STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted 8/8/2023 through 8/10/2023. Event ID # PJCK11. The following intakes were investigated NC00205606, NC00205361, NC00205507, and NC00205694. 3 of 4 complaint allegations did result in a deficiency.	F 000	Past noncompliance: no plan of correction required.	
F 600 SS=G	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; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, Psychiatric Physician's Assistant interview, and the Medical Director interview the facility failed to protect the rights of a resident to be free from abuse. Resident #1 was found bleeding with a laceration to her upper lip, and a bruise to her right index finger and hand. Resident #2 had struck Resident #1 with the bed adjustment remote control causing the laceration to Resident #1's lip and pulled a ring from Resident #1's right index finger. This was for 1 of	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/20/2023

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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3 residents reviewed for resident-to-resident abuse (Resident #2).

Findings included:

Resident #2 was admitted to the facility on 6/5/22 with diagnoses of Chronic Obstruction Pulmonary Disorder (COPD), panic disorder, depression, and anxiety.

The quarterly Minimum Data set (MDS) assessment dated 7/4/23 coded Resident #2 as cognitively intact. She was assessed to need extensive assistance with bed mobility, dressing, toileting, and eating.

Resident #2's care plan, dated 2/28/23 revealed she was dependent on staff for meeting emotions, intellectual, physical, and social needs related to debility and depression. Resident #2 was also care planned for Activities of Daily Living (ADL) deficit related to debility and weakness.

Resident #1 was admitted to the facility on 1/8/23 with diagnoses that included Alzheimer's disease, depression, and psychotic disturbance.

Resident #1's quarterly Minimal Data Set (MDS) dated 6/28/23 revealed the resident was moderately cognitively impaired. Resident #1 was coded as independent with bed mobility, toileting, transfers, and used a walker for mobility. The resident was not coded for behaviors and was not receiving antipsychotic medications during the 7-day lookback.

A review of Resident #2's physician orders revealed as follows:
" Duloxetine HCl Capsule Delayed Release

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Particles 30 MG Give 1 capsule by mouth one time a day for mood symptoms ordered 06/01/2022.
" Sertraline HCl Tablet 50 MG Give 3 tablet by mouth one time a day for Depression/anxiety/ PTSD ordered 3/17/2023.
" Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride) Give 0.5 tablet by mouth at bedtime related to Alzheimer's Disease ordered on 8/04/2023.

Review of the progress note written by Nurse# 1 on 8/4/23 at 11:55 AM revealed the nurse was walking in the hallway when Resident #2 called for help in her room. As Nurse #1 entered the room, she observed Resident #2 lying in bed on her back with a laceration on her upper lip that was bleeding, and her hands had some smears of blood on them. When Nurse #1 asked the resident what had happened, Resident#1 stated that her roommate/husband (Resident #2) had punched her in the face and on her right index finger. The note revealed Resident #1's index finger was bruised and swollen. A progress note written by Nurse #1 at 12:55 PM revealed Resident #1 was sent to the hospital for evaluation.

A progress note written by Nurse #1 on 8/4/23 at 11:55 AM for Resident #2 revealed Resident #1 had called out for help and Nurse #1 went into the room and observed Resident #1 lying in bed with a bleeding lip. The nurse asked Resident #2 what happened, and he responded that he had hit his wife (Resident #1) in the face with the remote and pulled the ring off her right index finger. A subsequent progress note written on 8/4/23 at 2:50 PM revealed Resident #2 was taken into custody by law enforcement officers and would be

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potentially held until Monday related to domestic physical assault resulting in injury. The nursing staff dispensed medication for Resident #2 while in custody.

A review of Resident #1's hospital records discharge summary revealed she was evaluated on 8/4/23 and had a 1.5-centimeter-long laceration to her upper lip. The resident received 3 dissolvable sutures and was released back to the facility with an antibiotic. Resident #1 returned to the facility at 7:30 PM on 8/4/23.

