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	345509	A. BUILDING ______ B. WING ______	C 02/13/2020

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ACCORDIUS HEALTH AT ABERDEEN	**915 PEE DEE ROAD** **ABERDEEN, NC 28315**

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F 000	INITIAL COMMENTS A complaint survey was conducted on 2/4/20 and 2/5/20. Immediate Jeopardy was identified at: CFR 483.12 at tag F 600 at a scope and severity K Tag F 600 constituted Substandard Quality of Care. Immediate Jeopardy began on 8/2/19 and was removed on 2/6/20. An extended survey was conducted on 2/13/20. One of two allegations was substantiated. On 03/02/2020, the 2567 was amended to change the date of Immediate Jeopardy removal from 2/6/2020 to 2/7/2020 to allow the facility to complete the inservicing.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		2/14/20

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

Electronically Signed | 02/21/2020

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 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, psychiatric nurse practitioner interview, and physician interview the facility failed to prevent a resident (Resident #1) who had multiple incidents of agitated behaviors of hitting residents, threatening residents, pushing residents, kicking a resident, and throwing objects at others from abusing 5 (Residents #3, #4, #5, #6 and #7) of 5 sampled residents reviewed for abuse. Resident #3 sustained a large head laceration when she had a fall while near Resident #1 and Resident # 1 said he hit her. Resident #3 was taken to a hospital for treatment and it required 5 staples to close her head laceration. Resident # 5 sustained a head laceration and hematoma when Resident # 1 threw a toy after he became agitated which hit Resident #5 in the head. Resident #5 was taken to a hospital for treatment and it took 3 staples to close the head laceration. Resident #4 sustained a red eye after being hit in the eye by Resident #1. Resident #6 expressed his hand hurt after his hand was caught in a door that was slammed by Resident #1. Resident #3 sustained a skin tear when she fell after being shoved by Resident #1 and Resident #3 was kicked in the face by Resident #1. Resident #7 was hit in the back by Resident #1. The findings included: Immediate Jeopardy began on 8/2/19 when Resident #3 was found on the floor with a large head laceration and Resident #1 stated he hit Resident #3 because she deserved it. Resident # 3 was in close proximity to Resident #1 at the time of her fall. The immediate jeopardy was	F 600	F-600 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Executive Director and the Director of Nursing discussed on 2/6/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff on how to manage difficult behaviors, how to recognize escalating anxiety and aggression that potentiates a risk to others and what actions) should be taken when recognized. For affected residents: Resident number #1 was placed on 1:1 on 2/6/2020 to remove any risk of harming residents #3, #4, #5, #6, #7. For other residents with the potential to be affected:	

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removed on 2/7/20 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.

Record review revealed Resident # 1 was admitted to the facility on 4/26/19 to the facility's secured unit. The resident had diagnoses of dementia with behavioral disturbance, anxiety, and insomnia.

Resident # 1's 8/4/19 quarterly Minimum Data Set (MDS) assessment coded the resident as having severe cognitive impairment. The resident's last quarterly MDS assessment, dated 11/4/19, also coded the resident as having severe cognitive impairment. On the 11/4/19 MDS, Resident # 1 was also coded as having physical, verbal, and other behavioral symptoms, rejecting care; and ambulatory. According to the 11/4/19 MDS assessment, the frequency of the behaviors occurred as follows: physical behaviors were displayed for one to three days during the assessment period, verbal behaviors were displayed on four to six days of the assessment period, and other behaviors were displayed on one to three days of the assessment period.

Resident # 1's care plan which was initiated on 4/26/19, and most recently updated on 1/24/20, revealed the facility included the following problem which had originated at the time of Resident # 1's admission. The problem remained current. "(Resident) has a behavior problem and has a LEVEL II PASARR (The Level II PASARR

F 600

All residents have the potential to be affected by this alleged non-compliance. Resident #1 was placed on 1:1 on 2/6/2020 to remove any risk of harming any additional residents.

Facility plan to prevent re-occurrence:
All facility staff was re-educated on 2/6/2020 through 2/7/2020 by either the DON, SDC, or Administrator regarding the prevention of abuse or/neglect and managing difficult behaviors, recognizing escalating anxiety and aggression that potentiates a risk to others and what action(s) should be taken when recognized.

On 2/11/2020 the facility staff met with the psychiatrist, the Medical Director, Resident #1s medical physician, the psychiatric NP, and family to discuss interventions to handle his aggressive behavior towards other residents. Resident #1s medications were reviewed by both the medical physician and the psychiatrist and adjustments were made accordingly. Resident #1 will also remain on 1:1 until physician deems safe to remove.

The DON reviewed with the IDT all residents on the secure unit with behaviors that could potentially affect the safety of other residents. Those identified as not currently having psychiatry services were referred to psychiatrist for consult and med review.

