PLAN OF CORRECTION

Edgewood Spring Creek Boise, LLC
10681 West McMillan Road
Boise ID 83713

Provider ID: RC-1006

On 07/20/2023, a Health Care Complaint Investigation survey was conducted by Department staff at Edgewood Spring Creek Boise, LLC. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

**Rule Violation** .510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE.

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

In relation to: DAPA 16.03.22.010.01, IDAPA 16.03.22.215.01, Title 39, Chapter 33, Idaho Code, and IDAPA 16.03.22, IDAPA 16.03.22.215.07, IDAPA 16.03.22 215.08.a, IDAPA 16.03.22 215.08.b, IDAPA 16.03.22 215.08.c, IDAPA 16.03.22 215.08.e, IDAPA 16.03.22.510
Resident #1:

- Behavior Management plan was reviewed and updated with appropriate interventions for redirecting resident's behaviors.
- All staff were inserviced on appropriate interventions for behavior management.

Resident #2:

- Behavior Management plan was developed and instituted at the time of the incident to direct staff in appropriate interventions to assist resident.
- Behavior management plan has been reviewed by Community Leadership for continued appropriateness of interventions.
- All staff were inserviced on appropriate interventions for behavior management.

Caregiver A:

- Removed from resident care and placed on administrative leave on 7/3/2023.
- Employment terminated.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

- Executive Director and Leadership Staff inserviced on Abuse Policy and immediate reporting expectations.
- All staff re-educated on Abuse Policy and Mandatory reporter status.
- Continuing education at monthly staff meetings on Policy and expectations.
- Review of Resident's Behavior Management plans for appropriate behavior intervention directions for staff members.

Specific steps the administrator will take to conduct a thorough investigation including:
-Interviewing the alleged victim and all potential witnesses.

- The alleged victim will be interviewed by the Executive Director in conjunction with the nursing staff in a manner consistent with the cognitive ability of the memory care resident. If applicable to the resident's condition the resident's Primary Care Provider and/or family members will be included in the interview process. The interview will be conducted in the resident's

apartment or in the nursing office, wherever the resident is most comfortable. The interview will take place as soon as possible after the alleged abuse has been witnesses or reported.

- All potential witnesses will be interviewed by the Executive Director at the time of the report of alleged abuse.
  - Identified witnesses will be interviewed first.
  - All staff on shift at the time of the report will be interviewed before leaving the community.
  - If the report refers to an earlier time frame than the time of the report, all staff who were on site at the time of the alleged abuse and all staff who have worked or been onsite since the identified time will be interviewed.
  - Any potential witnesses who are not onsite at the time of the report will be notified to return to the community ASAP for an onsite interview.
- The applicable Edgewood suspected abuse interview guideline will be used by the interviewer while conducting the interview of the resident.
- The interviewer will document all aspects of the interview staff interview and ensure that the individual interviewed signs the interview statement.

-Who will conduct the interviews and how privacy will be ensured during interviews.

- The Executive Director and nurse will conduct staff interviews in either the Nurse's office or ED's office with door closed to ensure privacy.
- Resident interviews may be conducted in the resident's room with door closed for privacy to ensure the resident feels comfortable.
- If the Executive Director or community nurse are identified as being the alleged abuser, the interviews will be conducted by the Regional Vice President and/or the Regional Nursing Director.

-Identification and interview of other persons who might have knowledge of the incident or of the alleged perpetrator's previous interactions with the alleged victim and other potential victims.

- Identification of all staff who have been on shift or worked with the resident will be identified using the as worked schedule for the community.
- All staff who have worked at the same time as the alleged perpetrator within the previous several days will be identified and interviewed.
- To identify other potential victims. interviews of all residents that the alleged perpetrator has had contact with, as identified through the as worked schedule, and documentation records, will be interviewed using the Edgewood suspected abuse interview guideline.

-Documenting and implementing the various conclusions the administrator may reach including at a minimum, whether the alleged event occurred, and whether it constituted abuse, neglect or exploitation from the investigation.

- All interview documents will be reviewed and maintained by the Executive Director.
- The Executive Director will document their investigation and conclusions on the alleged abuse incident report.

-Reporting to adult protection and law enforcement, if applicable.

- Adult protection will be notified as soon as possible after the report of the alleged abuse.
  - The staff member who witnesses the alleged abuse and/or receives the report is to notify the Executive Director immediately.
  - As soon as the Executive Director and/or nursing staff have ensured the safety/health of the alleged abuse victim, the Executive Director will report the alleged abuse or assist the staff member to make the report.
- Law enforcement will be notified in the same manner if applicable.

