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	NH0121	A. BUILDING: _____ B. WING _____	C 12/16/2022

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L 000	INITIAL COMMENTS A licensure complaint survey was conducted from 12/14/22 through 12/16/22. The following intakes were investigated NC00195353 and NC00195280. Intake NC00195280 was a facility reported incident. Two of the two complaint allegations were substantiated resulting in a deficiency (10A NCAC 13D .2210 (A). A Type B violation was identified at 10A NCAC 13D .2210. A "Type B Violation" means a violation by a facility's licensee of the regulations, standards and requirements set forth in G.S. 131E-117 or applicable State or federal laws and regulations governing the licensure or certification of a facility which is detrimental to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm will occur.	L 000		
L 049	.2210(A) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (a) A facility shall take measures to prevent patient abuse, patient neglect, or misappropriation of patient property, including orientation and instruction of facility staff on patients' rights and the screening of and requesting of references for all prospective employees. This Rule is not met as evidenced by:	L 049		

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Based on observation, record review and staff interview the facility failed to protect a resident's right to be free from abuse for 1 of 1 sampled resident (Resident #1). Nurse Aide (NA) #1 was recorded on the facility's video camera pushing Resident #1. Resident #1 fell to the floor. Following physical assessment, Resident #1 did not have any physical injury. Resident #1 did not have the cognition to express an adverse outcome, however, a person residing in a nursing home would not have expected a caregiver to push any resident to the floor. This action by staff would have been unexpected and resulted in increased agitation following the fall for which the facility administered a psychotropic medication.

The findings included:

An observation of video surveillance recorded on 11/6/22 was conducted on 12/15/22 at 10:36 AM. The video recording was visual only. There was no sound recorded. The video surveillance was saved in four different files. The four different files contained four different views of the South Hall where the alleged abuse occurred with Resident #1. The videos revealed the following:

a.) Video surveillance #1 revealed Resident #1 walking down the hall exiting a resident's room. The Resident #1 was then observed to enter another resident's room. NA #1 was observed pushing a tray cart down the hall. When NA #1 passed the room that Resident #1 entered, Resident #1 was observed exiting the room and began following NA #1. Resident #1 was not wearing pants and was gripping a towel around her waist with one hand. Resident #1 was observed to reach out and grab NA #1's arm and NA #1 was observed to jerk her arm out of Resident #1's grasp. NA #1 and Resident #1 were

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observed to leave the view of the video surveillance. Nurse #1 was observed to come into view of the camera coming down South Hall and attempted to redirect Resident #1. Nurse #1 attempted to calm Resident #1 by standing directly behind Resident #1 and holding Resident #1. NA #1 threw off her mask as Nurse #1 redirected Resident #1.

b.) Video surveillance #2 briefly showed NA #1 pushing a tray cart as Resident #1 followed. Video surveillance #2 was a view of the resident lounge area where two residents were sitting.

c.) Video surveillance #3 showed NA #1 with tray cart, NA #1 stopped briefly halfway in the view of the camera and appeared to shout down the hall. NA #1 turned around to face Resident #1, NA #1 pointed and appeared to say something to Resident #1. NA #1 was observed to place her hands on Resident #1's shoulders and began pushing Resident #1 from the front, resident's body turned as NA #1 continued to push Resident #1 out of the view of camera. Video ended.

d.) Video surveillance #4 revealed Resident #1 walking behind NA #1 at the end of the hall. Resident #1 and NA #1 stood in front of the nurse's station. NA #1 turned around and pushed Resident #1 and Resident #1 fell to the floor on her bottom. NA #1 was observed standing directly over the resident and appeared to be yelling. After standing over Resident #1, NA #1 was observed to attempt to pull Resident #1 up by her arms to get her up off the floor. NA #1 was unsuccessful in getting Resident #1 off the floor by herself. Nurse #1 appeared in view of coming down the hall to assist with Resident #1.

Interview was conducted on 12/15/22 at 9:29 AM

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with NA #1. She revealed Resident #1 required constant redirection and could be aggressive. She stated on 11/6/22 she was picking up food trays when Resident #1 had come out of a room and "ran up on her". NA #1 stated Resident #1 kept "coming" at her even though NA #1 was attempting to redirect the resident. NA #1 stated she suffered from anxiety and the way Resident #1 had approached her gave her "flash backs". NA #1 stated while Resident #1 continued to approach her, NA #1 called out for a nurse to come and get Resident #1 away from her. As Resident #1 approached NA #1 she stated she put her hands up causing Resident #1 to trip and fall. She stated she did not recall which nursing staff made it to her location first, but she recalled Nurse #1 arrived when Resident #1 fell on the floor. She stated it was Nurse #1 who assisted her with getting Resident #1 off the floor. NA #1 stated after the incident she was angry, left and went outside the building to calm down. When NA #1 returned into the building, she was asked to make a report and then leave. The next day she was terminated due to the facility stating they had her on camera and she had pushed Resident #1.

