STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345482	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKDALE CARRIAGE CLUB PROVIDENCE	5804 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226

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

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, medical record review and review of facility records, the facility failed to prevent and protect a cognitively impaired resident with behaviors from staff to resident abuse. Resident #1 accused Nurse Aide #1 of striking him on the head twice, forcefully putting him to bed, screaming in his face and repeatedly telling him to shut up. When assessed, Resident #1 was noted with an unexplained skin tear on his left arm, an unexplained bruise on his right cheek and an unexplained bruise on his forehead. This occurred for 1 of 3 sampled residents reviewed for abuse. The findings included: Resident #1 was admitted to the facility [DATE] from the hospital, transferred to the hospital on [DATE] for a medical procedure and returned to the facility on [DATE] with Hospice services. Resident #1 expired in the facility on [DATE]. [DIAGNOSES REDACTED]. A nursing admission data collection tool dated [DATE], assessed Resident #1 as able to understand/be understood, clear speech, alert to person, place and time with intact short-term and long-term memory, adequate vision with corrective lenses, adequate hearing with hearing aids bilateral, a skin tear to the right forearm and a stage 2 sacral pressure sore. An admission Minimum Data Set assessment, dated [DATE], assessed Resident #1 with clear speech, understood/understands, adequate vision with corrective lenses, adequate hearing with bilateral hearing aide, moderately impaired cognition, verbal behavior to include threatening others, screaming at others, and cursing at others, required extensive to total assistance with activities of daily living (ADL) (bed mobility, transfers, locomotion, dressing, personal hygiene, bathing, toilet use), and had a stage 2 sacral pressure ulcer. An initial care plan, dated [DATE], and a revised care plan, [DATE], identified Resident #1 required skin interventions due to actual impairment to his skin on admission as evidenced by a skin tear to the right forearm, a surgical incision for placement of a pace maker and a stage 2 pressure sore to his coccyx. Interventions included, in part, to assist with positioning; reduce friction/shearing with use of lift/transfer sheets; evaluate his skin on a daily/weekly basis; monitor/document location, size and treatment of [REDACTED].#1 was also identified with self - care performance deficits related to his diagnoses, need for an assistive device with transfers, and risk for falls. Interventions included, in part, to assist Resident #1 with ADL and to monitor his skin integrity. The revised care plan dated [DATE] also identified Resident #1 was at risk for impaired behavioral patterns due to yelling out. The care plan goal was that Resident #1 would not sustain injury related to his impaired behavioral patterns. Staff were to anticipate his needs, approach him calm, and monitor for the occurrence of the targeted behavior (yelling). Daily nursing progress notes for each shift from [DATE] - [DATE] recorded no new skin concerns for Resident #1. An Initial Allegation of Abuse Report, dated [DATE], completed by the Administrator, documented an allegation of resident abuse. The Initial Allegation of Abuse Report documented, in part, that Resident #1 rang his call bell at 7:34 AM on [DATE]. When Nurse #1 responded, Resident #1 voiced that the male nurse aide (NA #1), told Resident #1 to shut up and was rough, which resulted in a skin tear. Nurse #1 observed Resident #1 with a skin tear to his left forearm. A written statement from Nurse #1 dated [DATE] at 8:00 AM, which accompanied the Initial Allegation of Abuse Report, documented that Nurse #1 observed Resident #1 with a skin tear on his left forearm. When Nurse #1 asked Resident #1 what happened, he stated NA #1 grabbed him, punched him twice in the head, screamed in his face and repeatedly told him to shut up. The statement also documented that Resident #1 stated NA #1 was very aggressive and mean. Nurse #1 documented in her statement that she spoke to NA #1 who admitted to telling Resident #1 to shut up and stop screaming. NA #1 denied striking the Resident. Nurse #1 documented in her statement that she told NA #1 not to go back into Resident #1's room. A Weekly Skin Integrity Review, dated [DATE] at 9:00 AM, recorded Resident #1 had a new skin issue, a skin tear to his left forearm, redness to his forehead and a bruise to his right cheek. A Comprehensive Nursing Note, dated [DATE] at 2:07 PM, recorded in part, Resident #1 was