-Steps taken to protect alleged victims and other potential victims.

- Any staff member identified as an alleged abuser will be immediately removed from actively working with any resident.

o During the investigation the staff member will be placed on administrative leave and not allowed in the building, with the exception of being interviewed in a non-resident area of the community.

- The identified resident will be placed on more frequent health/safety checks during the process of the investigation

-Measures put in place and/or actions taken to prevent recurrence.

- All staff have been reeducated on the policy to identify and report potential abuse.
- Appropriate staff have received formal coaching (write-ups)
- Regional Nursing Director is performing random audits of staff performance and understanding of the policies and procedures.

-Describe who, how, when and where the investigation will be documented.

- The Executive Director along with the nurse will conduct the investigation immediately.
- The nurse will chart notes related to the resident's health and medical/emotional condition in alleged victim's chart.
- The ED will document all interview notes, conclusions, and follow-up in the alleged abuse incident report and complaint investigation file.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

- Monthly Safety Committee Meetings to review incident's, policies, processes, and compliance.
- Compliance audits performed by Regional Nursing Director to ensure adherence to plan, policy, and procedures.
- Random Audits by Regional Nursing Director to review resident's charts for appropriateness of Behavior Management Plan Interventions and timeliness of reporting of incidents.

Date when corrective action will be completed.

September 03, 2023

Program Comments

*POC needs to include the following for approval.

Describe specific steps the administrator will take to conduct a thorough investigation including:

-Interviewing the alleged victim and all potential witnesses.
-Who will conduct the interviews and how privacy will be ensured during interviews.
-Identification and interview of other persons who might have knowledge of the incident or of the alleged perpetrator's previous interactions with the alleged victim and other potential victims.
-Documenting and implementing the various conclusions the administrator may reach including at a minimum, whether the alleged event occurred, and whether it constituted abuse, neglect or exploitation from the investigation.
-Reporting to adult protection and law enforcement, if applicable.
-Steps taken to protect alleged victims and other potential victims.
-Measures put in place and/or actions taken to prevent recurrence.
-Describe who, how, when and where the investigation will be documented.

# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
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| Edgewood Spring Creek Boise, LLC | RC-1006 | 10681 West McMillan Road | 208-954-5660 |
| Administrator | City | Zip Code | Survey Date |
| Jamie Korsgaard | Boise | 83713 | 07/20/2023 |
| Survey Team Leader | Survey Type | | Response Due |
| Oldfield, Michael | Health Care Complaint Investigation | | 08/19/2023 |

| Item # | Rule (16.03.22) | Description |
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| 1 | .215.01. Administrator Responsibility. | The facility did not ensure policies and procedures were implemented to fulfill the requirements in Title 39, Chapter 33, Idaho Code and IDAPA 16.03.22. For example: The facility's May 2023 "Incident Management Policy" documented "all incidents or adverse events occurring in the community or on community property must be reported immediately," and "an incident report is to be completed when there is any unexpected event...to be completed prior to exiting the community." During the investigation, any witnesses to the event were to be interviewed and "...review what is written and sign the form." The facility's July 2022 "Abuse Prohibition" policy documented, "any staff member that observes or suspects abuse should ensure the resident is safe and then report immediately to their direct supervisor." The policy failed to instruct any staff member who witnessed abuse to report it to Adult Protection as mandated reporters. In addition, the administrator stated when an incident occurred on 3/7/23 between Resident #2 and a caregiver, in which the resident sustained a head injury, she did not interview the other staff members working at the time of the incident to see if they had any additional information. After this same caregiver abused |

