STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-KINSTON	**2150 HULL ROAD KINSTON, NC 28504**

(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 The survey team entered the facility on 02/13/24 to conduct a complaint survey and exited on 02/15/24. Additional information was obtained on 02/29/24. Therefore, the exit date was changed to 02/29/24. The following intakes were investigated NC00212984, NC00203029, NC00208040, and NC00210508. 1 of the 4 complaint allegations resulted in deficiency.	F 000		
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, and staff, physician, and police detective interviews, the facility failed to protect a cognitively impaired resident's right to be free from abuse when a staff member hit the resident in the face for 1 of 1 resident investigated for employee to resident	F 600	What Corrective Action will be accomplished for the resident found to have been affected by the deficient practice? A body audit was completed on the	3/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/14/2024

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

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abuse (Resident #4).

The findings included:

Resident #4 was admitted to the facility on 06/30/21 with diagnoses which included, in part, vascular dementia with behavioral disturbance, muscle weakness, unspecified lack of coordination, auditory hallucinations and visual hallucinations.

A review of Resident #4's quarterly Minimum Data Set (MDS), dated 12/13/23, revealed that Resident #4 was severely cognitively impaired, was sometimes understood and sometimes had the ability to understand others. The MDS indicated Resident #4 was dependent on staff for oral hygiene, toileting, shower/bathing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident #4 required substantial/maximal assistance with eating, upper body dressing and chair/bed-to-chair transfers.

A review of Resident #4's Care Plan, last revised 12/27/23, revealed the following problems:
--Resident is on the memory support unit due to elopement risk and current wandering behavior. Interventions included (a) avoid overstimulation, (b) maintain a calm environment and approach to the resident.
--Resident requires assistance with activities of daily living (ADLs) and at risk for decline related to cognition status. Interventions included (a) bath assistance x 1 person, (b) dressing/grooming assistance x 1 person.
--Resident has difficulty hearing. Interventions included (a) provide a quiet, non-hurried environment, free of background noises and

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affected resident on 2/6/24 by the LPN on duty.

A pain audit was completed on the affected resident on 2/6/24 by the LPN on duty.

The physician and the responsible party were informed of the incident on 2/6/24. The accused aide was suspended and terminated from the facility on 2/6/24. The affected resident was interviewed on 2/6/24 by the social worker after the incident and has no recall related to the incident. The social worker completed a second follow up with the family later in the day to ensure they were aware of what happened to the resident earlier that morning on 2/6/24. The family stated they understood what happened to the resident.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

A body audit was completed on all residents by Administrative/charge nurses on 2/6/24.

The Social Services Team completed resident/family interviews regarding abuse on 2/9/24 using the audit tool Resident Questionnaire on Abuse.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur?

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distractions.
--Resident has history of visual and auditory hallucinations. Interventions included (a) maintain a consistent routine, (b) provide safe, quiet, low-stimuli environment.
--Resident has diagnosis of unspecified dementia without behavioral disturbance. Interventions included (a) support and reassure resident in new situations.

Review of the Nurse Practitioner (NP) progress note, dated 02/07/24 revealed the following:
--Chief Complaint: patient is being seen today for abuse discussion
--History of Present Illness (HPI): "Patient is seen today sitting up in his wheelchair in the dining room, eating lunch, appearing well and appropriate with a small bump and bruise to his right eyebrow. According to staff, a CNA was assisting resident with ADLs. There was some sort of altercation in patient's room in which CNA struck patient in the face. Patient denies pain, x-ray performed by the facility, no facial fracture present. Small hematoma noted. CNA has since been released from working at facility. Staff is to monitor patient closely and note any issues from incident and will notify providers if any such issues arise. No other issues to note, will continue to monitor.
--Past behavioral health: " ...with history of dementia with behaviors ..."
--Physical Exam: Skin - normal temp, hematoma to right eyebrow
--Assessment / Plan: "1. Contusion of eye - staff to monitor site for s/s of worsening swelling and/or pain. No s/s of cellulitis or soft tissue infection noted; monitor neuro status ... stable/monitor."
--Diagnoses: " ...contusion of right eyelid and