Nurse #1 was interviewed on 12/15/22 at 8:47 AM. She revealed on 11/6/22 she was passing medications and heard NA #1 yelling, "Come get this patient". Nurse #1 stated when NA #1 was yelling, she had pills in her hands and was administering medications. She stated after she administered the medication she walked to where the yelling was coming from. Nurse #1 stated that when she arrived at the location, NA #1 was yelling. She observed Resident #1 on the floor. She stated she had not seen how the resident fell and another staff (name unknown) and herself assisted Resident #1 off of the floor. another staff

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(name unknown) and herself assisted Resident #1 off the floor. Resident #1 was able to get on her feet and was really agitated. Nurse #1 indicated following the fall she felt Resident #1's agitation was due too many staff attempting to assist her at once (NA#1, NA#2 and NA#3). Resident #1 was observed moving around really fast and trying to hit at staff. The resident appeared to be trying to get away from everyone. Nurse #1 indicated she informed all the staff to back off, but they couldn't get Resident #1 to calm down. After the incident, Resident #1 was escorted to her room by NA#3 and Nurse #1 indicated she called the doctor and obtained an order to give the resident something to calm down. Nurse #1 could not recall the medication provided to Resident #1 but recalled it being effective. Nurse #1 revealed she thought the staff that escorted Resident #1 to her room was NA #3. NA #1 left the facility after Resident #1 was assisted up on her feet, then threw her badge and facemask to the ground. The Administrator was contacted. Nurse #1 stated she had told the Administrator she had not seen how the incident occurred, so she could not say for sure if the resident had been pushed. Nurse #1 described Resident #1 as being confused and combative at times. She stated she assessed Resident #1 following the incident and there were no visible injuries.

Review of Resident #1's November 2022 Medication Administration Record (MAR) revealed an order that stated Trazadone 50 milligrams (mg) give 25 mg by mouth every 12 hours as needed (PRN) for agitation. Resident #1 was administered 25mg of Trazadone on 11/6/22.

Interview with NA #2 on 12/15/22 at 11:16 AM

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revealed she worked the day of the incident involving Resident #1 on 11/6/22. She stated she was providing incontinent care when she heard a commotion. She stated when she got to the location the commotion was coming from, she saw NA #1 throw her badge on the floor. She revealed NA #1 stated Resident #1 had hit her with a towel and she was leaving. NA #2 stated Resident #1 was already off the floor when she arrived, and she had not witnessed NA #1 push Resident #1 or witness how Resident #1 fell. Resident #1 had no visible injuries.

Resident #1's incident report dated 11/6/22 and written by Nurse #1, revealed she had a fall at 6:30 PM. The incident report further revealed Resident #1 was agitated at the time of the incident. The description of the incident stated, "See witness form statement". Resident #1 had no injury identified on the incident report. The incident report had two attachments titled, Witness statements.

1) The witness statement written by Nurse #1 stated an incident occurred at the end of the south hall by the new nursing station. Nurse #1 was notified by a nurse aide that Resident #1 had fallen. The witness statement continued that the NA was being followed by Resident #1 while she was collecting dinner trays. Per the NA, Resident #1 was agitated during the event and had slapped the NA in the face twice with an open hand. The writer of the witness statement documented that she had not witnessed the fall but had come to assess the resident once it was reported by the NA. Resident #1 was observed on the ground on her buttocks with her legs extended. Resident #1 was described as alert and oriented to herself and was at baseline for her current status secondary to her

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progressive dementia. After the initial assessment, no immediate injures were noted, however, Resident #1 was more agitated, exhibited by swinging and getting into other staff faces. The on-call physician was notified with orders to administer Resident #1 Trazadone (hypnotic) now and call back within 30 minutes if Resident #1's behaviors continued.