Subsequently, Furniture was re-arranged

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screening is triggered by evidence of a serious mental illness (MI), Intellectual or Developmental Disabilities (IDD) or condition related to Intellectual or Developmental Disabilities (RC) as defined by state and federal guidelines.). He has inappropriate verbal and physical behaviors, wandering, invading others personal space and disorganized thinking related to dementia." Initial interventions, which were placed on the care plan on 4/26/19 and which remained as an active part of the care plan were as follows: Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet the resident's needs. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Praise any indication of the resident's progress/improvement in behavior. The resident's care plan also noted he used psychotropic medications for his behaviors. The goal for the resident was that he would have "fewer episodes of inappropriate verbal and physical behaviors, wandering, invading others personal space and disorganized thinking by review date."

On 8/2/19 Nurse # 2 documented at 4:45 PM in Resident # 1's record, "Resident was in close proximity of another resident that fell. This resident stated, 'I hit her and she deserved it.' Resident was noted to be aggressive towards staff and was medicated with PRN (as needed) Klonopin." (Klonopin is a drug used to treat anxiety. According to Resident # 1's physician

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on the secured unit in a pattern to decrease the likelihood that resident #1 would be agitated by pacing and wheelchair mobile residents. Resident #1 was also placed in a private room with his own sofa and family brought in music that he may enjoy. On 2/17/2020 a unit manager was put in place to oversee the secured unit.

Facility plan to monitor its performance to make sure that solutions are sustained: A behavior audit sheet will be done daily (M-F) by the DON, Administrator, or designee to monitor the behavior of resident #1 and to identify high risk behaviors exhibited by any other resident on the secured unit that may put another resident at risk. In addition, the audit sheet will monitor whether the staff took appropriate action if a high-risk behavior was identified to de-escalate the situation along with implementing an effective intervention. This monitoring process will take place daily (M-F) for 2 weeks, weekly for 2 weeks, then monthly for 3 months.

The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 2/14/2020.

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orders at the time of the 8/2/19 incident, Resident # 1 was receiving Klonopin on an as needed basis, Depakote, a medication for mood, on a scheduled basis; and Namenda, a medication for Alzheimer's dementia, on a scheduled basis.)

During an interview with the Director of Nursing (DON) on 2/5/20 at 8:45 the DON stated the resident who had fallen on 8/2/19 was Resident # 3.

Review of Resident # 3's record revealed she had a diagnosis of Alzheimer's. Resident #3 was assessed as having severe cognitive impairment on her 8/5/19 quarterly MDS and 11/5/19 MDS assessments. She was coded as ambulatory on both of these MDS assessments.

According to Resident # 3's nursing notes she was transferred to the hospital on 8/2/19 at 5:05 PM following the incident due to sustaining a large laceration to the back of her head during her fall. Nurse # 2 noted in Resident # 3's nursing notes, the resident returned to the facility on 8/2/19 at 10:45 PM with five staples to the back of her head.

During the interview with the DON on 2/5/20 at 8:45 AM, the DON reported the following. Resident # 3 had a history of falls, and it was not believed Resident # 1 had anything to do with Resident # 3's fall. There was no investigation regarding where the two residents were in relation to each other before the incident occurred. Resident # 1 was severely demented and he often took blame for things he did not do. She did not think that just because he said he had hit Resident # 1 meant that he had actually done so. On 2/5/20 at 5:00 PM, it was validated with the

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DON that she had not spoken to all of the staff members who had been working on the secured unit during the 8/2/19 incident before concluding that Resident # 1 had nothing to do with Resident # 3's fall and injury.

Nurse # 2 was interviewed on 2/4/20 at 5:00 PM and again on 2/5/20 at 11:10 AM and reported the following about the 8/2/19 incident. When she last looked at the residents prior to the 8/2/19 incident, Resident # 1 had been seated on the couch. Resident # 3 had been diagonally in front of him about five or six feet away. When she next looked up, Resident # 3 was on the floor and hurt near Resident # 1. When she went to check Resident # 3, Resident # 1 then made the statement he had hit her and she deserved it. Nurse # 2 stated Resident # 1 could be aggressive, and he could go from "zero to sixty in a minute"; indicating he was without behaviors one minute and within 60 seconds could be displaying aggressive behavior. The nurse stated he did threaten other residents, but he was confused. The nurse stated Resident # 1 would not always give signs that he was about to become combative or strike out. At other times, he would start talking about the dead and at times this indicated he was starting to get agitated and threatening to others.

A psychiatric Nurse Practitioner (NP), who sees Resident # 1 for care on a monthly basis, was interviewed on 2/5/20 at 3:00 PM. The NP was interviewed regarding Resident # 1's ability to recall his actions. The psychiatric NP stated he did still recall his family, and she felt his short term memory was intact for the immediate moment to the point if he said he did something, she felt he had the ability to recall for the moment

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he had done so.

On 8/25/19 a nurse noted at 6:45 PM in Resident # 1's nursing notes the resident was "getting really aggressive threatening to hit others. Staff has moved him away to a different area to diffuse the situation. He puts his fist up threatening to hit, talking about killing." There was no documentation Resident # 1 hurt anyone on 8/25/19.

On 9/8/19 Nurse # 5 noted at 6:00 PM in Resident # 1's nursing notes he was "threatening to hit another resident. Cursing, talking loudly and waving his arms about. Saying he will take them out. Threatened writer, when writer intervened. Resident taken to room and is lying down now." The nurse noted she would continue to monitor his behavior. There was no documentation Resident # 1 harmed anyone on 9/8/19.