F 600

Abuse identification and reporting education was started by the Performance Improvement Nurse, Social Worker, Environmental Service Manager and Dietary Manager for all employees beginning on 2/6/2024. If the partner does not receive the education by the date of compliance of 2/12/2024 due to FMLA, PTO or any other circumstance, the partner will receive the education prior to working their next shift. The Performance Improvement Nurse is monitoring for education compliance. Additional educational courses related to identifying and reporting abuse, staff burnout, and understanding dementia with behaviors were assigned to all current partners on 2/14/24. If the partner does not receive the education by the date of compliance of 2/26/2024 due to FMLA, PTO or any other circumstance, the partner will receive the education prior to working their next shift. The assigned courses are (1) Taking Care of You, (2) Preventing, Recognizing and Reporting Abuse (3) Dementia and Behaviors. Partners will be required to pass a test after each assigned course with a score of 80% to 100%. The Director of Nursing and the Performance Improvement Nurse are tracking compliance for the additional assigned education courses.

How will the facility monitor its performance to make sure that solutions are sustained to assure that the deficient practice will not reoccur?

All residents and/or family members will

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F 600

Continued From page 3
periocular area, sequela"

Review of Medical Doctor (MD) progress note dated 02/08/24:
--Chief Complaint: " ...presenting with bruising on the right eye after an incident with staff."
--HPI: " ... Patient's condition has been mostly stable since the last visit. However, two days ago, the patient was involved in an incident with staff, which is currently under investigation for potential abuse. The patient has developed bruising on his right eye, which is healing, and does not appear to be in any pain or distress. Due to the patient's advanced dementia, he is unable to provide a reliable review of systems ..."
--Physical Exam: " ...Eye - conjunctiva normal, no traumatic injuries. Head, Ear, Nose, Throat - normocephalic, bruising around right eye ..."

Review of Resident #4's facial bones x-ray, performed on 02/06/24, revealed a normal examination.

Review of Resident #4's progress note, dated 02/06/24 at 2:12 p.m. by Nurse #2, revealed a normal neurological exam, bruise right eye with red discoloration.

Review of the Initial Allegation Report, dated 02/06/24, indicated "CNA was assisting other CNA's with a.m. care. It was reported that [name of Resident #4] was resisting care and swinging at staff ... [name of nursing assistant #1] admits to hitting [name of Resident #4] back in the forehead. Other CNA reports hearing the 'sound' and seeing [name of Resident #4] holding his face." Details of physical or mental injury/harm indicated [name of Resident #4] with redness around right eye. The report was signed by

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be interviewed by the social services department regarding abuse using the audit tool Resident Questionnaire on Abuse monthly x 3. The results of the interviews will be reviewed monthly x 3 by the Administrator and presented to the Executive Quality Assurance team no less than monthly x 3.

Staff members will be interviewed regarding abuse and reporting of abuse using the Abuse Questionnaire beginning 3/5/24, twenty-five staff members will be tested weekly across all shifts to include weekends x 4 weeks, then 25 employees monthly x 2 months. The Director of Nursing, Dietary Manager, Environmental Services Manager, Performance Improvement Nurse, Administrator, and other members of the administrative team will conduct the testing. Staff who do not achieve 90% or greater will receive individual abuse identification and reporting education until 90% competency or greater is obtained. The results of the tests will be reviewed weekly x 4, then monthly x 2 by the Performance Improvement nurse and presented to the Quality Assurance team no less than monthly x 3.

On 2/14/24, an audit tool was created by the Performance Improvement Nurse to track educational compliance with the plan of correction. The first column lists all active employees. The following four columns will note the completion of each required component of education in the POC. A second compliance form has

