RN#1 revealed she was the RN supervisor on the 9/17/21 "day shift". RN #1 denied being notified by CNA #2 of any alleged abuse of Resident #1 but stated she had been made aware that a complaint had been voiced regarding alleged abuse against Resident #2 by CNA #1 and went to check on Resident #2 along with the RN #2. RN #1 stated Resident #2 confirmed that she felt that CNA #1, who was assigned to assist her on 9/17/21, had "moved too fast" while providing care. RN #1 stated she and RN #2 assessed Resident #2 and noted no signs of injury or abuse, and Resident #2 denied pain or injury. RN #1 stated she reassigned Resident #2 to CNA #3. RN #1 stated "I let the DON know as well".

On 9/21/21 at 3:45 PM an interview with Resident #2 revealed she was alert, oriented, and able to communicate well. Resident #3 stated CNA #1 was her CNA on 9/17/21 during the 7-3 shift. Resident #2 stated she had suffered a stroke which left her unable to use her right side including her right arm and right leg. Resident #2 stated that on 9/17/21 she reported to RN #1, RN #2, and the DON that "She (CNA #1) was moving too fast". Resident #2 stated she did not intend to report it because "I didn't want to make a big deal out of anything". Resident #2 denied pain and stated, "I wasn't hurt, she was just moving too fast, and I didn't like it". Resident #2 stated she had never had any problem or conflict of any kind with CNA #2 prior or since the 9/17/21 incident.

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| F 609 | Continued From page 6 | F 609 | | |

Resident #2 confirmed she reported the incident to RN #1 and the RN #2 but had not reported it to anyone else, until the DON came and asked her about it the same day.

On 9/21/21 at 5:12 PM the DON confirmed she was aware of both complaints about CNA #1 on Friday 9/17/21. She stated she received and read the statement written by CNA #2 "around 4:50 PM". The DON stated she had not notified the families or RPs of the allegations of abuse. The DON stated the physician, nor the facility's Medical Director had been notified. The DON stated she and the Administrator spoke about the allegation on 9/17/21 and the Administrator read both the statement written by CNA #2 and a statement of response written by CNA #1. The DON stated RN #1 brought to her attention another, separate report concerning CNA #1 and she interviewed Resident #2 (who the DON described as alert and oriented). The DON stated Resident #2 reported she "didn't like the way CNA #1 handled her. Resident #2 said CNA #2 "just works fast". I concluded on the allegations of abuse that there was no harm to the residents". She stated she did not attempt to notify Resident #1's Responsible Party (RP), nor Resident #2's RP because she "did not want to start conflict". She stated she did not notify the state agency of survey and certification, or any other external entity of the allegations.

On 9/21/21 at 6:00 PM an interview with the Administrator revealed the DON notified him of the allegations made in CNA #2's written statement and he read the statement. He stated he was notified about the allegations made by Resident #2 on 9/20/21(not the date it was reported). He stated the facility did not report the

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| F 609 | Continued From page 7<br>allegations to the SA. The Administrator stated he thought CNA #2 was "not trustworthy" and "she misinforms". He stated when he was made aware of the 9/17/21 allegations, he "had to consider the source". When asked if he considered CNA #2's statement an allegation of abuse, the Administrator responded CNA #2 "is not trustworthy" and "she doesn't tell the whole truth". The Administrator stated the allegation by CNA #2 was deemed false. The Administrator stated his impression of the allegation made by Resident #2 wasn't abuse. When asked why the facility had not followed its own policy and procedure for abuse allegation, the Administrator stated, "I don't know. We should have done that.". He confirmed the allegation had not been reported to state agency.<br><br>An interview on 9/22/21 at 6:32PM with Resident #2's Responsible Party (RP) revealed the facility did not notify him of any allegation of abuse. | F 609 | | |
| F 610 SS=E | Investigate/Prevent/Correct Alleged Violation<br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in | F 610 | | 10/21/21 |