On 9/17/19 Nurse # 1 documented in Resident # 1's nursing notes (with no time entry), "Resident observed resting on couch when this nurse heard a resident yell out in pain observed resident with his hand balled up into a fist. While separating resident's resident states 'I will hit you again' with his fist balled up. Refused vital signs." According to the note the physician and family were notified.

Nurse # 1 was interviewed on 2/5/20 at 10:15 AM and reported the following. On the date of 9/17/19 Resident # 1 was seated on the couch as Resident # 4 went by him. She (the nurse) heard Resident # 4 yell out. She had not seen Resident # 1 actually hit the resident but saw him have his fist balled up and say he had done so. She saw Resident # 4's eye was red.

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A review of Resident # 4's record revealed she had a diagnosis of Alzheimer's and a quarterly MDS assessment, dated 9/17/19, noted Resident # 4 had severe cognitive impairment. A nursing note in Resident # 4's record regarding the incident read, "Resident noted to be propelling around unit. This nurse heard resident yell out in pain. Observed Resident moving her hand towards her right eye sitting in front of couch where another resident was resting on. Residents separated and this resident assessed. Area surrounding rt (right) eye red, non-tender to touch. When asked what happened Resident states, 'He hit me' and points to her right eye."

During an interview with the DON on 2/5/20 at 8:45 AM, the DON stated the incident had occurred at 12:10 PM according to the incident report. She stated Resident # 4 propelled herself in a wheelchair and stopped in front of the couch where Resident # 1 was seated. Resident # 4's eye was reddened when Resident # 1 hit Resident # 4 in the eye. The residents were immediately separated.

On 9/17/19 at 9:00 PM Nurse # 2 noted in Resident # 1's nursing notes he had been up most of the shift and at 6:00 PM had been agitated, yelling and threatening other residents. He was medicated with Klonopin per a PRN order to do so and had no further behaviors after the PRN medication. There was no documentation anyone was hurt on 9/17/19.

On 9/26/19 at 2:11 PM Nurse # 3 documented in Resident # 1's nursing notes, "Resident was sitting on the sofa in the common area near the dining room. He was fussing at a female resident as well as kicking at her. This caused other

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resident to stumble and fall. He then stated, 'That's why I kicked her.' Residents were separated and redirected." Nurse # 3 further noted the resident's physician was notified.

Nurse # 3 was interviewed on 2/5/20 at 11:28 AM and reported the following. The resident who fell on 9/26/19 was Resident # 3. Prior to the fall, Resident # 1 had already been agitated that morning. He was on the couch at the time of the incident and Resident # 3 went up to him and tried to talk to him. He started to kick at her upper legs in a manner to signify go away. She was facing him as he was kicking at her. As he kicked, she turned, stumbled and fell. Nurse # 3 stated she could not tell if the actual kick made Resident # 3 fall or if in turning to get away from him she fell. Resident # 3 was not hurt.

A review of Resident # 3's nursing notes for 9/26/19 and 9/27/19 revealed no injuries had been sustained from the incident and fall.

According to Resident # 1's care plan, an update was made noting the incident. Under interventions, a notation was made for the 9/26/19 incident which read, "Residents were separated by staff. Activities provided to divert residents attention."

During an interview with the DON on 2/5/20 at 8:45 AM, the DON stated the residents were separated on 9/26/19 and provided activities on that day as an intervention.

On 9/26/19 at 5:15 PM Nurse # 2 documented in Resident # 1's nursing notes, "agitated, yelling at other residents making verbal threats." Nurse # 2 noted he could not be redirected and therefore

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was medicated with PRN Klonopin with "some effect." There was no documentation a resident was harmed at that time.

On 9/27/19 at 10:20 PM Nurse # 2 documented in Resident # 1's nursing notes, "heard a banging noise coming from resident's room then the door opened, and resident came out cursing and yelling at roommate. He then slammed the door catching roommates hand. He then stated, 'I hit him.' Staff separated the residents." Nurse # 2 further documented the physician was called and Resident # 1's Depakote was increased to 250 mg twice per day. (His prior dosage had been 125 mg twice per day.)

Nurse # 2 was interviewed on 2/5/20 at 11:10 AM and reported the following about the 9/27/19 incident. She (Nurse # 2) had been standing at the nursing desk facing Resident # 1's room when the door was opened. Resident # 1 stood inside the doorway facing out towards her and the desk. Resident # 6 (the resident's roommate) was outside the doorway facing towards their room and therefore had his back towards the nurse. She saw Resident # 1 slam the door and then Resident # 6 held his hand as if it was hurt. Although Resident # 1 said he hit Resident # 6, she had not witnessed this and saw no evidence of an injury from a hit.

Resident # 1's care plan was updated to reflect the physician reviewed Resident # 1's medication and his medication (Depakote) was increased on 9/27/19.