Nurse #1, the assigned nurse for Resident #1 and #2 on 8/4/23 was interviewed on 8/8/23 at 1:21 PM. Nurse #1 stated she was on her medication cart in the hallway on 8/4/23 and she heard Resident #1 yell for help. Nurse #1 immediately went to check on Resident #1 and she was bleeding from her lip. Resident #1 told Nurse #1 she was hit by Resident #2. Nurse #1 yelled for help and stayed in the room; Resident #2 was sitting on his bed while Resident #1 was lying in her bed. Nurse #2 entered the room and was asked to call the Administrator. Nurse #2 called the Administrator, Unit Nurse Manager, and the Social Worker (SW) and they all went to the residents' room. Nurse #1 asked Resident #2 what happened, and he stated he hit her in the face and her right pointing finger. The SW removed Resident #2 from the room, and he was placed on 1 to 1 monitoring. Nurse #1 then assessed Resident #1 and found her to have a cut on her upper lip and a bruised and bleeding right index finger. Resident #1 told Nurse #1 that her roommate had hit her in the face. The MD was called by Nurse #1 and gave orders for Resident #1 to be sent to the Emergency Room (ER). Nurse #1 stated the police were called by

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the Administrator, and Resident #2 was sent to the jail. Nurse #1 stated Resident #2 was cowering and shaking because he was upset with himself for what he had done. Resident #2 told her that he had hit his wife in the face because she kept asking for her medications that she had already been given.

Resident #1 was interviewed on 8/8/23 at 2:15 PM. She stated her husband, Resident #2, came up to the edge of her bed and hit her in the mouth and did something to her right hand. Resident #1 stated he had never done anything like that before, and she was not afraid to be around him after the incident happened. She stated she missed him and wanted to see him badly. Resident #1 was observed to have a scabbed area to her upper lip with 3 sutures. Her right hand near her index finger was swollen and bruised with a small, scabbed area.

An interview with Resident #2 revealed on 8/10/23 at 10:38 AM Resident #1 was asking him for her pills but the nurse had already given her pills to her. He reported, "she asks for her pills often when she has already had them, and I was trying to help her stop asking for the pills. I slapped her in the mouth with the bed remote that was lying beside her, she stuck her right hand up in the air and I grabbed her ring and pulled it off her hand." Resident #2 stated he felt bad for what he did and had never hit her before in 56 years of marriage. He stated he missed being with his wife and did not want to lose her.

The Unit Manager stated in an interview at 2:45 PM on 8/8/23 that she did not witness the incident that occurred on 8/4/23. The Unit Manager stated she was called to the residents' room

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because Resident #2 had hit Resident #1. She stated she assessed Resident #2 for injuries while he was isolated from Resident #1 in another room. The Unit Manager stated she had not known Resident #2 to be aggressive or show any behavior like that and while he was with her, he stated he was upset with him-self and looked very remorseful for what he had done to his wife.

On 8/8/23 at 3:58 PM the Social Worker (SW) was interviewed and stated she was called to the Resident #1 and #2's room with the Administrator. The SW stated Resident #2 had hit Resident #1 and she called the police. While with Resident #2 in a separate room, he stated to her that he hit Resident#1 with the bed controller on her mouth and took a ring off her finger. The SW said Resident #2 was upset with himself that he had struck Resident #1 and said he felt responsible for her and that he never wanted to harm his wife. She stated the police arrested Resident #2 and he was taken to jail for 48 hours. The police stated to the SW that Resident #2 had to be arrested because the incident had resulted in an injury for Resident #1. Resident #2 did not have any behaviors while being arrested and was sad that he was unable to see his wife.

Nurse #2 was interviewed at 2:10 PM on 8/9/23 and stated she was at the nurse's station on 8/4/23 when she heard Nurse #1 call out for help. She went to Resident #1 and Resident #2's room and saw the two residents had been separated by Nurse #1. Resident #1 was lying on her back in her bed, and Resident #2 was sitting on his bed calmly without any aggression. Nurse #2 then went to find more help while Nurse #1 stayed in the room with Resident#1 and Resident #2.