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| | | Resident #1 on 6/30/23, she did not interview any staff members other than the perpetrator and one other caregiver who witnessed the event. Therefore, she was unaware the witness informed the Business Office Manager of this incident on 7/1/23, but neither staff member notified the administrator of the abuse until 7/3/23. In addition, neither the witness nor the Business Office Manager reported the 6/30/23 incident to adult protection nor completed an incident report, nor signed a witness statement. The facility administrator did not ensure the facility's policies for abuse, nor for incident reporting, were implemented to prevent abuse or potential abuse of residents. |
| 2 | .215.05. Responsibility for Acceptable Admissions. | The administrator knowingly retained Resident #4 who required care as defined in Section 152.03 of Idaho Code 39-3307. Resident #4 was admitted on 3/28/22, and their 3/31/23 care plan documented they required one-person assist with transfers. However, Resident #4 subsequently declined in strength in their legs, and their transfer needs increased beyond a one person assist. Several caregivers interviewed, including the facility nurse, stated it took up to four staff members to lift this resident who weighed 300-400 pounds, and four caregivers were not available during all shifts, or the caregivers on shift were not strong enough to lift the resident. Resident #4 fell at least 23 times at the facility until they died in early February 2023. Between April 2022 through January 2023, on at least seven occasions, the facility had the resident's family assist staff in transfers of the resident or contacted non-emergency lift assist for Resident #4 when staff were unable to complete the transfer. The facility nurse stated they had requested a Hoyer lift approval from corporate but was denied. |
| 3 | .215.07. Notification to Adult Protection and Law Enforcement. | The administrator failed to report all allegations of abuse, to Adult Protection when Resident #1 was held down in their room and called a foul name by a staff member on 6/30/23, as witnessed by another caregiver, who informed the Business |

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| | | Office Manager of the incident on 7/1/23. Adult Protection was not notified by the administrator until 7/3/23. |
| 4 | .215.08.a. Administrator Notification. | The facility administrator was not notified a caregiver had abused Resident #1 on 6/30/23 until 7/3/23. The administrator stated she was unsure why the witnessing staff member and the Business Office Manager had not informed her of the abuse until 7/3/23, as policy stated abuse must be reported immediately. |
| 5 | .215.08.c. Resident Protection. | The administrator was not notified after a caregiver witnessed a caregiver hold down Resident #1 in bed and called them a foul name on 6/30/23, and the staff continued to work the remainder of their shift on 6/30/23, as well as the overnight shifts on 7/1/23 and 7/2/23. Other staff members stated this caregiver worked alone with residents in their rooms between 6/30/23 and 7/2/23. The administrator confirmed she had not been notified of the allegation of physical and verbal abuse until 7/3/23, in which she took the caregiver off the schedule. |
| 6 | .330.04.c.xi. Resident Care Records. | Staff did not consistently document unusual incidents or accidents. For example: When Resident #1 was abused by a caregiver on 6/30/23, the witnessing staff member did not document the event in an incident report or in the resident's record. The Business Office Manager did not document the witness had informed her of the abuse on 7/1/23. The facility administrator stated she did not have the witnessing staff member or the Business Office Manager document an incident report for the 6/30/23 abuse of Resident #1, nor did she have the witness sign their statement they made on 7/4/23 about the 6/30/23 event. The administrator stated she did not document she had spoken to the caregiver involved in the altercation a staff member had with Resident #2 immediately after it occurred on 3/7/23, nor had she documented a complete investigation report into this incident, other than to note in the offending employee's file that she had spoken to the caregiver about working with residents with dementia and |

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| | | required the staff member to complete additional training on the subject. In addition, documentation in Resident #4's record was inconsistent, as the facility nurse's note documented the resident passed away on 1/3/23, caregiver notes documented cares for the resident until 2/5/23, and the facility's admission/discharge log documented the resident was discharged on 3/14/23. |
| 7 | .330.14. As Worked Schedules. | The facility's as-worked schedule did not document the actual times the caregivers worked at the facility in June and July 2023. In addition, after caregivers were no longer employed by the facility, such as after a caregiver was terminated for abuse on 7/7/23, the administrator stated their system completely deleted that caregiver off the as-worked schedule. |

# CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
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| Edgewood Spring Creek Boise, LLC | RC-1006 | 10681 West McMillan Road | 208-954-5660 |
| Administrator | City | Zip Code | Survey Date |
| Jamie Korsgaard | Boise | 83713 | 07/20/2023 |
| Survey Team Leader | Survey Type | | Response Due |
| Oldfield, Michael | Health Care Complaint Investigation | | 07/30/2023 |

| Item # | Rule (16.03.22) | Description |
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| 2 | .510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE. | Based on record review and interview, it was determined the facility did not protect 2 of 5 sampled residents (#1 and #2) from abuse when the administrator failed to immediately notify adult protective services, complete thorough investigations according to the facility's policy, and protect residents after a caregiver reportedly abused a resident. This had the potential to affect 100% of the residents residing at the facility. The findings include:<br><br>IDAPA 16.03.22.010.01 - Defines abuse as the non-accidental act of sexual, physical, or mental mistreatment or injury of a resident through the action or inaction of another individual.<br><br>IDAPA 16.03.22.215.01 - The administrator is responsible for ensuring that policies and procedures are developed and implemented to fulfill the requirements in Title 39, Chapter 33, Idaho Code, and IDAPA 16.03.22, "Residential Assisted Living Facilities."<br><br>IDAPA 16.03.22.215.07 - The administrator must ensure that adult protection...are notified in accordance with Sections 39- |