During an interview with the DON on 2/5/20 at 8:45 AM, the DON stated Resident # 6's hand had been x-rayed by a mobile company after the

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9/27/19 incident and Resident # 6 had no broken bones from the incident. She did not feel Resident # 1 deliberately slammed the door on Resident # 6's hand.

According to physician orders, Resident # 1 was begun on Seroquel 25 mg twice per day on 10/4/19.

On 10/10/19 Nurse # 2 documented in Resident # 1's nursing notes for the "3-11 shift", "Became agitated with a female resident when she tried to pass by him. He threw a cup of water on her when she tried to pass by him and called her derogatory names including racial slurs." There was no documentation the resident was physically hurt.

On 10/14/19 at 11:50 AM Nurse # 1 documented in Resident # 1's nursing notes, "Resident threatening to hit other resident (2). Punching the walls. Knocking over side table. Cursing and telling people he's going to kill them dead." Nurse # 2 noted the physician was called and an order for Haldol 5 mg for a one-time dose was given. There was no documentation a resident was harmed on this date.

On 10/28/19 Nurse # 1 documented at 10:00 AM in Resident # 1's nursing notes he was quietly cursing at residents as they walked by from time to time. He would stand up and walk towards staff and threaten "to hit someone in the head and kill the dead." The nurse noted she was able to distract Resident # 1 with a magazine. On 10/28/19 at 11:30 AM Nurse # 1 documented Resident # 1 was threatening other residents and his cursing at staff was increasing. He had attempted to hit another resident on the couch

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F 600	Continued From page 11 who was asleep and he had thrown the side table around. The nurse noted she tried to medicate Resident # 1 with PRN Klonopin and he spit it out. A call was placed to the physician. At 12:25 PM on 10/28/19 Nurse # 1 noted the behaviors were still present and no return call had been received. At 12:33 PM on 10/28/19, Nurse # 1 noted an order was obtained from the medical director to administer an IM dose of Haldol 5 mg. The medication was given at 12:35 PM with great difficulty as Resident # 1 hit and kicked staff. There was no documentation a resident was harmed on this date. Nurse # 1 was interviewed on 2/5/20 at 10:15 AM and recalled the table that Resident # 1 had thrown was a bedside table. She did not recall specific residents he had threatened in particular or used racial slurs towards. According to the nurse he threatened different residents, and the resident who had been asleep on the couch had not been bothering him. According to Nurse # 1 he was not targeting any particular resident. He just became upset with others and at times there was no apparent reason or trigger. On 11/1/19 at 5:30 AM a night shift nurse documented in Resident # 1's nursing notes he had been up most of the night and that he "was nice one minute and not nice the next." On 11/5/19 at 6:00 AM Nurse # 4 documented in Resident # 1's nursing notes, "Resident is very agitated, pacing, cursing, threatening staff and other residents." Nurse # 5 documented she administered the resident's PRN Klonopin with little effect. There was no documentation a resident was hurt on this date.	F 600		

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On 11/11/19 at 7:10 AM Nurse # 1 documented in Resident # 1's nursing notes, "Resident came out of his room and rolled a wheelchair into a seated resident at a table." Nurse # 1 noted the social worker was on the unit and helped distract the resident. The nurse noted she tried to administer Resident # 1's PRN Klonopin but he refused to take it. On 11/11/19 at 7:25 AM, Nurse # 1 documented "Resident pushing resident in wheelchair cursing and trying to push him into the table. Refusing to let wheelchair handles go. Able to distract resident with needing him to look at work order. Resident still cursing, calling people names, and threatening to kill people." Nurse # 1 noted on 11/11/19 at 7:35 AM that she was able to administer the PRN Klonopin to the resident. The nurse noted on 11/11/19 at 7:41 AM that the physician would be in to see Resident # 1.

Nurse # 1 was interviewed on 2/5/20 at 10:15 AM and reported the following. She did not recall who the resident was that was seated at the table. The staff kept a wheelchair available in the common area for emergency purposes. On 11/11/19 Resident # 1 had taken the empty wheelchair and rolled it into the back of a resident's chair as he was seated at a table, thereby pushing the resident into the table.

On 11/12/19 at 12:00 PM Nurse # 1 documented in Resident # 1's nursing notes he was "cursing threatening to hit staff and residents. Unable to distract resident with food, music and fixing a table." The resident was given PRN Klonopin. There was no indication anyone was hurt.

On 11/12/19 at 9:15 PM Nurse # 2 noted in Resident # 1's nursing noted he had been combative and threatening "others" earlier in the

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shift and was medicated with Klonopin. There was no documentation he harmed anyone.

On 11/14/19 at 8:30 PM Nurse # 2 documented in Resident # 1's nursing notes, "agitated, yelling, threatening other residents and trying to hit staff." He was medicated with PRN Klonopin. There was no documentation he harmed anyone.

On 12/5/19 at 3:15 PM, Nurse # 2 documented in Resident # 1's nursing notes he was "agitated and making verbal threats 'I'm going to kill you' to other residents." Nurse # 2 documented Resident # 1 was given PRN Klonopin and it had "some" effect. There was no documentation anyone was harmed on this date.