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F 600	Continued From page 6 The Medical Director (MD) was interviewed on 8/8/23 at 11:50 AM. He reported Resident #2 had not shown aggression prior to the incident on 8/4/23. The MD stated he was notified by the facility on 8/4/23 that Resident #2 had struck Resident #1 and gave an order to send Resident #1 to the ER for evaluation. The MD said he was aware Resident #2 had been arrested and sent to a detention center and was not allowed to see or speak to Resident #1. The MD had assessed Resident #1 earlier on 8/8/23, and said she seemed good, but wanted to see her husband (Resident #2). Prior to the incident, the MD stated he had no concerns with Resident #1 and Resident #2 residing in the same room together and felt they would be safe to room with each other again. An interview conducted with the Psychiatric Physician Assistant (PA) on 8/9/23 at 5:05 PM revealed she had not known Resident #2 to have any aggressive behavior towards his roommate or any other resident since she had been seeing him since December 2022. She stated after the incident she assessed Resident #2 and felt he was remorseful for his actions and stated to her he was embarrassed for what he had done. The Psychiatric PA stated she did not feel Resident# 2 was a threat to any other resident. Resident #2 stated to the Psychiatric PA that Resident #1 was begging for medications that she had already received, he got frustrated and popped Resident #1 with the bed remote and made her lip bleed. The Psychiatric PA stated Resident #2 was not allowed to see or Speak to Resident #1 per court orders until the case has been resolved. On 8/10/23 at 10:38 AM the Administrator was interviewed. He stated Nurse #2 notified him of a	F 600		

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F 600	Continued From page 7 situation between Resident #1 and Resident #2. When the Administrator entered the residents' room, he observed Resident #2 shaking his head and saying he did not mean to do that. Resident #2 was placed on 1 to 1 observation and removed from the room and the SW was asked to call the police. The Administrator asked Resident #1 what happened, and Resident #1 stated she aggravated him, and he got up and hit me. When asked if Resident #1 wanted to press charges, she replied "no". the Administrator stated EMS arrived and would not take Resident #1 to the hospital until police arrived at the room. The police arrived and the Administrator gave them a statement. The police spoke with Resident #2 and stated they needed to take him to jail for 48 hours because Resident #1 sustained injuries from him. The family of the residents were notified of the incident, and informed Resident #1 was being sent to the hospital and Resident #2 was being sent to the jail. The Administrator stated he began the investigation into the incident and interviewed Nurse #1. Nurse #1 stated to him she was passing medications on the hall, heard Resident #1 call for help and immediately went to the room to see Resident #1 bleeding from her upper lip. Nurse #1 told the Administrator Resident #2 did not have any behaviors prior to the incident. The nursing assistants, therapy, and housekeeping were interviewed for any observation they may have had of Resident #2. They indicated everything was normal with Resident #2 prior to the incident. The Administrator stated when Resident #2 returned from jail on 8/6/23 to the facility, he was placed on 1 to 1 observation until he was cleared for every 15-minute observation by the physician on 8/6/23. The facility did a chart review, medication review, and interviewed all	F 600		

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F 600	Continued From page 8 staff who interacted with the resident. Everything with Resident #2 was normal until the incident occurred. On 8/9/23 the Administrator provided the following corrective action plan: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: On 8/4/23, Resident was heard by a staff member calling for help from her room where she resides with Resident #2. When the nurse entered the room, Resident #1 was in her bed and her mouth was bleeding and her right index finger was bruised and swollen. When the nurse asked Resident #1 what had happened, she stated that her husband Resident #2 had hit her in the face. (with remote control device) Staff immediately intervened and removed Resident #2 from the room, and he was placed on 1:1 supervision. The facility administrator was notified immediately after providing safety for the residents. The nurse completed resident assessment on Resident #1 and first aid was administered, notification to MD with orders to send Resident #1 to ER for evaluation of injuries. Administration notified and made appropriate calls to police, resident representatives, APS and 2-hour NC State report submitted. Facility investigation initiated to include staff and resident interviews. Police came to the facility and placed Resident #2 under arrest, and he was taken into custody at that time. Facility ensured police were aware of Resident #2's diagnosis of Alzheimer's Disease and dementia. The officer at the facility notified his supervisor of the information but due to it being classified as domestic violence, Resident #2 would have to be taken into custody for at least 48 hours. The	F 600		