alert and oriented to person, place, time and situation, remained with bruises to his extremities and a dressing to his left forearm was in place for a skin tear. A progress note, dated [DATE], recorded by the Nurse Practitioner, documented that on [DATE], Resident #1 sustained a large skin tear to his left forearm which measured 3 cm by 4 - 5 cm. An Investigation of Abuse Report, dated [DATE], completed by the Administrator, documented an unwitnessed allegation of resident abuse regarding the same accusation as recorded on the Initial Allegation of Abuse Report. Additionally, the Investigation of Abuse Report described Resident #1 as alert with confusion noted at times and fearful of NA #1. The Investigation of Abuse Report recorded that Resident #1 reported the same allegation to the Administrator with the details unchanged. Resident #1 stated NA #1 hit him twice, once in the head and once in the cheek. The Administrator documented that Resident #1 was observed with a red spot on his forehead, and his left forearm was bandaged with notable bruising. The Administrator spoke to NA #1 via phone. He admitted to verbal abuse, denied physical abuse and was suspended. The allegation was substantiated for verbal abuse, reported to law enforcement and NA #1 was terminated. During a telephone interview with NA #1 on [DATE] at 9:55 AM, he stated that on [DATE] he worked the 11 PM - 7 AM shift and worked independently with Resident #1 that night. He described Resident #1 often left his feet hanging off his bed and made frequent attempts to get out of his bed unassisted. NA #1 said this resulted in a history of falls where he sustained multiple bruises and skin tears to his skin. NA #1 stated that on the night of [DATE], Resident #1 constantly yelled out help me, help me over and over, which was his typical practice. NA #1 described this behavior as a little frustrating. NA #1 stated You could not ignore him, every time he yelled out, we had to go check on him because you did not know what could be wrong. NA #1 said he was in and out of the Residents room several times that night because Resident #1 continued to yell out and get out of bed without assistance. NA #1 stated he had to help Resident #1 put his legs back in the bed. NA #1 further stated I had to use some muscle to get his legs back in the bed because he was a big guy. NA #1 denied being aggressive/rough with Resident #1 and stated, I did not hurt him. NA #1 stated that once he put Resident #1 in bed, put his bed in a low position and a fall mat next to his bed, he left the room and Resident #1 yelled out again. NA #1 then stated, I was frustrated because he was keeping me from getting to my other patients. NA #1 stated he returned to the Resident's room, the Resident was yelling Help me over and over while attempting to get out of his bed again. NA #1 said he got right in the Resident's ear because he was hard of hearing and said, Hush all that fuss and advised the Resident that he was going to put him back to bed. NA #1 described being close to the Resident and stated that their heads touched. NA #1 said that when their heads touched, Resident #1 said Ouch you hit me in the head. NA #1 told the Resident that he did not hit him in the head. NA #1 said Nurse #1 came to him later in the shift, asked him what happened and advised him of an allegation of abuse made by Resident #1 against him. NA #1 said he told Nurse #1 he told Resident #1 to shut up but that he did not hurt him. Nurse #1 told NA #1 not to go back into the Resident ' s room. NA #1 said Nurse #1 asked him about the skin tear to the Resident's left forearm and he told Nurse #1 I noticed it, but I had nothing to do with it. NA #1 said this occurred between 6:30 AM and 7:00 AM, he did not go back to Resident #1's room and left the facility at the end of his shift. NA #1 said that once he got home, he received a phone call sometime after 8:00 AM from the Administrator to advise

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) him that he was suspended pending an abuse investigation. NA #1 said he told the Administrator the same thing that he told Nurse #1, that he told Resident #1 to shut up, but that he did not hurt the Resident. NA #1 said he received abuse and neglect training during orientation training at the facility and that he knew what abuse was and that it was not allowed. NA #1 further stated he did not return to the facility; the allegation of verbal abuse was substantiated and that he was terminated from employment. A telephone interview occurred on [DATE] at 1:45 PM with Nurse #1. During the interview, Nurse #1 stated she was the assigned Nurse for Resident #1 on [DATE] for the 11 PM - 7 AM shift. She described Resident #1 as alert/oriented, required extensive/total