STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING _____ B. WING _____	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(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 000	INITIAL COMMENTS An unannounced complaint survey was conducted on 08/03/23 through 08/07/23. Event ID MTHY11. The following intake was investigated NC00205054. 1 of the 2 complaint allegations resulted in a deficiency.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		8/30/23

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

Electronically Signed | 08/30/2023

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F 609	Continued From page 1 by: Based on record review and staff interviews, the facility failed to develop and implement their abuse policy in the area of reporting for 2 of 2 residents reviewed for abuse (Resident # 1 and Resident #2) The findings included: A review of the facility's policy titled, "Abuse Prevention Program: Policies and Procedures" dated revised 10/24/22 indicated all alleged violations involving abuse, neglect, and misappropriation of patient property were to be reported immediately to the Administrator and the Director of Nursing (DON). The policy also indicated that any time there was an allegation of staff to resident abuse Adult Protective Services (APS) was to be contacted. Additionally, the policy stated the administrator or his/her designee will report allegations to the Health Care Personnel Registry within the specified timeframes: (a) immediately, but no later than 2 hours if the alleged violation involves abuse or results in serious bodily injury or (b) not later than 24 hours if the alleged violation involved neglect, exploitation, mistreatment, or misappropriation of resident property, and does not result in serious bodily injury, and (c) the administrator or his/her designee, will provide the Health Care Personnel Registry Section of the division of Facility Services, with a written report of the findings on their investigation within 5 days of the alleged occurrence of the incident. 1. Resident #1 was re-admitted to the facility on 05/30/23 with diagnoses that included anxiety disorder, depressive disorder, and respiratory failure.	F 609	1) The facility contacted local Law Enforcement on July 25th, 2023, for the allegation pertaining to Resident #1. On that same day, Law Enforcement immediately came out to question and assess Resident #1 on the events that occurred on July 13th, 2023. Questioning was completed with Resident #1, no further investigation being initiated. The Surry County Adult Protective Services Department was contacted on July 25th, 2023, for the allegation pertaining to Resident #1. Surry County DSS completed the report and filed it on July 25th, 2023, no further investigation being initiated. The facility contacted local Law Enforcement on August 8th, 2023, for the allegation pertaining to Resident #2. On that same day, Law Enforcement immediately came out to question and assess Resident #2 on the events that occurred on August 8th, 2023. Questioning was completed with Resident #1, no further investigation being initiated The Surry County Adult Protective Services Department was contacted on 8-8-23, for the allegation that occurred with Resident #2. Surry County DSS completed the report and filed it on August 8th, 2023, no further investigation being initiated. 2) The facility currently has no pending investigations surrounding any type of abuse or neglect allegations. With any new type of allegation of abuse, neglect, misappropriation of resident property, the	

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F 609	Continued From page 2 The quarterly Minimum Data Set (MDS) assessment dated 06/05/23 revealed Resident #1 was cognitively moderately impaired and could usually make herself understood and was able to understand others. A review of the facility's 24-Hour Initial Report dated 07/13/23 indicated there was an allegation of staff to resident abuse made by Resident #1. The report indicated the incident between Resident #1 and Nurse Aide (NA) #2 on 07/13/23 was not reported to the local law enforcement or APS. The report indicated Resident #1 alleged NA #2 hit her on her left forearm. An interview on 08/04/23 at 9:41 AM with NA #1, who cared for Resident #1 the morning of the alleged abuse revealed at approximately 3:30 AM, when she entered Resident #1's room with NA #2 to change her brief and Resident #1 asked her for the name of the person (NA #2) who was in her room 15 minutes prior. NA #1 stated she told Resident #1 she did not know but would find out. NA #1 stated Resident #1 reported the person who was in her room 15 minutes earlier hit her on her left forearm. She stated Resident #1 stated when she asked NA #2 why she had hit her, NA #2 replied "because you touched me, don't touch me." NA #1 stated NA#2 did not say anything while they were in the room when Resident #1 verbalized her allegation or when she reported the allegation to Nurse #1 and Nurse #2. She stated Nurse #1 and Nurse #2 went to speak to Resident #1 and when they returned to the nurses' station, they escorted NA #2 to the chapel and called the Administrator and the Director of Nursing (DON) to report the allegation. She stated they all knew it was NA #2	F 609	proper steps will be taken, including, contacting local Law Enforcement and Surry County Department of Social Services (APS) department. Our facility does not condone any form of abuse and will continually educate staff on facility abuse policies and procedures. 3) The facility will add to its current abuse policy and procedure the following: to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency, adult protective services, and local law enforcement where the state law provides jurisdiction in long-term care facilities). Education on this policy was given to all staff, by the Administrator, starting August 22nd and was completed on August 25th. 4) Audits will be done by the Administrator, and/or his designee, to ensure that all appropriate officials will be contacted in every case of an abuse, neglect, or misappropriation of resident property allegation. All abuse allegations will be reviewed as	

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because she had told her when she was at lunch that she had been in Resident #1's room, and she was the only other NA working on the 300 hall. She stated the Administrator and DON came into the facility quickly, interviewed Resident #1 and NA #2, and NA #2 never came back to work. NA #1 stated she looked at Resident #1's left arm and saw no signs of injury. NA #1 stated Resident #1 had some periods of confusion but was very clear, alert, and oriented when she reported that she had been hit.