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F 600	Continued From page 4 Nurse #1. Review of the two hand-written statements by Nursing Assistant (NA) #1 read as follows: 1. "I [name of NA #1] was helping [name of NA #2] with [room number of Resident #4] and he was hitting me in my head and face and side. I didn't (mean) to hit him back but my reflex I did in the forehead try to help him calm down with open hands not fist trying to get his attention to stop." Dated 02/06/24. 2. "I [name of NA #1] went into said room to assist [name of NA #2] with resident in said room. [Name of Nurse #2] was in the room helping her. So I told her that I would help. She said ok. I began to help and said resident began hitting me and [name of NA #2] so we both talked to him to calm he down. Before finishing he began kicking and hitting again. I [name of NA #1] was trying to block him from still hurting me while trying to finish dressing him. I put up my hand which was open hand to his upper face which it made a hitting noise that's when staff asked what happened. I said he got me and I was trying to stop him from hurting himself and me. I put my hand out to block him from falling from bed onto the floor." This statement was not dated. Review of the handwritten statement by Nurse #2 read, "Today, 2/6/2024, I was present in [room number of Resident #4] with aide and resident [name of Resident #4]. I was assisting aide w/AM care. Another aide, [name of NA #1] came in room and stated she would help with residents' care. I agreed and continued to do a quick skin assessment on [name of Resident #4] while the aides continued to get resident dressed. [Name of Resident #4] was sitting on the side of the bed, feet dangling. [Name of NA #1] was standing in	F 600	been completed to track completion of random employee testing. It will track how many tests were completed, the shift of completion, number of tests administered, and the percentage scored on the test by the employee. The Quality Assurance team will take all audit findings to Executive Quality Assurance Committee no less than monthly x 4 or until substantial compliance has been achieved. Date of Compliance is 3/22/2024	

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front of him trying to put his shirt on. Resident was pushing aide off, I did not see if he hit her because I looked down to write down my skin assessment notes. I did state to let the resident calm down and attempt again to put his shirt on, when the resident calmed down a bit. After several seconds, I look up again and resident is blindly swinging and I witnessed [name of NA #1] hit resident w/a closed fist in the R eye. Resident then was holding his eye after. I immediately got up to intervene between the resident and aide, aide stated she was defending herself. I assessed resident's face, performed body audit, and asked aide to remove herself from his room so me and the other aide could de-escalate the situation. Resident was put in wheelchair, this writer checked vital signs on resident, which were normal. I then went to HR office to make them aware of event."

Review of the handwritten statement by NA #2 read, "On Tuesday February 6, I witnessed abuse from a aide. Me and the [name of Nurse #2] walked into [name of Resident #4] room and we started to provide patient care. Another aide [name of NA #1] walks in and told the nurse that she could help. [Name of Resident #4] started being combative. As we were getting him up he started swinging at aide. I did not visually see the aide hit resident but I heard a sound and seen the resident hold his face."

Review of the Investigation Report, completed by the Administrator and dated 02/13/24, read in part, the accused employee was NA #1 and the resident was Resident #4. The report indicated the date of the incident was 02/06/24, the date and time the facility became aware of the incident was 02/06/24 at 8:30 a.m. The incident was

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F 600	Continued From page 6 reported to law enforcement on 02/06/24 at 9:30 a.m. The original allegation details included, "Aide was assisting other aide and a nurse with morning care of a resident. It was reported that resident was resisting care and swinging at [name of NA #1]. [Name of NA #1] stated she did hit [name of Resident #4] in the forehead. Another aide reported hearing the 'sound' and seeing [name of Resident #4] holding his face." A description of the resident's injury/harm included "redness around right eye." A summary of the facility's investigation read as follows: "the accused aide was assisting the resident with dressing. The resident was sitting on the side of the bed and began swinging at the accused aide. The accused aide wrote in her statement that she was blocking the resident from hurting her and trying to keep him from falling forward to the floor and swung forward hitting him in the eye with an open hand. The nurse in the room stated she saw the accused aide draw her fist back and make contact with the resident's skin. The nurse in the room at the time stated she heard the accused make contact with the resident's skin. The other two aides in the room did not see the accused aide hit the resident. She only heard the sound and saw the resident holding his face. The other aide did not see or hear." Corrective actions following the incident included, "the nurse immediately intervened in the incident. The aide was suspended and sent home. The aide has been terminated. Staff in-servicing on abuse began on 02/06/24. All residents and/or RPs were interviewed regarding abuse. Skin assessments were completed on all other residents in the facility. In-servicing was also started for staff regarding staff burnout, abuse, caring for combative residents." The facility substantiated the allegation of abuse and	F 600		

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terminated NA #1 on 02/07/24 for abuse.

An observation of Resident #4 was conducted on 02/13/24 at 1:39 p.m. Resident #4 was sitting in his wheelchair at a table in the common area of the locked dementia unit. He was appropriately dressed and appeared well-groomed. Resident #4 was alert and unable to answer any questions. No bruising or redness to his face, particularly his right eye area, was noted.