staff assistance with his nursing care, and frequently used his call bell to request staff assistance. Nurse #1 stated NA #1 was the assigned nurse aide for Resident #1 that night, he was a new employee who she had not previously worked with before. Nurse #1 stated that around 5:30 or 6:00 AM on the morning of [DATE], while the nurse aides completed their final rounds, Resident #1 put his call light on. She stated that she observed NA #1 enter Resident #1's room, turned off the Resident's call light and after a short time, he left the Resident's room. Nurse #1 stated moments later, Resident #1 put his call light back on while yelling Help me repeatedly. Nurse #1 stated it was common practice for Resident #1 to yell out. She responded to the Resident's call light and observed Resident #1 bleeding from a skin tear to his left forearm, a bruise to his right cheek and a bruise to his forehead. Nurse #1 stated these were new changes to his skin that she had not observed on him earlier in the shift. When she entered the room, she stated Resident #1 screamed That guy beat me up and told me to shut up; don't let him back in here. Nurse #1 stated to calm Resident #1 down, she had to assure him that NA #1 would not be allowed back into his room; she cleaned him up with staff assistance and dressed the skin tear. Nurse #1 asked Resident #1 to tell her what happened. Resident #1 stated that NA #1 got in his face, struck him twice in the head, forcefully put him in bed and told him to shut up because he kept yelling. Nurse #1 stated after Resident #1 was cleaned up, she found and confronted NA #1. Nurse #1 stated she asked NA #1 what happened with Resident #1. NA #1 told Nurse #1 I just told him to shut up and be quiet. Nurse #1 said she advised NA #1 that he could not speak to a resident that way and told NA #1 not to go back into Resident #1's room. Nurse #1 said she told NA #1 that Resident #1 accused him of abuse and did not want him back in his room. Nurse #1 stated she contacted the Administrator, left a voice message and completed a nursing round on all the residents who were assigned to NA #1 that shift. Nurse #1 stated I went behind him to make sure no other residents were abused, because if he would do that to an alert and oriented resident, I did not know what else he would do. Nurse #1 stated that she did not identify any other signs of abuse. Nurse #1 then stated when the Administrator returned her call, Nurse #1 advised the Administrator of the allegation of abuse Resident #1 made against NA #1. Nurse #1 said the Administrator asked Nurse #1 if NA #1 was still in the facility and she told the Administrator that he had already left. Nurse #1 stated she could not recall the specific time the Administrator returned the phone call, or the specific time NA #1 left the facility. Nurse #1 stated the Administrator arrived at the facility around 8:00 AM and asked Nurse #1 to write a statement about the abuse allegation and to conduct a second nursing round on all residents. Nurse #1 stated she conducted a second round on all residents assigned to NA #1 that shift and on all other residents in the facility; she stated that she did not find evidence of abuse for any other resident. During a telephone interview on [DATE] at 3:30 PM, the Administrator stated while she was at home, she received a voice message from Nurse #1 around 7:34 AM and returned the call. The Administrator stated Nurse #1 told her that Resident #1 stated NA #1 struck him twice in the head, put him back to bed forcefully and told him to shut up. The Administrator said she asked if NA #1 was still in the facility and Nurse #1 told her he had already left shift. The Administrator said she immediately went to the facility, asked Nurse #1 to complete a round on all residents regarding any signs of abuse and interviewed Resident #1. The Administrator stated Nurse #1 did not identify any signs of abuse for other residents. The Administrator stated when she interviewed Resident #1, his statement was consistent with what he told Nurse #1. The Administrator stated she called NA #1, asked him to tell her what happened; he stated he told Resident #1 to shut up, but denied any physical abuse. The Administrator stated she told NA #1 he would be suspended pending an investigation of an allegation of abuse for Resident #1. During the interview, the Administrator reviewed the Initial Allegation of Abuse Report and the Investigation of Abuse Report and stated both reports were accurate. The Administrator stated she reported the abuse allegation to the police, a police report was filed, but no charges were filed. She stated the facility substantiated the allegation of verbal abuse as NA #1 admitted to aggressively telling Resident #1 to shut up; but did not substantiate physical abuse because the staff to resident interaction and unexplained injuries were unwitnessed.