On 12/10/19 at 1:30 AM Nurse # 4 documented in Resident # 1's chart, "Resident awake and came out of room very agitated; cursing and threatening 'to kill' and hit staff and residents awake in common area. Redirection unsuccessful, all attempts to calm resident unsuccessful." The nurse noted she medicated Resident # 1 with PRN Klonopin and it was "seem-effective." There was no documentation he harmed anyone at that time.

On 12/10/19 at 4 PM Nurse # 1 documented that at 2:40 PM "Resident pushed another resident that was trying to sit down next to him on the couch. Then Resident punched a resident in the back (middle) when resident had stopped propelling to talk to another resident." Nurse # 1 noted she medicated Resident # 1 with PRN Klonopin.

Nurse # 1 was interviewed on 2/5/20 at 10:15 AM and reported the following about the incident of

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12/10/19. Resident # 1 had been on the couch and Resident # 3 had walked up to the couch to sit down beside of him. Resident # 1 hit Resident # 3 in the back causing her to fall forward. She would have fallen forward but Resident # 7 was in a wheelchair in front of them and caught Resident # 3 as she fell. As Resident # 7 leaned forward to catch Resident # 3, then Resident # 1 also hit Resident # 7 in the back. Resident # 7 was not hurt. Resident # 3 had a red imprint from the hit to her back which was blanchable and disappeared in a short time. She did not bruise.

On 12/11/19 at 5:40 PM Nurse # 2 documented in Resident # 1's nursing notes he was agitated, cursing, and verbally threatening other residents. The nurse noted Resident # 1 "continues to state he is going to kill them." The resident was medicated with PRN Klonopin. There was no documentation anyone was harmed on this date.

On 12/13/19 at 10:30 AM Nurse # 1 documented in Resident # 1's nursing notes he was "agitated, cursing and yelling with staff and other resident. Threatening and following with objects in hand behind staff and other resident. Unsuccessful with distractions of offering food and redirection." Nurse # 1 documented she administered PRN Klonopin and Resident # 1 stopped threatening and following others.

Nurse # 1 was interviewed on 2/5/20 at 10:15 AM and reported she remembered just that one day that he followed residents around with objects and would shake the objects, but he did not harm anyone that day. The objects were metal utensils and plastic plates and cups. The nurse did not recall any specific resident that Resident # 1 was following or targeting but followed different ones

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F 600	Continued From page 15 around on 12/13/19 with the objects. On 12/13/19 at 10:00 PM Nurse # 1 documented in Resident # 1's nursing notes he was cursing, yelling and saying derogatory and racial slurs to another resident. He attempted to hit the resident. There was no documentation the other resident was hit or harmed. On 12/17/19 at 6:05 PM Nurse # 2 documented in Resident # 1's nursing notes, "This writer heard a bang and came out of another resident's room. O.T. (Occupational Therapist) reported that the resident had shoved another resident knocking her to the floor." The nurse noted the physician was notified. During an interview with the DON on 2/5/20 at 8:45 AM, the DON stated the resident who had been knocked to the floor was Resident # 3 and she had sustained a skin tear. The O.T., who had witnessed the incident, was interviewed on 2/5/20 at 2:00 PM and reported the following. She (the O.T.) had been in the common area and there were other staff members at other tables helping other residents. Resident # 1 was at a table in the common area by himself. He had his elbow propped on the table and his face in his hand as if he was about to fall asleep. He was not agitated in anyway. Resident # 3 routinely walked around the common area. As Resident # 3 came up beside Resident # 1 from the rear of where Resident # 1 was sitting, Resident # 1 swung his arm outward and backward; thereby backhanding Resident # 3. The OT pointed to a wall partition in the middle of the secured unit's common area during the interview. The partition was about four feet from	F 600		

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where the OT stated Resident # 1 had been sitting. The O.T said she heard a "thunk" as Resident # 3 hit the partition and landed on the floor from the hit. The O. T. said Resident # 3 never knew Resident # 1 was in the world before the hit. She was just walking in her normal manner by him and he in turn had showed no signs of agitation. The swing was sudden and unanticipated by any staff in the area. Resident # 1 had not been looking at Resident # 3 before he hit her.

Part of the interview with the O. T. was held on the unit. At the end of the interview, Resident # 3 was observed to be walking independently around the unit. She came up to the O. T., hugged the O. T. and touched her clothing. She appeared very confused and affectionately wanted to be close and touch the O. T.

Twelve hours and forty minutes after the 12/17/19 incident, Nurse # 4 documented on 12/18/19 at 6:45 AM in Resident # 1's nursing notes, "Resident told fellow resident (Resident # 3) he was going to 'knock her on her ass again.' CNAs (certified nursing assistants) aware to watch for resident behavior. Will continue to monitor."

Nurse # 4 was interviewed on 2/5/20 at 10:53 AM and reported the following. She did not know if Resident # 1 recalled hitting Resident # 3 on the previous shift when he threatened her on the morning of 12/18/19. Nurse # 4 stated she just documented what Resident # 1 said. Nurse # 4 was interviewed regarding the resident's behaviors in general. Nurse # 4 reported that during the night shift, most residents were asleep and therefore it was easier to supervise him regarding other residents, but he was very

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combative with care. Nurse # 4 reported Resident # 1 could be fine and "then before you can blink" he changes and starts swinging.