2) The witness statement written by NA #1 stated at around 6:30 PM she was picking up dinner dishes. When NA #1 approached a resident room, Resident #1 was coming out of another resident's room not wearing pants, with a towel wrapped around her bottom area. Resident #1 walked up on NA #1 as she always did, and NA #1 asked Resident #1 to go the other way towards her room. Resident #1 told NA #1 no and she continued to follow NA #1. NA #1 continued to ask Resident #1 to move and please get out of her face. NA #1 yelled for Nurse #1 to come and get Resident #1 out of her face. Resident #1 then smacked NA #1 in the face with a towel. She had laughed in NA #1's face. Resident #1 approached NA # 1 again and attempted to push NA #1. NA #1 put her arm out to block Resident #1 from hitting her a second time and Resident #1 fell while approaching NA #1.

Interview with the Director of Nurses (DON) on 12/15/22 at 11:02 AM revealed Nurse #1 contacted her on 11/16/22, two to three minutes after the incident happened. She stated Nurse #1 indicated she thought NA #1 had pushed Resident #1 and she wanted to know how to proceed. She stated after the incident she contacted the information technology (IT) department to deactivate NA #1's badge. The DON stated she further contacted the

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Administrator and the police department via the non-emergency line. The Administrator and herself reviewed the camera footage on 11/6/22 and determined NA #1 had pushed Resident #1 and she identified it as abuse. The camera footage showed Resident #1 following NA #1 down the hall. The camera footage did not have audio so it could not be determined what was being said, but NA #1 was speaking to Resident #1. NA #1 was observed on the video to push the resident causing Resident #1 to fall. The observation of the video footage of the event was abuse and the resident appeared to be agitated following the event.

Review of a 24-Hour Initial Report dated 11/6/22 at 6:39 PM revealed an alleged abuse to Resident #1 by NA #1. Law enforcement had been notified on 11/6/22 at 7:09 PM for suspicion of a crime with no serious bodily injury. The report was signed by the administrator on 11/7/22.

Police report dated 11/6/22 at 7:09 PM revealed there was an active investigation of simple assault that had occurred against Resident #1. The report was assigned an Investigating Officer (IO) on 11/7/22 through an automated service. Per the police report no injury or threat was noted at the time of the incident.

Interview with the Investigating Officer on 12/15/22 at 9:42 AM revealed the facility had filed a report online or through the non-emergency number. He stated he did not see the resident, nor did he arrive onsite to the facility. According to the report, Resident #1 was not injured and did not seek medical attention following the incident. The family did not wish to press charges.

A 5-Working Day Report dated 11/11/22 revealed

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reasonable suspicion of abuse to Resident #1. The incident description stated an incident occurred at 6:30 PM on 11/6/22 on the second-floor healthcare (Memory Care Unit). The Director of Nursing (DON) was notified by Nurse #1 who was on duty after hearing NA #1 screaming for assistance to assist Resident #1 from the floor after a fall. Nurse #1 noted Resident #1 was on the floor by the hydration station in new south hall expansion/nursing station. NA #1 was standing over Resident #1 upon Nurse #1's arrival. Administration reviewed security cameras the evening of 11/6/22 and suspected physical abuse towards Resident #1 by NA #1 after NA #1 was observed pushing Resident #1 to the ground which resulted in a fall. Resident #1 was noted to have a psychological exacerbation following the fall and was given a psychotropic medication. There was no physical injury or harm noted or mental anguish lasting 5 days or longer. Law enforcement was notified on 11/6/22 at 7:09 PM and an investigating officer was assigned. The 5-Working Day Report was signed by the Administrator on 11/11/22.

On 12/15/22 at 11:30 AM an interview was conducted with the Administrator. The DON indicated she was made aware of the incident on 11/6/22 at 6:30 PM by Nurse #1. Resident #1 had a fall and Nurse #1 suspected NA #1 had pushed Resident #1. The DON contacted the local police department, and a report was immediately filed on 11/6/22 at 7:00 PM. The cameras were also viewed on 11/6/22 that night when the incident was reported, and Resident #1 could be seen going into different rooms. When Resident #1 came from room #2, the resident was only wearing a top and had a towel to cover the bottom portion. Resident #1 was seen on camera following NA #1 while NA #1 was collecting

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L 049	Continued From page 9 dishes. There was no audio in the video at the time, so it was not clear what was being said by NA #1 and Resident #1. NA #1 was seen pushing Resident #1 causing Resident #1 to fall on the floor. The Administrator stated that Resident #1 was given an as needed medication due to agitation. The Administrator was notified of the Type B Violation on 12/16/22 at 2:11 PM. The facility provided a written plan regarding how the facility immediately removed the Type B Violation in order to protect residents from further risk or additional harm. The immediate removal plan will be included in the plan of correction.	L 049		