A telephone interview was conducted with NA #1 on 02/14/24 at 1:16 p.m. NA #1 confirmed she worked at the facility on 02/06/24 from 7:00 a.m. until 3:00 p.m. and indicated she had not been assigned to care for Resident #4 on that date. NA #1 explained the nursing assistants on the dementia unit tend to help each other when assistance is needed and stated NA #2, who had been assigned to care for Resident #4, had mentioned earlier in their shift that she would need assistance providing morning care to Resident #4. NA #1 stated when she noticed NA #2 on her way to Resident #4's room, she had decided to go and help her. She explained when she entered the resident's room, Resident #4 was lying on his back in his bed and Nurse #2 was in the room assisting NA #2. NA #1 stated she told Nurse #2 that she would help NA #2 and after that, Nurse #2 moved back away from the resident but stayed in the room. NA #1 stated while she was assisting in the resident's care, NA #2 began talking with Nurse #2. NA #1 explained she continued providing care to the resident when he became combative, hitting and kicking out. NA #1 stated between her and NA #2, they managed to calm the resident and put his shirt on. NA #1 stated she sat Resident #4 up on the side of his bed while NA #2 talked with Nurse #2

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F 600	Continued From page 8 and that the resident started "acting up" again, swinging his arms towards her trying to hit her. NA #1 stated she tried to explain to the resident what she was doing however he continued to swing his arms towards her. NA #1 indicated she held the resident's pants in her left hand and raised her right arm and hand in an attempt to block his arms from hitting her as well as to prevent him from hurting himself. NA #1 stated when she made that move, her right hand hit the right side of the resident's face near his eye and forehead. NA #1 stated both NA #2 and Nurse #2 asked her what happened as they had heard the noise of her hand touching the resident and indicated she said "he got me" and indicated she still had her hand up towards the resident's face. NA #1 stated Nurse #2 informed her that she would have to report the incident because the resident was going to have a bruise. NA #1 explained she did not say anything else however she indicated she finished getting the resident dressed, got him to stand and pivot into his wheelchair and then brought him to the table in the dayroom. NA #1 indicated a few minutes later the lady from Human Resources (HR) came to her on the dementia unit, told her to gather her belongings, and asked her to follow her to the HR office. NA #1 stated once she was there, she stated she was told to write a statement about the incident and was then asked to leave the premises. When asked why she had written two statements, NA #1 explained that when the HR lady asked her to write her first statement, she said she hit the resident. She admitted that while she did make contact with his face with her hand, she was adamant that she was blocking the resident from hitting her and from falling off the bed onto the floor. NA #1 explained after thinking about the incident more, she wanted to write	F 600		

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F 600	Continued From page 9 another statement with more details about why she did what she did. A telephone interview was conducted with NA #2 on 02/15/24 at 10:16 a.m. NA #2 confirmed she worked from 7:00 a.m. to 3:00 p.m. on 02/06/24 and had been assigned to care for Resident #4 on that date. NA #2 explained she and Nurse #2 went to Resident #4's room to provide morning care to him before breakfast was served. NA #2 indicated the amount of assistance the resident requires depends on the day as some days he requires more assistance than others. NA #2 indicated the resident has dementia and can sometimes communicate with staff but mostly staff must anticipate his needs. On that morning as she and the nurse were in the resident's room, NA #1 entered and informed Nurse #2 that she would assist with his care. NA #2 indicated the nurse stepped back away from the resident but did not leave the room. NA #2 explained the resident became combative towards the end of his care as they were trying to get him into his wheelchair. NA #2 further explained she and NA #1 took a minute to allow the resident to calm down as this was what they had been trained to do. NA #2 indicated she had turned around, away from the resident, and began talking with NA #3, who had entered the room. NA #2 indicated NA #1 was still attempting to provide care to the resident while she and NA #3 were talking and she heard a noise and described it as a "boom". She stated she did not know what that sound was and turned around, saw the resident was in his wheelchair and he was holding his head with one of his hands. NA #2 did not recall if the resident said anything or not and stated after, all staff left the room. NA #2 explained she and NA #3 discussed who was going to report the	F 600		

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incident and thought Nurse #2 would since she was in the room at the time of the incident. NA #2 indicated NA #3 decided she would go to HR and report the incident and left the unit and NA #2 stated she followed her to the HR office. NA #2 stated she did not recall if NA #1 said anything at the time of the incident and stated she did not recall who pushed Resident #4 out of his room and into the common area of the unit.