According to the resident's care plan, on 12/17/19 one on one staff was placed with the resident after the 12/17/19 incident.

On 12/18/19 Klonopin was added to Resident # 1's regularly scheduled medications in the dosage of .25 mg every six hours. Also, a PRN order was given for a topical psychotropic medication to be added to the medication regimen; ABH gel every twelve hours as needed. (It is a combination medication of Ativan, Haldol, and Benadryl).

Interview with the DON on 2/5/20 at 3:30 PM revealed a one on one staff member was placed with Resident # 1 for three days after the 12/17/19 incident in which he backhanded Resident # 3. After three days Resident # 1 was cleared by his physician before the staff member was removed. The topical ABH gel was a totally new medication for the resident also. It had to be compounded in the pharmacy, and it could be applied to the resident's skin when he was agitated.

On 12/26/19 at 2:30 PM Nurse # 1 documented in Resident # 1's nursing notes, "Resident sitting on the couch kicked another resident in the face when other resident bent over to pick up something on the floor." According to the nursing note, the physician was contacted and increased Resident # 1's Klonopin dosage. (According to orders, it was increased from .25 mg to .5 mg every six hours.)

According to Resident # 3's nursing notes, she

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was the resident kicked in the face on 12/26/19. The resident was not documented as injured.

On 1/24/20 at 7:34 PM a nursing note read in Resident # 1's record, "Resident was noted to be chewing on a large object thought to be paper. NA (nurse aide) attempted to look in resident's mouth and resident became angry and started yelling and grabbed a wooden and metal toy to throw at NA, but the toy went the other way and struck another resident in the back of the head. Resident continues to yell and swing at anyone nearby."

Review of Resident # 5's nursing notes revealed she was the resident who was hit in the head on 1/24/20. According to her nursing notes, she was sent to the hospital because the toy caused a hematoma and laceration to her head. She returned to the facility on 1/25/20 at 12:30 AM with three staples to her head due to the head laceration.

Review of Resident # 1's care plan revealed it was updated on 1/24/20 to reflect Resident # 1 had been redirected, given ice cream, and medicated with PRN medication for behaviors following the incident. Residents were removed from the area. Staff were educated to step away from the resident when he becomes belligerent and give him time to de-escalate. Staff were educated to refrain from physically trying to remove objects from resident if he is not in harms way or causing harm to others.

NA # 1 was interviewed on 2/4/20 at 4:20 PM and reported the following. She had been concerned about Resident # 1 on 1/24/20 because he had put a wad of paper napkin/towel in his mouth. The

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wad was such that if he had swallowed it, he would have probably choked. At times the resident would trade food and give up to staff what he had in his mouth, but that did not work that night. Therefore, NA # 2 held his hands and she (NA #1) removed the wad of paper so he would not choke. He got mad after that, walked away, picked up the toy and threw it hitting Resident # 5 in the head. NA # 1 reported there had been other times she had witnessed Resident # 1 sitting quietly and then for no reason he would start cursing and become agitated. It did not always take a specific reason for him to have behaviors.

NA # 2 was interviewed on 2/4/20 at 4:40 PM and reported the following regarding the 1/24/20 incident. Following the removal of the wad of paper from Resident # 1's mouth, he became angry. He picked up the toy and "slung it." The NA said she thought Resident # 1 was intending to hit her with it, but it hit Resident # 5 instead. NA #2 reported she had witnessed Resident # 1 throw objects before the incident such as plastic cups, glasses and a plate. She said he "talked about killing people." She said the staff were trained to try to get other residents away from him when he became agitated.

Nurse # 2 had been the nurse on duty at the time of the 1/24/20 incident. Nurse # 2 was interviewed on 2/4/20 at 5:00 PM and reported the following. She had been coming out of another room to the nursing desk when she saw Resident # 1 throw the toy and hit Resident # 5 in the head. Nurse # 2 showed the toy that had been thrown. The toy was observed to be a "roller coaster" toy which had a wooden base approximately 12 inches in length and 5-8 inches in width. From the base,

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there were wires attached in a roller coaster pattern of curves, and pegs could be maneuvered along the wires. According to Nurse # 2 when the resident threw the toy, he threw the whole toy.

NA # 3 was interviewed on 2/5/20 at 8:20 AM and reported the following. She usually worked on the secured unit. She had witnessed Resident # 1 throw objects such as metal utensils and plastic cups before. Sometimes there were no clear reasons why he became agitated and it could happen suddenly. They tried to monitor him the best they can.

NA # 4 was interviewed on 2/5/20 at 9:55 AM and reported Resident # 3 "swings at everybody." She did not think he targeted any one person. Within the past 2 months she had witnessed Resident # 1 throw the roller coaster toy twice before he threw it on 1/24/20. The first two times he threw it, it did not hit anyone. She had witnessed that when Resident # 1 got agitated, he would just grab whatever he saw and had thrown plastic things as well. The staff tried to let him walk until he calmed down. Walking sometimes helped him calm down and other times it didn't.