In a written statement by the facility Administrator dated 07/14/23, he documented that the Director of Nursing (DON), the Social Worker (SW), and himself all interviewed Resident #1 and that Resident #1 gave the same details in all the interviews. In the Administrator's written statement, he reported that during Resident #1's interviews, she stated she had been hit on her left forearm by an African American person (NA #2). She stated NA # 2 hit her intentionally because when Resident #1 asked NA #2 why she had hit her, and NA #2 told her it was because Resident #1 had touched her, and she didn't want Resident #1 to touch her.

A phone interview on 08/04/23 at 4:38 PM with the Administrator revealed he submitted the 24-Hour Initial Report and the 5-Working Day Report for Resident #1 to the State Survey Agency within the required timeframes; however, he was not aware that he was required to notify the local law officials. He stated he knew he had to notify APS regarding Resident #1's allegation, but he had not yet contacted them at the time the State Survey Agency called him on 07/25/23.

A follow up phone interview was conducted with

part of the facility□s Quality Assurance Process Improvement (QAPI) program. Reports will be presented by the Administrator and Director of Nursing.

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the Administrator on 08/07/23 at 3:41 PM who stated that when the incident with Resident #1 occurred he was unaware of the requirement for notification to local law enforcement and to APS. He stated on 07/25/23 he received a call from the State Survey agency inquiring if he had contacted local law enforcement and APS and during that phone call he learned of the requirement. He also confirmed that his policy was not up to date with the most current reporting requirements and time frame and that it would need to be amended and updated.

2. Resident #2 was re-admitted to the facility on 07/03/23 with diagnoses that included diabetes, respiratory failure, anxiety disorder and depressive disorder, anxiety disorder, depression disorder, paralysis pf vocal cords and larynx and obstructive sleep apnea.

The admission Minimum Data Set (MDS) assessment dated 07/07/23 revealed Resident #2 was cognitively intact and could make herself understood as was able to understand others.

A review of the facility's 24-Hour Initial Report dated 07/25/23 indicated there was an allegation of staff to resident abuse made by Resident #2. The report indicated the incident between Resident #2 and Nurse #3 on 07/25/23 and was not reported to the local law enforcement or APS. The report indicated Resident #2 alleged Nurse #3 took her nebulizer treatment from her before it was finished.

Per a written statement by the Director of Nursing (DON) on 07/25/23, she documented that on the morning of 07/25/23 a family member of Resident #2 informed her when she told Nurse #3 that she

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needed go to the bathroom, Nurse #3 told Resident #2 that she didn't need to go to the bathroom. Additionally, the family member stated that Nurse #3 unhooked "something" and said to Resident #2 "I've had enough, I'm done with you." The written statement further revealed that the DON interviewed Resident #2, and Resident #2 reported that on 07/25/23 around 4:30 AM, Nurse #3 took her nebulizer treatment away from her before it was completed, and she felt like she couldn't get any air. Resident #2 then said that Nurse #3 told her "I've had enough, I'm done with you."

In an interview on 08/03/23 at 11:15 AM with Resident #2, she stated a nurse (Nurse #3) came into her room a few days ago and took away her nebulizer treatment before it was finished. She stated she told Nurse #3 the treatment was not done and needed it for her breathing and Nurse #3 told her she "had enough, and she was done with her." She stated she was not having problems breathing at that time.

A phone interview on 08/04/23 at 4:38 PM with the Administrator revealed the Administrator submitted the 24-Hour Initial Report and the 5-Working Day Report for Resident #2, to the State Survey Agency within the required timeframes; however, he was not aware that he was required to notify the local law officials.

A follow up phone interview was conducted with Administrator on 08/07/23 at 3:41 PM who stated that when the incidents with Resident #2 occurred he was unaware of the requirement for notification to local law enforcement and to APS. He stated on 07/25/23 he received a call from the State Survey agency inquiring if he had contacted

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F 609	Continued From page 6 local law enforcement and APS and during that phone call he learned of the requirement. The Administrator stated he had not yet contacted local law enforcement and APS regarding Resident #2, but he planned to. He also confirmed that his policy was not up to date with the most current reporting requirements and time frame and that it would need to be amended and updated.	F 609		