A telephone interview was conducted with Nurse #2 on 02/15/24 at 10:39 a.m. Nurse #2 confirmed she worked from 7:00 a.m. to 7:00 p.m. on 02/06/24 and had been assigned to care for Resident #4; she explained she had been suspended from work since the incident for not removing NA #1 from the unit immediately after the incident involving Resident #4. Nurse #2 explained around 8:00 a.m. on 02/06/24, NA #2 informed her she would need help with Resident #4's morning care, which is usual, and that she went to the resident's room to help. Nurse #2 explained that once she entered his room, he was lying in his bed. She stated the resident had dementia and required total care for his bed baths but his transfers from his bed to his wheelchair is a 2-person assist with no mechanical lift needed. The nurse detailed the care they provided noting that Resident #4 grunted and groaned during his bed bath and incontinent care however that was usual for him. Nurse #2 stated as she and NA #2 were finishing up, NA #1 entered the room and informed her that she would finish helping NA #2. Nurse #2 explained she stayed in the resident's room as she had to complete some assessments that were due for the resident such as his respiratory assessment and skin assessment. Nurse #2 described NA #1 and NA #2 being on either side of the resident's bed while she stood

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NC STATE VETERANS HOME-KINSTON	2150 HULL ROAD KINSTON, NC 28504

(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 11 at the foot of the bed. She indicated the nursing assistants sat the resident on the side of his bed, facing his dresser and TV, and NA #1 was struggling while trying to put the resident's shirt on and the resident was saying, "oh let me go, let me loose." Nurse #2 stated she informed NA #1 to step back and give him a second. Nurse #2 indicated she was looking at her notebook one minute and the next she looked up to see the resident had begun swinging his arms at NA #1. Then Nurse #2 stated she witnessed NA #1 make a fist with her right hand and strike the resident in his right eye area. Nurse #2 explained the resident said, "oh, oh" and was observed holding his face. Nurse #2 explained NA #1 immediately stated, "it was self-defense," repeated it and then said, "if anything happens, he hit himself on the bed." After that, Nurse #2 asked NA #1 if she was okay and what was going on and stated NA #1 said the resident had hit her and stated, "that's why I said it was self-dense." Nurse #2 explained she and NA #2 assisted Resident #4 into his wheelchair and left his room, leaving NA #1 in the room. Nurse #2 stated "this is where I could have done better" and when asked to elaborate, she explained after leaving the room, she and NA #2 discussed the need to report the incident while in another resident's room and stated after approximately 15 minutes they left to report the incident to the HR director. Nurse #2 indicated when she returned to the unit, she saw Resident #4 sitting in his wheelchair at the table in the common area and he was holding his eye with his hand. She explained she assessed his face and there had been no obvious marks noted at that time; she stated as the day progressed, she noticed some swelling to the resident's right eye and some redness on his right lower orbital area. Nurse #2 stated she made a nurses' note about	F 600		

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F 600	Continued From page 12	F 600		

the incident and spoke with the Supervisor who advised her to continue to monitor him. Nurse #2 indicated the resident denied pain however did receive his scheduled doses of Tylenol at 9:00 a.m. and 2:00 p.m. When asked why she had been suspended from work, Nurse #2 indicated because she did not immediately remove NA #1 from the resident and/or unit after the incident. She explained the HR director came to the dementia unit around 8:20 a.m. and removed NA #1 off the unit.

A telephone interview was conducted with NA #3 on 02/14/24 at 2:37 p.m. NA #3 confirmed she worked from 7:00 a.m. to 3:00 p.m. on 02/06/24 and had not been assigned to care for Resident #4. NA #3 explained she entered Resident #4's room to assist NA #2 with his morning care before breakfast but when she entered the room, NA #1 was already in the room providing assistance. NA #3 also indicated Nurse #2 was in the room. NA #3 stated that while she was in the room at the time of the incident that she did not see it occur. She stated that she did hear NA #1 say, "well he caught me off guard" and asked the others in the room what had happened. NA #3 stated NA #2 told her that NA #1 had punched Resident #4. NA #3 explained she told everyone that the incident had to be reported and stated she felt they were dragging their feet so she left the unit and reported the incident to the HR director. NA #3 stated she had to write a statement about the incident while in the HR office.