During an interview with the DON on 2/5/20 at 8:45 AM and a follow up interview on 2/5/20 at 3:30 PM, the DON reported the following. On the incident of 1/24/20, Resident # 1 had not been aiming at a resident when he threw the toy and the toy ricocheted off a partition before it hit Resident # 5. The DON was not aware Resident # 1 had thrown the roller coaster toy before the incident of 1/24/20. She reported another cognitively impaired resident spent a great deal of time with the roller coaster toy and it helped to engage this other resident. The facility had tried

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multiple medication adjustments with Resident # 1. Having worked with Resident # 1 she did not think his actions were targeted towards any resident. They had educated their staff to remove other residents from the area when he became agitated so they would be out of harm's way.

Resident # 1's medical physician was interviewed on 2/5/20 at 4:20 PM and reported the following. She recognized Resident # 1's behaviors could pose a threat to other residents, and they had tried multiple medication adjustments. Regarding the specific incident that had occurred on 8/2/19 the MD stated Resident # 1 may have hit Resident # 3, but she did not feel that just because he said he did so, meant that he did do it. According to the MD, Resident #1 could have said he hit her but may not have done so and Resident # 3 could have just fallen. The MD also stated that she cared for Resident # 3 and Resident # 3 is very active; getting close to residents as she wanders around the unit. According to the MD if Resident # 1 had hit Resident # 3 or any other resident, then his dementia was advanced, and he struck out as a part of his disease process. The physician did not feel Resident # 1 singled Resident # 3 or any other resident out, but Resident # 3 was more at risk because she unknowingly had habits of wandering into his space.

Resident # 1 was observed on 2/4/20 at 11:20 AM as staff tried to direct him to walk to the visiting eye physician. Resident # 1 appeared confused. He would stand, look at the staff member without moving for a while, cross his arms, continue to stand without moving, and then start to walk with a great deal of prompting and guidance from staff.

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The Administrator was interviewed on 2/5/20 at 5:00 PM. According to the Administrator he had just become employed at the facility during the previous week, which began on 1/26/20, and therefore he had not been present during any of the incidents that had occurred.

On 2/6/20 at 2:25 PM the Administrator was informed of the Immediate Jeopardy. The facility provided a credible allegation of Immediate Jeopardy removal on 2/6/20. The allegation of Immediate Jeopardy removal indicated:

F600
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
On 8/2/19 Resident #3, who has a known history of falls, was observed on the floor in the proximity or Resident #1 who claimed, "I hit [ ] and [ ] deserved it". Because of the frequent falls of Resident #3 and a history of Resident #1 claiming blame for acts he was known not to have been responsible for, staff was unable to determine that Resident #1 had in anyway caused the fall. Resident #1 has a diagnosis of dementia with a Brief Interview of Mental Status (BIMS) Score of 2 out of 15 with 15 being an indication of no memory impairment. Resident #3 was sent to the hospital for a laceration of the head that required 5 staples to close. As a plan of care was in place that included medication and behavioral interventions and the cause was not conclusive, no changes were made to the plan of care.

On 9/17/19 Resident #4 shouted "Ow". Staff noted that Resident #1 had a balled-up fist and was standing in front of Resident #4. Resident #4

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was noted to have a reddened area around the eye suggesting that Resident #4 had been struck. The plan of care was reviewed, determined to be appropriate and continued. On 9/19/19, Medications were adjusted after conferring with the physician.

On 9/26/19 Resident #1 kicked Resident #3 when Resident #3 attempted to talk with him. The kick caused Resident #3 to fall but did not sustain an injury. Resident #1's care plan was revised to reflect the need to keep Resident #1 and Resident #3 separated and to divert Resident #1's attention away from Resident #3.

On 9/27/19 Resident #6's hand was caught in the door when Resident #1 slammed it shut. Resident #6 was a roommate to Resident #1 at the time. It could not be determined if this was accidental or a deliberate act to injure Resident #6. Resident #6 did not sustain an injury. Resident #1's medications were reviewed and adjusted by the physician. On 10/4/19, medications were further adjusted after conferring with the physician.

On 10/14/19 Resident #1 was displaying anxiety with agitated behaviors, threatening others. In effort to address this anxiety, the physician was notified and a "Now" dose of psychotropic was ordered as well as adding new dose schedule. The resident remained under control and no other Residents were involved.