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| F 610 | Continued From page 8<br>accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and resident interview and facility policy review, the facility failed to thoroughly investigate an allegation of physical abuse for two (2) of four (4) sampled residents investigated for abuse of 20 residents screened for abuse. Resident #1 and Resident #2<br><br>Findings Include:<br><br>A review of the facility's policy titled "Abuse Prevention Program", with a revision date of December 2017 and review date of July 2019, revealed the facility's administration was to identify, assess, investigate, and report any allegation of abuse within timeframes as required by federal requirements.<br><br>A review of the facility's policy titled "POLICIES AND PROCEDURES FOR ABUSE PREVENTION, INVESTIGATION AND REPORTING", dated 1/01/21, revealed following an allegation of mistreatment or abuse " .... The Administrator or designee will initiate an investigation utilizing the "Alleged Abuse Incident Report" form. The Facility will complete its investigation and submit a written report within 72 hours, pursuant to the MS Vulnerable Persons Act and provide a verbal report of the findings to the Resident's family." The policy and procedure further stated the facility's investigation would include, but not be limited to the following: 1) A summary of the Investigation; 2) Written | F 610 | Resident#1 was assessed by the Director of Nursing on 9/17/2021, and Resident #2 was assessed by the Staff Development Nurse and the Nurse Unit Manager on 9/17/2021, and both residents were not found to have any physical or psychosocial harm nor did they state any problems related to the alleged deficient practice.<br><br>All residents have the potential to be affected by the alleged deficient practice.<br><br>An inservice was conducted by the Corporate Compliance Officer for the Administrator and the Director of Nursing on 10/7/21 regarding the Policies and Procedures for abuse prevention, investigation and reporting that include, but not limited to " all allegations of abuse, including injury of unknown origin, will be investigated and reported according the the facilty's policy and within the timeframes as required by federal requirements." An inservice was also, conducted for all the staff by the Staff Development Nurse on 9/21/2021 regarding the policies and procedures for reporting of the alleged abuse, neglect exploitation of a vulnerable adult and on | |

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| F 610 | Continued From page 9<br>statements of Witnesses; 3) Documentation of Resident's Assessment; and 4) Conclusion - valid, invalid, or inconclusive. The Administrator or designee was to complete the "alleged Abuse Disposition Checklist" to ensure appropriate interventions had been implemented.<br><br>A review of the facility's policy titled "Abuse Investigation and Reporting", with a revision date of July 2017 and a review date of July 2019, stated ... "Investigative Process: The individual conducting the investigation will, as a minimum ...Interview the person(s) reporting the incident; Interview any witnesses to the incident; Interview the resident (as medically appropriate); Interview the resident's Attending Physician as needed ...Interview the staff members (on all shifts) who have had contact with the resident during the period of the alleged incident ...Interview other residents to whom the accused employee provides care or services; and Review all events leading up to the alleged incident".<br><br>An interview on 9/21/21 at 11:10 AM with the Administrator and the Director of Nurses (DON) revealed they had not had any recent complaints or incidents reported to them.<br><br>In an interview on 9/21/21 at 12:51 PM with the DON she stated "There was a thing between two staff not getting along. The CNA wrote a note and gave it to someone but not me. As soon as I found out I did an investigation."<br><br>Resident #1<br><br>A review of the facility's Face Sheet for Resident #1 revealed the facility admitted the resident on 6/4/21 with diagnoses including Hemiplegia, | F 610 | the policies on Abuse Prevention, Investigation and Reporting.<br><br>Daily, beginning October 8, 2021, the Clinical Interdisciplinary Team along with the Administrator will monitor its effectiveness by discussing any reports of alleged abuse with the required reporting documentation related to the facility policies and procedures during the Standards of Care daily meetings Monday through Friday, for maintaining compliance. The Administrator and Director of Nursing will give an oral report monthly, beginning October 20, 2021, to the Quality Assurance and Assessment Committee along with the Quality Assurance Performance Improvement Committee, that includes the Medical Director on all "Allegations, Abuse and Any reports to the MS State Department of Health" and will show the documents as required in the policies and procedures if any allegations of abuse are reported. Any concerns or issues will addressed immediately and reported to the corporate ompliance Officer in order to maintain and sustain compliance. | |

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Hemiparesis, Aphasia, and Dysphagia all following Nontraumatic Intracerebral Hemorrhage (Stroke), and Dementia.
A review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/25/21, Section C, revealed Resident #1 had no Brief Interview for Mental Status (BIMS)score, which indicated the resident had significant cognitive impairment.