An interview was conducted with the HR Director (HRD) on 02/15/24 at 9:53 a.m. The HRD explained NA #3 came to her office on 02/06/24 around 8:25 a.m. to report the incident that had

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occurred between NA #1 and Resident #4. She explained that NA #3 informed her that she had not seen the incident happen but was in the room when it occurred. She further explained that NA #3 related the information about the incident as she knew it, wrote her statement and then left after approximately 10 minutes. The HRD stated NA #2 and Nurse #2 then arrived to report the incident. The HRD explained she informed the two of them to return to the unit and write their statements. The HRD explained both the Administrator and the Director of Health Services (DHS) were both out of the facility on that date and she placed a call to the Performance Improvements Coordinator (PIC) and informed her of the abuse allegation; she indicated a text message had already been sent to the DHS. The HRD stated the DHS called her and informed her of the steps of the facility investigation she needed to begin to take. The HRD stated she went to the dementia unit and removed NA #1 from the unit, brought her to the HR office and asked her to write a statement about the incident. While NA #1 was writing her statement, a text message was received from the DHS who wanted to speak with NA #1 on the phone. The HRD placed NA #1 in the office located directly across from hers. The HRD did not stay to listen to their conversation. Afterwards, NA #1 returned to the HR office, retrieved her belongings and the HRD escorted her out of the building and observed her leaving the facility grounds. The HRD indicated she participated in the abuse in-services that were begun immediately.

An interview was conducted with the Registered Nurse Supervisor on 02/15/24 at 11:22 a.m. The supervisor indicated she was the supervisor for the whole facility on 02/06/24 and worked from

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7:00 a.m. until 3:00 p.m. The supervisor explained that she was not on the dementia unit at the time of the incident however she had been made aware of it when she entered the unit by Nurse #2 and NA #2. The supervisor stated the HRD came to the unit at that time and removed NA #1 from the unit and stated she went to assess Resident #4 who was sitting in his wheelchair at the table in the day room. She described Resident #4 as sitting with his head down like he was sleepy. She stated she talked with him and got him to look at her and she asked him if he was hurting and stated he shook his head no. She stated the area around his right eye was reddened but there had been no bruise evident at that time and no open areas. The supervisor stated she applied a cool pack to the area and that the resident really did not want to leave that in place. The supervisor indicated Nurse #2 called the resident's Responsible Party (RP) and an electronic communication was sent to the medical provider. The supervisor explained an investigation was immediately begun and an x-ray of the affected area was ordered. She further explained she re-assessed the resident several times throughout the rest of her shift and noted the area to be getting darker as the day progressed stating the area was red initially but it began to turn blue later in the day. The supervisor stated she participated in the planning of the in-services for all of the facility staff as well as completing the assigned in-services herself.

An interview was conducted with the facility medical director (MD) on 02/15/24 at 12:49 p.m. The MD reported she evaluated Resident #4 on 02/08/24 and he had bruising on his face by his right eye and it appeared to be 2-3 days old with

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no other signs of trauma. The MD stated Resident #4 is cognitively impaired and was unable to offer any information about the incident. The MD stated the resident had a normal x-ray after the incident. The MD stated she felt the facility handled the incident appropriately and that she participated in the abuse in-services to the staff.

A telephone interview was conducted with a detective from the local police department on 02/15/24 at 12:11 p.m. The detective indicated they received a call from the supervisor of the facility on 02/06/24 informing them of the alleged abuse of Resident #4 by NA #1. The detective stated they were informed the facility was conducting their own investigation of the incident, that no officer went to the facility, and there is no on-going investigation related to this incident.