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of facility records, the facility failed to implement its abuse policy for protection of residents. The facility allowed Nurse Aide #1 to continue a nursing assignment, unsupervised, after Resident #1 accused Nurse Aide #1 of staff to resident verbal and physical abuse for 1 of 3 sampled residents reviewed for abuse. The findings included: The facility policy, Abuse, Neglect & Exploitation Policy, effective [DATE], last revised [DATE], recorded in part, Protection of Resident, upon learning of alleged abuse, neglect, mistreatment or exploitation, the administrator or supervisor on duty should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of abuse neglect, mistreatment or exploitation. If an allegation of abuse, neglect or mistreatment, or exploitation is made against an associate or associates, the accused individual should be suspended until the matter has been investigated and a determination made as to the underlying allegation. Resident #1 was admitted to the facility [DATE] from the hospital, transferred to the hospital on [DATE] for a medical procedure and returned to the facility on [DATE] with Hospice services. Resident #1 expired in the facility on [DATE]. [DIAGNOSES REDACTED]. A nursing admission data collection tool dated [DATE], assessed Resident #1 as able to understand/be understood, clear speech, alert to person, place and time with intact short-term and long-term memory, adequate vision with corrective lenses, adequate hearing with hearing aids bilateral, a skin tear to the right forearm and a stage 2 sacral pressure sore. An admission Minimum Data Set assessment, dated [DATE], assessed Resident #1 with clear speech, understood/understands, adequate vision with corrective lenses, adequate hearing with bilateral hearing aide, moderately impaired cognition, verbal behavior to include threatening others, screaming at others, and cursing at others, required extensive to total assistance with activities of daily living (ADL) (bed mobility, transfers, locomotion, dressing, personal hygiene, bathing, toilet use), and had a stage 2 sacral pressure ulcer. An initial care plan, dated [DATE], and a revised care plan, [DATE], identified Resident #1 required skin interventions due to actual impairment to his skin on admission as evidenced by a skin tear to the right forearm, a surgical incision for placement of a pace maker and a stage 2 pressure sore to his coccyx. Interventions included, in part, to assist with positioning; reduce friction/shearing with use of lift/transfer sheets; evaluate his skin on a daily/weekly basis; monitor/document location, size and treatment of [REDACTED]. Interventions included, in part, to assist Resident #1 with ADL and to monitor his skin integrity. Daily nursing progress notes for each shift from [DATE] - [DATE] recorded no new skin concerns for Resident #1. A Weekly Skin Integrity Review, dated [DATE] at 9:00 AM, recorded Resident #1 had a new skin issue, a skin tear to his left forearm, redness to his forehead and a bruise to his right cheek. A Comprehensive Nursing Note, dated [DATE] at 2:07 PM, recorded in part, Resident #1 was alert and oriented to person, place, time and situation, remained with bruises to his extremities and a dressing to his left forearm was in place for a skin tear. A progress note, dated [DATE], recorded by the Nurse Practitioner, documented that on [DATE], Resident #1 sustained a large skin tear to his left forearm which measured 3 cm by 4 - 5 cm. An Initial Allegation of Abuse Report, dated [DATE], completed by the Administrator, documented an allegation of resident abuse. The Initial Allegation of Abuse Report documented, in part, that Resident #1 rang his call bell at 7:34 AM on [DATE]. When Nurse #1 responded, Resident #1 voiced that the male nurse aide (NA #1), told Resident #1 to shut up and was rough, which resulted in a skin tear. Nurse #1 observed Resident #1 with a skin tear to his left forearm. A written statement from Nurse #1 dated [DATE] at 8:00 AM, which accompanied the Initial Allegation of Abuse Report, documented that Resident #1 accused NA #1 of punching him in the head twice, screamed in his face and repeatedly told Resident #1 to shut up. Nurse #1 documented in her statement that she spoke to NA #1 who admitted to telling Resident #1 to shut up and stop screaming. NA #1 denied striking the Resident. Nurse #1 documented in her statement that she told NA #1 not to go back into Resident #1's room. An Investigation of Abuse Report, dated [DATE], completed by the Administrator, documented an unwitnessed allegation of resident abuse regarding the same accusation as recorded on the Initial Allegation of Abuse Report. Additionally, the Investigation of Abuse Report described Resident #1 as alert with confusion noted at times and fearful of NA #1. The Investigation of Abuse Report recorded that Resident #1 reported the same allegation to the Administrator with the details unchanged, NA #1 admitted to verbal abuse and was suspended. The allegation was substantiated, reported to law enforcement and NA #1 was terminated. During a telephone interview with NA #1 on [DATE] at 9:55 AM, he stated that on [DATE] he worked the 11 PM - 7 AM shift and worked