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| | | 5303 and 39-5310, Idaho Code, which documents any employee of a health facility "...who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission."<br><br>IDAPA 16.03.22 215.08.a - The administrator or person designated by the administrator, must be notified of all...allegations of abuse, neglect or exploitation immediately...<br><br>IDAPA 16.03.22.215.08.b - The facility administrator or designee must complete an investigation...for each...allegation of abuse, neglect or exploitation.<br><br>IDAPA 16.03.22.215.08.c - Any resident involved must be protected during the course of the investigation.<br><br>IDAPA 16.03.22.215.08.e - When abuse, neglect, exploitation, incidents, and accidents occur, corrective action must be immediately taken and monitored to ensure the problem does not recur.<br><br>IDAPA 16.03.22.510 - The administrator must ensure policies and procedures are implemented to ensure all residents are free from abuse.<br><br>The facility's July 2022 "Abuse Prohibition" policy documented, "Any staff member that observes or suspects abuse should ensure the resident is safe and then report immediately to their direct supervisor." The policy documented the facility administrator (or designee) would work with the staff to report to adult protection (as well as law enforcement if indicated) immediately, and the effected resident and any other vulnerable resident must be protected from further |

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| | | abuse. This included immediate suspension of the employee, so he/she is unable to abuse the victim and/or any other vulnerable resident. The investigation into the abuse was to include identifying actions and behaviors exhibited by the abuser and education for all staff members on specifics of similar abuse to watch for. The investigation was to include witness statements, as well as implementation of corrective actions for any deficiencies identified during the investigation. The investigation report was to include “a description of the allegation, immediate action taken to protect the resident and any other potential victims, reporting made, conclusions, (whether the alleged event occurred, whether it constituted abuse, neglect, or exploitation) and actions being taken to prevent recurrence." The policy failed to instruct any staff member who witnessed abuse to report it to adult protection as mandated reporters.<br><br>The facility’s May 2023 "Incident Management Policy" documented, "All incidents or adverse events occurring in the community or on community property must be reported immediately," and "an incident report is completed on the shift that the incident occurred.” The policy documented during the investigation, any witnesses to the event were to be interviewed and "...review what is written and sign the form."<br><br>Caregiver A worked at the facility beginning on 2/13/23. Caregiver A was reprimanded on 3/8/23 for their conduct and behavior with a resident on 3/7/23. Caregiver A was subsequently reprimanded on 4/27/23, for “making rude comments, bad mouthing other staff and use of foul language.” Caregiver A was instructed “…to use respectful words when talking to other staff, around other staff or around the resident.” Caregiver A was terminated on 7/10/23, following an incident with another resident on 6/30/23. |

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| | | Between 7/18/23 and 7/20/23, staff members stated the following regarding Caregiver A's treatment of residents:<br><br>*Caregiver C stated Caregiver A was "rough with residents."<br><br>*Caregiver L stated other staff members said Caregiver A had an "attitude with residents and staff," and they were "suspicious" of this caregiver because of previous incidents with residents.<br><br>1. According to Resident #2's record, they were 83 years old and were admitted to the facility on 9/19/22, with diagnoses including dementia with behavior disturbance.<br><br>According to the Reportable Incident report in FLARES, on 3/7/23, Resident #2 took Caregiver A's coat and phone from the caregiver and would not let go. Caregiver A tried to retrieve the phone, but it "…slipped out of [Caregiver A's] hand and the recoil from [Resident #2] pulling back caused a laceration to the left side of [Resident #2's] head…" EMS was called, and the resident received four staples to their head in the emergency room.<br><br>There was no investigation report completed for this 3/7/23 incident, to include steps taken to reduce the potential of similar incidents of resident abuse from occurring in the future.<br><br>A "Coaching and Correction Form," dated 3/8/23, documented Caregiver A "…did not appropriately de-escalate the situation and attempted to physically retrieve [Caregiver A's] belongings. This resulted in an injury to the resident." The form documented the caregiver was to "Review Treatment of |

