STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 03/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	**300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278**

(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 A complaint investigation was conducted on 3/16/2024. Event ID # 66VR11. The following intake was investigated NC00214189. One of the one allegation did not result 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 by:	F 609		

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

Electronically Signed | 03/19/2024

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F 609	Continued From page 1 Based on staff interviews and record review the facility staff failed to immediately report an alleged allegation of abuse to administration for two (Resident #1 and Resident #2) of three residents reviewed for abuse allegations. The findings included: Documentation the facility policy entitled Abuse, Neglect, Misappropriation of Resident Property, and Exploitation dated as last reviewed on 1/19/2023 stated in part under reporting, "Any employee who witnesses or suspects that abuse, neglect, misappropriation of resident's property or exploitation has occurred, must immediately report the alleged incident to the nursing supervisor, who must immediately report the incident to the Administrator or Director of Nursing." Resident #1 was admitted to the facility on 2/5/2024 and had multiple diagnoses one of which included Alzheimer's disease. Documentation on an admission Minimum Data Set (MDS) assessment dated 2/18/2024 revealed Resident #1 was coded as severely cognitively impaired. Resident #2 was admitted to the facility on 8/25/2023 and had multiple diagnoses which included but was not limited to dementia and aphasia. Documentation on a quarterly MDS assessment dated 1/5/2024 revealed Resident #2 was coded as severely cognitively impaired with behavioral symptoms not directed toward others for one to three days of the assessment period.	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 2	F 609		

An interview was conducted with Nurse Aide (NA #2) on 3/16/2024 at 10:45 AM. NA #2 revealed she received a voice message on a social media application from NA #1 on Thursday, 2/29/2024 in the afternoon. NA #2 stated she did not listen to the voice message until the evening of Friday, 3/1/2024 at approximately 6:45 PM. NA #2 revealed the voice message she recognized to be from NA #1 indicated in part, NA #1 had "popped [Resident #2] in the mouth" and NA #1 bit Resident #1 after being bitten by Resident #1. NA #2 stated the voice message described Resident #1 to be "the old white [female dog]." NA #2 revealed on the evening of Saturday, 3/2/2024 the voice message would be expired and automatically be deleted so, before the evidence of the voice message was deleted, she went to a nursing supervisor (Nurse #4) and let her listen to the message. NA #2 stated she knew that NA #1 was not on the schedule to work in the facility until Tuesday, 3/5/2024, so she was not concerned NA #1 would be in the facility in the next couple of days if the voice message was factual.

An interview was conducted with Nurse #4 on 3/16/2024 at 1:55 PM. Nurse #4 revealed NA #2 came to her home late on Saturday, 3/2/2024 and informed her she had something for her to listen to. Nurse #4 stated she listened to the voice recording sent by NA #1 on the social media application, and stated she was in "shock." Nurse #4 stated she recorded the voice message on her personal phone and when she returned to work on Monday, 3/4/2024 she brought the voice recording to the attention of the Director of Nursing (DON). Nurse #4 stated she knew NA #1 was not on the schedule to work until 3/5/2024, so at the time she thought informing the DON of

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F 609	Continued From page 3	F 609		

the voice recording sent by NA #1 could wait until Monday, 3/4/2024.

The Director of Nursing (DON) was interviewed on 3/16/2024 at 1:25 PM. The DON confirmed she was made aware by the Nursing Supervisor on the morning of 3/4/2024 of the voice recording made by NA #1 alleging abuse to Resident #1 and Resident #2. The DON stated she recognized the nursing staff did not report the allegation of abuse to her or the Administrator immediately and she initiated a plan of correction to make sure this did not happen again. The DON confirmed NA #1 did not work in the facility from 3/1/2024 to 3/4/224 picking up extra shifts she was not assigned for and was suspended pending the outcome of the investigation on 3/4/2024. The DON also confirmed there was no evidence after an investigation was conducted to prove the alleged abuse of Resident #1 or Resident #2 occurred but, NA #1 was terminated from her employment for unprofessional behavior and insubordination.

The facility's plan of correction dated as completed on 3/8/2024 was reviewed with the following corrective actions put in place. Included in the plan was the assessment of Resident #1 and Resident #2 revealing no physical or residual adverse effects of the alleged abuse. An audit was conducted on 3/4/2024 by Nurse #1, the Nurse Manager, to identify if there were any other allegations of abuse that had not been reported timely. All allegations of abuse for the past 30 days were reviewed by Nurse #1 and found to have been reported timely. On 3/4/2024 the staff development coordinator provided education to Nurse #4 and NA #2 on the facility written policy and procedure for reporting abuse allegations. On

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F 609	Continued From page 4	F 609		

3/4/2024 the staff development coordinator began educating all employees to include nursing, dietary, housekeeping, and therapy on the facility written policy and procedure for reporting abuse allegations immediately to a supervisor who should then report the allegation immediately to the Administrator or Director of Nursing. The education on reporting of abuse was completed on 3/8/2024. Any staff who were out on leave or on as needed status were educated prior to their assignment by the Director of Nursing/designee. All newly hired staff and contracted staff were to be educated on the abuse policies and procedures during orientation by the staff development coordinator. All employees receive training on abuse policies and procedures annually. An audit tool was developed to audit all allegations of abuse, neglect, misappropriation of resident's property or exploitation to ensure all the allegations have been reported immediately to administrative staff and state agencies as required by policy. The audits were conducted weekly for 12 weeks to ensure continued compliance with the plan of correction. The results of the audits were to be brought to the Quality Assurance Performance Improvement committee monthly for three months.

The facility plan of correction was reviewed, and the following documentation, interviews, and observations were made for confirmation of corrective action. Documentation revealed skin assessments were conducted on 3/4/2024 for Resident #1 and Resident #2. Documentation was reviewed of audits completed on 3/4/2024 and 3/15/2024 for reporting of abuse investigations revealed initial and continued monitoring. Documentation of education of abuse allegation reporting on 3/4/2024 through 3/6/2024

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F 609	Continued From page 5 for the entire staff included signed confirmation. Staff, including Nurse #4 and NA #2, were interviewed to confirm knowledge of the policy for abuse allegation reporting was received and retained. Interviews and observations with residents revealed they felt safe and protected in the facility and did not reveal any evidence of unreported abuse. The facility's date of compliance of 3/8/2024 was validated.	F 609		