On 10/28/19 the resident was again behaving in an agitated manner threatening staff verbally and physically. Because this agitation has led to aggression in the past, staff contacted the physician who prescribed a "Now" dose of psychotropic medication and again changed the

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	345509	A. BUILDING ______ B. WING ______	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24 dose schedule. On 11/11/19, Resident #1 pushed an empty wheelchair into an unidentified resident who was sitting at a table causing the resident to be propelled into the table. The unidentified resident was not injured. There was no change to Resident #1's care plan. The Psychiatric Nurse Practitioner say Resident #1 on 11/11/19 and medication adjusted. On 12/10/19, Resident #3 attempted to sit next to Resident #1 and Resident #1 hit Resident #3 on the back of the head causing Resident #3 to fall. Resident #3 was caught by another resident before completing the fall. Resident #3 had a red mark on back for a short period. Revisions to the Care Plan of Resident #1 include separating the two residents and redirecting Resident #1. Resident #1 was seen by the Psychiatric Nurse Practitioner on 12/9/19 and effective 12/10/19 medications were adjusted. On 12/13/19, Resident #1 was threatening, cursing and following another resident throughout the unit with objects that were noisy and potentially threatening. No injuries were associated with this action. Resident #1 had a medication adjustment as a result. On 12/17/19, Resident #3 was passing Resident #1 who appeared to be dosing off. Instead Resident #1 reached out and struck Resident #3 causing Resident #3 to lose balance and strike the wall. Resident #3 did not sustain an injury. The resident was placed on 1:1 in response. On 12/18/19 behavior was addressed with physician and medications adjusted. On 12/19/19 it was further adjusted to a routine medication. The	F 600		

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F 600	Continued From page 25 Psychiatric Nurse Practitioner saw Resident #1 on 12/23/19 and added an additional medication while discontinuing another. The resident was taken off 1:1 at that time. On 12/26/19, Resident #1 kicked Resident #3 in the face as Resident #3 bent down to pick something up from the floor. Resident #1 had an increase in psychotropic medications as a result. Resident #1 was seen by the Psychiatric Nurse Practitioner by 1/14/20. On 1/24/20, resident #1 threw a wooden and metal object against the wall where it broke causing pieces to ricochet into the back of Resident #5's head. All residents who reside on the unit with Resident #1 are at risk of injury from Resident #1 who may become aggressive without apparent provocation and in an unpredictable manner. Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when the Action will be complete. Resident #1 was placed on 1:1 on 2/6/20 for the protection of other residents. Resident #1 will remain on 1:1 for the duration of stay or until physicians and psychiatrists concur that the resident no longer poses a threat to others. The 1:1 staff have received additional focused training by the Director of Nursing regarding methods of engaging, distracting, de-escalating Resident #1 on 2/6/20. All Staff on each shift, including Nursing, Activities, Social Work, Dietary, housekeeping and maintenance, were re-educated by the Director of Nursing, Staff	F 600		

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F 600	Continued From page 26 Development Coordinator and/or Administrator on 2/6/20 through 2/7/20 on the Prevention of Abuse or/and Neglect. On 2/6 through 2/7/20, the Director of Nursing, Staff Development Coordinator and Administrator conducted trainings for all staff, on all shifts, including nursing, activities, Social Work, Dietary, housekeeping and maintenance, focused on Managing Difficult Behaviors, recognizing escalating anxiety and aggression that potentiates a risk to others, and what action should be taken when recognized. In order to expand the interdisciplinary problem solving, the facility has scheduled a meeting with the Ombudsman, Resident #1's family members, Psychiatrist, Attending Physician, Medical Director and facility leadership to discuss recommendations for improved management of Resident #1. Further the team will study the impetus for Resident #1's focus on Resident #3 and develop a plan to protect Resident #3 and improve quality of life for Resident #3 and all residents at risk on the Unit. The facility alleges removal of the Immediate Jeopardy as of 2/7/2020. On 2/13/20 the facility's plan for immediate jeopardy removal was validated by the following. On 2/13/20 at 9:55 AM, Resident # 1 was observed with a one on one staff member in place by his side. Resident # 1 was quiet and resting with his eyes closed. Review of inservice training records revealed staff from all shift and disciplines had been inserviced on 2/6/20 and 2/7/20 regarding abuse and "Escalation of Aggression and Anxiety" in residents. Beginning at 10:00 AM on 2/13/20 multiple interviews were conducted with staff in different departments/shifts. These interviews validated	F 600		

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F 600	Continued From page 27 staff had undergone training the previous week regarding abuse and dealing with agitated and confused residents who posed a risk to others. Interviews with direct care staff on 2/13/20 also confirmed Resident # 1 had a one on one staff member placed with him since 2/6/20. Interview with the DON and an observation of the secured unit on 2/13/20 at 9:55 AM revealed furniture had been rearranged in the secured unit in a new pattern. The new pattern placed the couch, where Resident # 1 usually sat out of the open pathway typically used for pacing and wheelchair mobile residents. Resident # 1 had also been placed in a private room where the facility had also placed a sofa and a blanket he enjoyed. The DON provided evidence facility staff had met with a psychiatrist, the medical director, Resident # 1's medical physician, and the psychiatric NP on 2/11/20 to discuss interventions to handle his aggressive behavior towards other residents. During that time the resident's medications were again reviewed by both the medical physician and the psychiatrist. It was felt the Resident's Namenda and Melatonin for sleep could be contributing to some of his agitation. Those medications were discontinued. Family provided music and activity options they felt were helpful and volunteered to sit with him twice per week. Per the DON, the facility was planning to place a unit manager on the secured unit and research specific training for her as well as research activity models used other places to keep dementia residents from escalating to an abusive point.	F 600		