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| | | Residents and Edgewood Core Values in the Employee Handbook. Follow protocols to de-escalate behaviors and ask help from fellow staff. Improvement needs to be seen immediately." The caregiver was assigned additional electronic trainings on topics such as working with residents with Alzheimer's dementia and being respectful.<br><br>On 7/20/23, Caregiver J stated they worked with Caregiver A at the time of the 3/7/23 incident. They did not see the incident occur, but they stated Caregiver A came to them after the incident "in a panic." Caregiver A told them when trying to retrieve their cell phone from Resident #2, when the phone "flipped" and struck the resident in the head. Caregiver J stated Caregiver A told them, "I didn't handle the situation well."<br><br>On 7/20/23 at 10:03 AM, the facility nurse stated she had no firsthand knowledge of the 3/7/23 incident between Resident #2 and Caregiver A. She stated she did carry out a change of condition assessment after Resident #2 returned from the hospital.<br><br>On 7/20/23 at 9:10 AM, the administrator stated Caregiver A informed her of the 3/7/23 incident with Resident #2 that same day, at the end of their shift. The administrator stated she instructed Caregiver A to go home. She did not instruct them to complete an incident report or a witness statement, as required by the facility's "Abuse Prohibition" policy. The administrator stated she did some "coaching" with Caregiver A about how to respond appropriately to residents' behaviors. The administrator stated she did not document this conversation with Caregiver A nor complete an investigation report into the 3/7/23 incident. The administrator stated she only interviewed Caregiver A about the 3/7/23 incident. The |

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| | | administrator stated she did not speak to any other staff members, residents, or any other person to see if they had information related to this incident or Caregiver A's treatment of residents overall. The administrator stated she was unaware any other caregivers' concerns with Caregiver A being "rough" with residents.<br><br>The facility failed to conduct nor document a thorough investigation, including interviews and corrective action to prevent further incidents, after a caregiver allegedly abused Resident #2 on 3/7/23.<br><br>2. According to Resident #1's record, the resident was 76 years old who resided at the facility since 3/17/20, with diagnoses including dementia with behavior disturbance.<br><br>According to the Reportable Incident report in FLARES, on 6/30/23, Caregiver A allegedly held Resident #1 down in bed by their wrist and called the resident a foul name. The resident sustained a bruise to their right wrist from the incident.<br><br>There was no incident report, "observations" note, nor investigation report for the 6/30/23 incident in Resident #1's record.<br><br>When the administrator was asked for a copy of her investigation into this incident, she provided a piece of paper dated 7/3/23, which documented she had spoken to Resident #1 about the 6/30/23 incident, but due to the resident's confusion, could not conduct a complete interview. The administrator documented on 7/3/23, she spoke with Caregiver A, who stated they did not recall restraining Resident #1, but if they did it was "not strong enough to hurt [them]." The administrator documented she received a statement from |

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| | | Caregiver L on 7/3/23 that they had witnessed Caregiver A holding Resident #1 “down on [their] bed with [their] blankets” and called the resident a “bitch.” The paper documented the administrator spoke with Caregiver A on 7/10/23 terminating them from employment for injuring Resident #1 during cares and “had previously been coached on approach with another resident…” There were no other interviews with staff members documented on this paper.<br><br>The administrator provided an email, dated 7/4/23, from Caregiver L to the administrator describing the events of the 6/30/23 incident as follows: “On the date 06/30/2023 at 10:00 PM at Edgewood Spring Creek on Five Mile and McMillan in Boise, ID. I clocked out to go home. Before exiting through the front door, I heard a prolonged scream coming from room 31. I made my way quickly to the room and first seen that the door was open, and the lights were off. I heard Resident from room 31 screaming and the alarm beeping from [their] wheelchair. I rushed into the room and saw [Caregiver A] holding down Resident with the blankets as if to restrain [them] from moving around. As soon as I turned the lights on I heard [Caregiver A] call [Resident #1] a ‘bitch’ as [Caregiver A] removed [themselves] from contact.” This statement was not signed by Caregiver L. On this same document, a handwritten note from the administrator, dated 7/5/23, documented she discussed the event with Caregiver L and reminded them they were a “…mandated reporter and has to report suspected abuse immediately.”<br><br>The administrator provided a copy of the report she made to adult protection on 7/3/23, related to the 6/30/23 incident of abuse. In this document, the administrator wrote that Caregiver A was holding Resident #1 down by their wrist and called them a foul name. |