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) independently with Resident #1 that night. He described Resident #1 often left his feet hanging off his bed and made frequent attempts to get out of his bed unassisted. NA #1 said this resulted in a history of falls where he sustained multiple bruises and skin tears to his skin. NA #1 stated that on the night of [DATE], Resident #1 constantly yelled out help me, help me over and over, which was his typical practice. NA #1 described this behavior as a little frustrating. NA #1 stated You could not ignore him, every time he yelled out, we had to go check on him because you did not know what could be wrong. NA #1 said he was in and out of the Residents room several times that night because Resident #1 continued to yell out and get out of bed without assistance. NA #1 stated he had to help Resident #1 put his legs back in the bed. NA #1 further stated I had to use some muscle to get his legs back in the bed because he was a big guy. NA #1 denied being aggressive/rough with Resident #1 and stated, I did not hurt him. NA #1 stated that once he put Resident #1 in bed, put his bed in a low position and a fall mat next to his bed, he left the room and Resident #1 yelled out again. NA #1 then stated, I was frustrated because he was keeping me from getting to my other patients. NA #1 stated he returned to the Resident's room, the Resident was yelling Help me over and over while attempting to get out of his bed again. NA #1 said he got right in the Resident's ear because he was hard of hearing and said, Hush all that fuss and advised the Resident that he was going to put him back to bed. NA #1 described being close to the Resident and stated that their heads touched. NA #1 said that when their heads touched, Resident #1 said Ouch you hit me in the head. NA #1 told the Resident that he did not hit him in the head. NA #1 said Nurse #1 came to him later in the shift, asked him what happened and advised him of an allegation of abuse made by Resident #1 against him. NA #1 said he told Nurse #1 he told Resident #1 to shut up but that he did not hurt him. Nurse #1 told NA #1 not to go back into the Resident's room. NA #1 said Nurse #1 asked him about the skin tear to the Resident's left forearm and he told Nurse #1 I noticed it, but I had nothing to do with it. NA #1 said this occurred between 6:30 AM and 7:00 AM, he did not go back to Resident #1's room, but that he did complete another round of nursing care on the remaining residents he was assigned and left the facility at the end of his shift. NA #1 stated he did not recall exactly how many residents he assisted the rest of his shift, but estimated he worked with approximately 7 residents independently after Nurse #1 told him about the allegation of abuse. NA #1 said that once he got home, he received a phone call sometime after 8:00 AM from the Administrator to advise him that he was suspended pending an abuse investigation. NA #1 said he told the Administrator the same thing that he told Nurse #1, that he told Resident #1 to shut up, but that he did not hurt the Resident. NA #1 said he received abuse and neglect training during orientation training at the facility and that he knew what abuse was and that it was not allowed. NA #1 further stated he did not return to the facility; the allegation of verbal abuse was substantiated and that he was terminated from employment. A telephone interview occurred on [DATE] at 1:45 PM with Nurse #1. During the interview, Nurse #1 stated she was the assigned Nurse for Resident #1 on [DATE] for the 11 PM - 7 AM shift. She described Resident #1 as alert/oriented, required extensive/total staff assistance with his nursing care, and frequently used his call bell to request staff assistance. Nurse #1 stated NA #1 was the assigned nurse aide for Resident #1 that night, he was a new employee who she had not previously worked with before. Nurse #1 stated that around 5:30 or 6:00 AM on the morning of [DATE], while the nurse aides completed their final rounds, Resident #1 put his call light on. She stated that she observed NA #1 enter Resident #1's room, turned off the