A review of Resident #1's Medical Record revealed no documentation related to an allegation of abuse, and no notification to the physician, practitioner, or Responsible Party (RP) regarding an allegation of abuse.

On 9/21/21 at 12:55 PM an interview and record review revealed the facility investigation consisted of a witness statement by Certified Nurse Assistant (CNA) #2 which alleged an incident of physical and verbal abuse against Resident #1 by CNA #1 and a statement by CNA #1 denying allegations of abuse. When the SA requested any other documentation of investigation, including documented assessment of Resident #1, the DON stated there was no other documentation, including no documentation of assessment of Resident #1.

On 9/21/21 at 2:15 PM observation revealed Resident #1 was resting quietly in her bed in room 101 with her eyes open. Resident #1 was able to respond when spoken to and when asked if she was comfortable responded "We're alright". She did not answer any other questions. She rested peacefully and exhibited no signs of being frightened or upset in any way. Her call light was in reach.

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On 9/21/21 at 2:18 PM an interview with CNA #1 revealed she had been called in to the DON's office on the afternoon of 9/17/21 regarding an allegation of abuse against her related to Resident #1. CNA #1 stated she had written and submitted a statement denying all allegations. CNA #1 stated she worked fast but was not abusive and denied verbally or physically abusing Resident #1.

On 9/21/21 at 3:00 PM an interview with the MDS RN revealed on the morning of 9/17/21 CNA #2 reported an incident on the morning of 9/17/21 at approximately 11:00 AM involving CNA #1 being "rough" with Resident #1 and "saying things she shouldn't in front of the resident". The MDS RN stated CNA #2 wrote a statement and gave it to her, (the MDS RN). The MDS RN stated she gave the statement to the DON "around lunch time".

Resident #2

A review Resident #2's Face Sheet revealed Resident #2 was admitted by the facility on 8/27/21 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction (Stroke) Affecting Right Dominant Side.
A review of Resident #2's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/3/21 Section C, revealed the resident had a Brief Interview for Mental Status (BIMS) indicated moderate cognitive impairment.

On 9/21/21 at 3:45 PM an interview with Resident #2 revealed she was alert, oriented, and able to communicate well. Resident #3 stated CNA #1 was her CNA on 9/17/21 during the 7-3 shift. Resident #2 stated she had suffered a stroke

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which left her unable to use her right side including her right arm and right leg. Resident #2 stated on 9/17/21 she reported to RN #1, RN #2 and the DON that "She (CNA #1) was moving too fast". Resident #2 stated she did not intend to report it because "I didn't want to make a big deal out of anything". Resident #2 denied pain and stated, "I wasn't hurt, she was just moving too fast, and I didn't like it".

An interview on 9/21/21 at 3:17 PM with RN #1 revealed she was the RN supervisor on Friday 9/17/21 "day shift". RN #1 stated she had been made aware that a complaint had been voiced regarding alleged abuse against Resident #2 by CNA #1 and went to check on Resident #2 along with the RN #2. RN #1 stated when asked, Resident #2 confirmed that she felt that CNA #1, who was assigned to assist her on 9/17/21, had "moved too fast" while providing care. RN #1 stated she and RN #2 assessed Resident #2 and noted no signs of injury or abuse, and Resident #2 denied pain or injury. RN #1 stated she reassigned Resident #2 to CNA #3. RN #1 stated "I let the DON know as well".