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facility supplied Buncombe County Detention Center with all needed medication and medication administration record to be able to care for Resident #2. Resident #1 returned to the facility via ambulance from the emergency department with 3 stitches in place to the inside of lip. No further injuries were noted upon evaluation at the emergency department. Resident #2 is a long-term care resident who was admitted to the facility on 4/6/22 with the primary diagnosis of Alzheimer's Disease, unspecified dementia without behavioral disturbance, major depressive disorder, unspecified atrial fibrillation, osteoarthritis, hypertension, and constipation. On 6/26/23 his BIM score was a 9 (moderately impaired). He receives ongoing psych services and was last seen on 7/18/23 by psych and seen on 7/31/23 by medical provider for follow-up post fall on 7/28/23.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Because all residents are at risk from being physically abused by other residents, the following plan has been formulated to address this issue:

On 8/4/23 at 1155 Resident #2 was placed on 1:1 staff supervision and assessment completed by the licensed nurses with no apparent injuries until transferred to the Buncombe County Detention Center by Police Department officer at 1450.

On 8/4/23, the Administrator notified the Regional Director of Clinical Services to discuss incident, investigative protocol and corrective action to

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address incident and prevent any further incidence to other residents at risk.

On 8/4/23, All staff were questioned specific to these residents and any situations witnessed that might have been indicative of possible abuse. No areas of concern identified. Staff have not witnessed any abuse, verbal, physical or mental, during their interactions. Family of residents also state there have never been concerns of an abusive relationship between the two.

On 8/4/23, education to all staff was initiated on the facility Abuse Policy and on the Behavior Management Policy. Staff not receiving education by 8/8/23 will not be allowed to work until completed. The DON will be responsible for monitoring completion of education.

On 8/6/23, Resident #2 was released from the Buncombe County Detention Center with orders to not have contact with SW when he returned to facility.

On 8/6/23 at 5:00pm Resident #1 returned to the facility on 1:1 supervision and was placed in Room 102 with an appropriate roommate on opposite unit of Resident #2.

On 8/6/23, Resident #2 was assessed by on-call medical provider for safety clearance to be placed on every 15-minute checks and removed from 1:1 supervision. The medical provider assessed Resident #2 and deemed him safe to proceed on every 15-minute checks with the directive if he attempted to go to the wing his wife was located, he would need to return to 1:1 supervision.

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Effective 8/6/23 at 7:16pm, Resident #1 removed from 1:1 staff supervision and placed on 15-minute staff supervision as ordered by the licensed Physician.

On 8/7/23, Resident #2 was seen for an acute visit by medical provider with no new orders received at this time. Psychiatry to continue following and visit scheduled at next available time.

On 8/7/23, the IDT had an AdHoc QAPI meeting to review the facility Abuse Policy and further discuss investigation, root cause analysis and corrective plan. Root cause analysis determined that an appropriate plan of care for Resident #1s behaviors was in place and followed and that Resident #1's behavior was related to disease progression and poor impulse control and there were no precipitating behaviors leading up to the incident that the facility staff failed to respond to prevent this occurrence.

On 8/7/23, following the AdHoc QAPI meeting, the IDT had a Risk Meeting to ensure all residents are free from abuse from other residents. Residents with a history of or potential for abusive behavior towards others were reviewed to ensure appropriate plans of care are in place and that they are not placed together as roommates. Current facility residents with previous resident-to-resident incidents, residents with diagnosis of PTSD or other neurological disorders and residents with care plans for at risk for aggression towards others were included in review.

Effective 8/7/23, the IDT will meet weekly to discuss residents with behaviors to ensure

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ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD** **ASHEVILLE, NC 28804**

(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 12 continued effectiveness of care plans. Changes will be made as appropriate. Effective 8/7/23, the Administrator is ultimately responsible for the implementation of this corrective plan. Alleged Date of Compliance: 8/8/23	F 600		