An interview was conducted with the DHS on 02/15/24 at 3:26 p.m. The DHS explained she was out of the facility on 02/06/24 but she had received a phone call from the HRD informing her of the abuse allegation involving NA #1 and Resident #4. The DHS explained she informed the HRD to remove NA #1 from the unit, get her to write a statement and then remove her from the premises. The DHS stated she also informed the HRD to call the police and begin an investigation into the incident. The DHS stated she then talked with Nurse #2 and told her to perform a body audit on Resident #4 as well as all the residents on the dementia unit. The DHS explained she returned to the facility and assisted with the ongoing investigation into the abuse allegation. The DHS indicated at the conclusion of their investigation, they determined the abuse did happen and NA #1 was terminated. The DHS

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F 600	Continued From page 16 stated she felt the abuse occurred because NA #1 did not know how to deal with a combative resident and explained they will be doing continuing education with the staff to help prevent this from happening to other staff and residents. An interview was conducted with the Administrator on 02/15/24 at 4:18 p.m. When asked why she thought NA #1 had abused Resident #4, the Administrator explained she was not sure as all staff had been trained on how to deal with combative residents. She stated, in hindsight, NA #1 may have experienced some personal burnout. The Administrator stated abuse of any kind will not be tolerated and that in the future, they will continue to educate the staff on abuse prevention and ensure the safety of the veterans in the facility.	F 600		
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	F 609		3/22/24

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F 609	Continued From page 17 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 by: Based on staff interview and record review, the facility failed to report an allegation of staff to resident abuse to Adult Protective Services for 1 of 1 resident investigated for employee to resident abuse (Resident #4). The findings included: Review of the Initial Allegation Report to the State Agency, completed by Nurse #1 on 02/06/24, indicated the allegation of staff to resident abuse occurred on 02/06/24. The facility became aware of the incident on 02/06/23 at 8:30 a.m. and reported it to the local law enforcement agency on 02/06/24 at 9:30 a.m. There was no indication on the report that the facility reported the incident to Adult Protective Services (APS). A review of the Investigation Report to the State Agency, completed by the Administrator and dated 02/13/24, did not indicate that the facility reported the incident to APS. A telephone interview was conducted with a detective from the local police department on 02/15/24 at 12:11 p.m. The detective confirmed	F 609	What Corrective Action will be accomplished for the resident found to have been affected by the deficient practice? The affected resident□s Investigation report information was reported to Lenoir County Adult Protective Services on 2/12/2024. How will the facility identify other residents having the potential to be affected by the same deficient practice? All Complaint Intake and Health Care Personnel Investigations that have been reported by North Carolina State Veterans Home-Kinston since 1/1/2024 that alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property were reported to Lenoir County Adult Protective Services on 3/14/2024. What measures will be put into place or	

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they received a call from the supervisor of the facility on 02/06/24 informing them of the alleged abuse of Resident #4.

An interview was conducted with the Administrator on 02/29/24 at 10:46 a.m. The Administrator confirmed she did not inform APS of the abuse allegation on 02/06/24 because the threat (i.e., the accused nursing assistant) to Resident #4 had been immediately removed from the facility on 02/06/24. The Administrator explained allegations of abuse are reported to the State agency and local law enforcement by herself or the Director of Health Services (DHS) depending on who is at the facility at the time of the incident. The Administrator further explained that typically, reports to APS are completed by the Social Worker.

An interview was conducted with the Social Worker on 02/29/24 at 11:48 a.m. The Social Worker explained she had not been aware abuse allegations had to be reported to APS at the time of an abuse allegation therefore she did not report Resident #4's allegation of abuse on 02/06/24. The SW further explained that going forward, she will report any allegations of abuse to APS.

F 609

systemic changes made to ensure that the deficient practice will not reoccur?

The Administrator was re-educated by the Senior Nurse Consultant via telephone on 3/14/2024 on the requirements of Federal Tag 609 that states 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. (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.
The Administrator began in-servicing the administrative nurse team on the requirements of Federal tag 609 on 3/14/2023. The education will be completed by 3/18/2023.

How will the facility monitor its performance to make sure that solutions

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F 609	Continued From page 19	F 609	are sustained to assure that the deficient practice will not reoccur? The Performance Improvement nurse will review all Complaint Intake and Health Care Investigations weekly x 10 using the QAPI Tool for APS Notification for F609. The results of of the weekly audits will be reviewed by the Administrator weekly x 10. The Quality Assurance team will take all audit findings to Executive Quality Assurance Committee no less than monthly x 3, or until substantial compliance has been achieved. Date of Compliance is 3/22/2024.	