On 9/21/21 at 5:12 PM the DON confirmed she was aware of both complaints about CNA #1 on Friday 9/17/21. She stated she received and read the statement written by CNA #2. The DON confirmed that after the allegations were received CNA #1 continued to work and was not suspended during the investigation of the allegations. The DON stated "I called CNA #1 into my office on Friday, 9/17/21 after receiving the note. The CNA told me that is not true (the allegations). The DON stated the investigation was started on 9/17/21 upon receiving the note. The DON stated CNA #1 worked two (2) shifts on

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9/17/21, 7-3 shift and 3-11 shift, but moved to another group of residents at 3:00 PM. The DON stated she and the Administrator spoke about the allegation on 9/17/21 and the Administrator read both the statement written by CNA #2 and a statement of response written by CNA #1. The DON stated RN #1 brought to her attention another, separate report concerning CNA #1 on 9/17/21 and she interviewed Resident #2 (who the DON described as alert and oriented) on 9/17/21. The DON stated Resident #2 reported Resident #2 "didn't like the way CNA #1 handled her. Resident #2 said CNA #2 "just works fast". The DON stated the decision was made to take CNA #2 off Resident #2's care. The DON stated based on her investigation "I concluded on the abuse that there was no harm to the residents". When asked if there needed to be further investigation into the allegations the DON stated "It did not cross my mind. I was at ease with no harm done. Maybe I need to do more with my investigations."

An interview on 9/21/21 at 6:00 PM with the Administrator revealed he stated he was notified by the DON on 9/17/21 of the allegations in CNA#2's written statement at approximately 4:40 PM and he read the statement. He stated he was notified about the allegations made by Resident #2 on 9/20/21, he was not sure of the time. When asked who was responsible for the investigation the Administrator stated, "Me. I am ultimately responsible". When asked if any actions were taken to protect the residents during any investigation, the Administrator stated CNA #1 was reassigned to other residents and Resident #1 and Resident #2 were assigned to other CNAs. He stated when he was made aware of the 9/17/21 allegations, he "had to

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consider the source". When asked if he considered CNA #2's statement an allegation of abuse, the Administrator responded CNA #2 "is not trustworthy and with her past history and she doesn't tell the whole truth". The Administrator stated the allegations made by CNA #2 regarding Resident #1 were determined false. The Administrator stated his impression of the allegation made by Resident #2 wasn't abuse. When asked why the facility had not followed its own policy and procedure for abuse allegation or completed the "Alleged Abuse Incident Report" form, the Administrator stated, "I don't know. We should have done that." When asked if he considered the investigation completed on 9/17/21 the Administrator responded "Yep". He stated, "we concluded there was no abuse". He confirmed the allegation had not been reported to state agency. The Administrator stated he did not have any documentation of an investigation related to the statements made by Resident #2 to RN #1 and RN #2.

On 9/22/21 at 10:00 AM an interview with the DON confirmed she did not complete the "Alleged Abuse Incident Report" form. The DON confirmed she had not yet interviewed the person reporting the incident, Interviews with any witnesses to the incident, interview the resident's Attending Physician as needed, or with other staff members (on all shifts) who had contact with the resident during the period of the alleged incident or interviews other residents to whom the accused employee provides care or services. She also confirmed any assessments of Resident #1 or Resident #2 were not documented.

On 9/22/21 at 3:10 PM an interview with CNA #4 revealed she had worked at the facility for "about

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a month". She stated she assisted CNA #1 with the care of Resident #2 on the afternoon of 9/17/21 and CNA #2 had not said or done anything untoward regarding Resident #2. She stated "Nothing happened. We changed her.". She denied any knowledge of any investigation done into any complaints voiced by Resident #2.

An interview on 9/22/21 at 3:25 PM with RN #3, the facility Infection Preventionist (IP) revealed it was her opinion and she understood the best way to provide protection for residents during an investigation would be to remove the accused staff member from patient care and do an investigation. She stated as a QAPI committee member she would expect a thorough investigation to include (but not be limited to) documented assessments of involved residents, interviews with all involved and witnesses, documentation of actions taken to prevent further injury and end results of the investigation.