Resident's call light and after a short time, he left the Resident's room. Nurse #1 stated moments later, Resident #1 put his call light back on while yelling Help me repeatedly. Nurse #1 stated she responded to the Resident's call light and observed Resident #1 bleeding from a skin tear to his left forearm, a bruise to his right cheek and a bruise to his forehead. Nurse #1 stated these were new changes to his skin that she had not observed on him earlier in the shift. When she entered the room, she stated Resident #1 screamed That guy beat me up and told me to shut up; don't let him back in here. Nurse #1 stated to calm Resident #1 down, she had to assure him that NA #1 would not be allowed back into his room; she cleaned him up with staff assistance and dressed the skin tear. Nurse #1 asked Resident #1 to tell her what happened. Resident #1 stated that NA #1 got in his face, struck him twice in the head, forcefully put him in bed and told him to shut up because he kept yelling. Nurse #1 stated after Resident #1 was cleaned up, she found and confronted NA #1. Nurse #1 stated she asked NA #1 what happened with Resident #1. NA #1 told Nurse #1 I just told him to shut up and be quiet. Nurse #1 said she advised NA #1 that he could not speak to a resident that way and told NA #1 not to go back into Resident #1's room. Nurse #1 said she told NA #1 that Resident #1 accused him of abuse and did not want him back in his room. Nurse #1 said she did not immediately suspend NA #1 because there was no one to replace him; but allowed him to complete his nursing rounds independently. Nurse #1 stated she contacted the Administrator, left a voice message and completed a nursing round on all the residents who were assigned to NA #1 that shift. Nurse #1 stated I went behind him to make sure no other residents were abused, because if he would do that to an alert and oriented resident, I did not know what else he would do. Nurse #1 stated that she did not identify any other signs of abuse. Nurse #1 then stated when the Administrator returned her call, Nurse #1 advised the Administrator of the allegation of abuse Resident #1 made against NA #1. Nurse #1 said the Administrator asked Nurse #1 if NA #1 was still in the facility and she told the Administrator that he had already left. Nurse #1 stated she could not recall the specific time the Administrator returned the phone call, or the specific time NA #1 left the facility. Nurse #1 stated the Administrator arrived at the facility around 8:00 AM and asked Nurse #1 to write a statement about the abuse allegation and to conduct a second nursing round on all residents. Nurse #1 stated she conducted a second round on all residents assigned to NA #1 that shift and on all other residents in the facility; she stated that she did not find evidence of abuse for any other resident. Nurse #1 stated that she received abuse and neglect training several times over the prior 2 years of her employment at the facility, but that she was not aware of the facility's policy to suspend a staff member accused of abuse. During a telephone interview on [DATE] at 3:30 PM, the Administrator stated while she was at home, she received a voice message from Nurse #1 around 7:34 AM and returned the call. The Administrator stated Nurse #1 told her that Resident #1 stated NA #1 struck him twice in the head, put him back to bed forcefully and told him to shut up. The Administrator said she asked if NA #1 was still in the facility and Nurse #1 told her he had already left shift. The Administrator said she immediately went to the facility, asked Nurse #1 to complete a round on all residents regarding any signs of abuse and interviewed Resident #1. The Administrator stated Nurse #1 did not identify any signs of abuse for other residents. The Administrator stated when she interviewed Resident #1, his statement was consistent with what he told Nurse #1. The Administrator stated she called NA #1, asked him to tell her what happened; he stated he told Resident #1 to shut up, but denied any physical abuse. The Administrator stated she told NA #1 he would be suspended pending an investigation of an allegation of abuse for Resident #1. During the interview, the Administrator reviewed the Initial Allegation of Abuse Report and the Investigation of Abuse Report and stated both reports were accurate. The Administrator stated she reported the abuse allegation to the police and a police report was filed. The Administrator stated that she was not made aware that NA #1 continued his assignment after Resident #1 accused him of physical/verbal abuse. The Administrator further stated NA #1 should have been suspended immediately, pending the outcome of the investigation and not allowed to care for other residents unsupervised.