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| | | The facility's payroll records documented Caregiver A worked the overnight shifts on 6/30/23, 7/1/23, on 7/2/23.<br><br>Between 7/18/23 and 7/20/23, staff members stated the following regarding Caregiver A's treatment of resident #1 on 6/30/23:<br><br>*Caregiver C stated on 6/30/23, they witnessed Caregiver A holding Resident #1 by the shoulders and called them a "bitch." Caregiver L then went into the room to help and took over.<br><br>*Caregiver J stated they were working on the 6/30/23 overnight shift with Caregiver A. Caregiver J stated they had no direct knowledge of the incident which occurred between Caregiver A and Resident #1 that evening, but they stated Caregiver A "worked alone most of the night" with residents for the remainder of the 6/30/23 shift, as well as the next evening shift on 7/1/23.<br><br>*Caregiver L stated on 6/30/23, they were just leaving after their shift, and they heard Resident #1 screaming from their room. The light in Resident #1's room was off, but the door was open. Caregiver L went in and saw Caregiver A holding Resident #1 down with blankets. Resident #1 was soiled and in their day clothes. Caregiver A stopped holding the resident down at that point, put their arms out and said, "what am I doing [Resident #1]?" Caregiver A then called Resident #1 "bitch". Caregiver L stated they talked to other staff about the incident, then face-timed the business office manager the next day who told them to document the incident and give it to the administrator, which they emailed to her. When Caregiver L was asked what they would do if they witnessed abuse in the |

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| | | future, they stated they were trained to contact management to report abuse, but they did not know who adult protection was or that they needed to report abuse to them.<br><br>*The business office manager stated Caregiver L "face-timed" them about the situation with Caregiver A and Resident #1 on 7/1/23, but they did not inform the administrator about the incident until 7/3/23. They stated they did not complete an incident report or contact adult protection. They stated they should have told Caregiver L to report it to adult protection.<br><br>On 7/20/23 at 10:03 AM, the facility nurse stated she found out about the 6/30/23 incident with Resident #1 on 7/3/23, and she and the administrator called Caregiver A on that date for their statement into the incident. Other than Caregiver L, she stated she did not talk to any other staff members about the incident. The nurse stated she was not aware Caregiver L had spoken with the business office manager on 7/1/23, and she did not know why Caregiver L nor the business office manager did not immediately report the incident to the administrator. The nurse stated she or the administrator were supposed to report abuse to adult protection and did not think caregivers were considered mandatory reports.<br><br>On 7/20/23 at 9:10 AM, the administrator stated after Caregiver A abused Resident #1 on 6/30/23, she did not interview any staff members other than the perpetrator and the caregiver who witnessed the event. Therefore, she was unaware the witness informed the business office manager of this incident on 7/1/23. She stated neither staff member notified her nor the facility nurse about the abuse until 7/3/23. In addition, she stated she did not know why neither the witnessing caregiver nor the business office manager reported the incident to adult protection nor completed an incident |

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| | | report. She stated Caregiver L was new and was verbally trained about reporting abuse after this incident. She said Caregiver L was previously trained on abuse when they worked in the facility in the past and was in the middle of more training. The administrator stated when she found out about the incident on 7/3/23, she asked Caregiver L for a statement. She stated on 7/3/23, she also interviewed Caregiver A, who told her they went into Resident #1's room to help Resident #1, who was "doing their usual yelling." The administrator stated Caregiver A was put on administrative leave and was not allowed to work after 7/3/23, but Caregiver A had worked the entire weekend after the event. She stated she would have taken Caregiver A off the schedule if she had known about the abuse of Resident #1 on 6/30/23. The administrator stated she did not know if Caregiver A filled out an incident report and did not instruct them to do so. She stated since the 6/30/23 incident, she and the facility nurse have discussed that staff members need to be trained they are all mandated reporters, but they had not completed this training at the time of the survey.<br><br>The facility did not protect Resident #1, and potentially all residents from abuse, when Caregiver A was allowed to continue to work for three days after they were observed holding down Resident #1 and calling them a foul name on 6/30/23. Witnessing staff had not been educated on the facility's abuse and incident reporting policies, including, but not limited to, immediately reporting the alleged abuse of a resident to the administrator and to adult protection.<br><br>The facility administrator failed to ensure the facility's policies for abuse, nor for incident reporting and investigation, were implemented to prevent abuse or potential abuse of residents. A thorough investigation was not conducted after Resident #2 |

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| | | sustained a significant injury to their head on 3/7/23. After Resident #1 was observed to be held down and called a foul name on 6/30/23 by a caregiver, this caregiver was allowed to continue working with residents the remainder of the shift, as well as on 7/1/23 and 7/2/23, allowing the potential for abuse of all residents in the facility. These failures resulted in abuse. |