STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING ______ B. WING ______	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

(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 survey was conducted from 3/4/24 through 3/6/24. Event ID# LHVT11. The following intakes were investigated: NC00209944, NC00211361, NC00211495, NC00211532, NC00213624, NC00213879, NC00214195 and NC00214269. Three (3) of the 25 complaint allegations resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		3/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/27/2024

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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time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure advanced directive information was up to date in the resident's electronic medical record for 1 of 1 resident (Resident #8) reviewed for advanced directives.

Findings Included:

Resident #8 was initially admitted to the facility on 8/23/22, with her latest admission date of 11/21/23. The resident was admitted to hospice on 1/16/24. Resident #8 passed away on 2/2/24 at the facility.

Review of the physician orders for Resident #8 showed an order dated 8/23/22 that read full code.

Review of hospice medical record showed a DNR form for Resident #8 dated 1/16/24.

Review of hospice progress note for Resident #8 completed by a contract hospice nurse dated 1/16/24 showed DNR (Do Not Resuscitate). The note further read, a copy will need to be signed

F 578

F-578

(1) How corrective action will be accomplished for resident(s) found to have been affected:
Resident # 8 no longer resides in the facility.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
On 3/8/2024 an audit was completed by the Director of Nursing and the Social Worker to ensure that all residents had an Advanced Directive (code status) in their medical record. Audit revealed that no other residents were affected.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 3/7/2024 the Administrator re-educated the Social Worker regarding

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and taken to facility.

Review of the care plan, most recently reviewed 2/2/2024, revealed no information regarding Resident #8's code status.

An interview was conducted on 3/6/24 at 9:37 A.M. with the facility Social Worker (SW). The SW worker stated Resident #8 had a DNR code status before she was accepted into hospice care. When the SW reviewed the chart during the interview, the SW stated the resident's electronic medical record did not show the resident was a DNR, but she thought the resident had become a DNR prior to her being enrolled into hospice. During the interview, the SW explained when a resident was accepted into hospice, the hospice agency completed a new DNR form and provided a copy to the facility. The SW indicated when the hospice staff brought the signed DNR paperwork to the facility, the paperwork was given to a nurse at the nursing station, who would then update the resident's electronic medical record. The SW was unsure why Resident #8's electronic medical record was not updated.

An interview was conducted on 3/6/24 at 11:40 A.M. with Nurse #5 who was assigned to Resident #8 on 2/2/24. Nurse #5 stated she was unsure when Resident #8 had become a DNR or why the order was not placed into her medical record. During the interview, Nurse #5 stated when she arrived for her shift on 2/2/24, Resident #8 was actively transitioning towards end of life. Nurse #5 indicated she was aware Resident #8 was under hospice care and when she looked in her electronic medical records, she observed Resident #8's chart showed she was a full code. Nurse #5 indicated Nurse #6, approached her,

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the requirement that all residents are to have an Advance Directive (code status) in their medical record.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that by reviewing on admission with the clinical team that the Advance Directive (code status) is listed and in the medical record along with care plan meeting review to ensure that any changes in the Advance Directive (code status) were updated and in the medical record. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months.

The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 3/27/2024

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F 578	Continued From page 3 and stated she had received an order for Resident #8 to be a DNR. An interview was conducted on 3/6/24 at 12:13 P.M. with Nurse #6 who stated the nurse assigned to the care of Resident #8 on 2/2/24 made her aware Resident #8 was in transition to end of life and her electronic medical records showed she was a full code. During the interview, Nurse #6 indicated any change of condition with a resident enrolled into hospice was immediately reported to the hospice agency. Nurse #6 further explained when she contacted the hospice agency, the hospice agency stated Resident #8 was a DNR. The hospice agency indicated they had a signed copy of the DNR form dated from the time Resident #8 was accepted into hospice care. An interview was conducted on 3/6/24 at 1:38 P.M. with the Director of Nursing (DON) who stated when Resident #8's code status was changed to a DNR, the nurse who received the order was responsible for changing the information in Resident #8's electronic medical record. The DON stated she was unsure if any of her staff had accepted the DNR paperwork from the hospice agency when they completed it or why Nurse #6 had not updated Resident #8's electronic medical record to show she was a DNR.	F 578		
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,	F 600		3/27/24

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F 600	Continued From page 4 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 record review, resident, staff, Physician, Psychiatric Nurse Practitioner, and Administrator interviews the facility failed to protect a resident's right to be free from employee to resident physical abuse, when an employee (receptionist) threw a plexiglass (acrylic) mask holder hitting Resident #2 on his forehead. The resident had a fall, and a laceration on his forehead. The resident was angry and upset when he was hit by the object thrown by the staff member. Resident #2 was sent to the emergency room and had undergone a procedure for 5 sutures on his forehead. This was for 1 of 2 residents reviewed for abuse (Resident #2). Findings included: Resident #2 was admitted to the facility on 1/12/22. Resident #2's cumulative diagnoses included Anxiety Disorder, Bipolar disorder, Mood disorder, and Diabetes Mellitus type 2. Review of the annual Minimum Data Set (MDS) assessment dated 1/20/24 revealed Resident #2 was assessed as cognitively intact and independent with Activities of Daily Living.	F 600	F-600 (1) How corrective action will be accomplished for resident(s) found to have been affected: The police and EMS were notified by the facility on 2/25/2024 and resident #2 was taken to the hospital for laceration sustained to forehead by object thrown by employee. Medical Director and emergency contact were notified. Psyche services notified for follow up to ensure psychosocial well-being. Accused employee was sent home and suspended per investigation results. A 24-hour initial allegation of abuse was sent in by the administrator on 2/25/2024. Adult Protective Services was notified by the Social Worker on 3/5/2024 for resident #2. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 2/25/2024 The Administrator	

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Resident #2 was assessed as having no observed behaviors during the assessment period. Assessment indicated the resident was ambulatory. Resident #2 received antianxiety and antidepressant medications during the 7 day look back period.

Review of Resident #2's care plan, which had a revision date of 1/15/24 revealed the resident was care planned for behaviors related to having verbally abusive behavior related to ineffective coping skills. The resident was also care planned for having inappropriate behavior with female staff. Intervention indicated when Resident #2 becomes agitated: staff to intervene before agitation escalated, guiding the resident away from source of distress, engaging calmly in conversation with the resident. If the resident becomes aggressive, staff had to walk calmly away and approach the resident at a later time.

Observation of the lobby on 3/4/24 at 2:45PM revealed the receptionist window was facing the front lobby. The receptionist office door was towards the hallway and could not been seen from the front lobby. There was no mask holder near the receptionist window. An observation of the person working in the receptionist's office revealed she had a table in front of her and was facing the window which was greater than arm's length from the window. The room was large and spacious for the receptionist to stand up and move back safely away from the window. The receptionist's office had a phone and copier machine. There was a clip board with paper and pen on the windowsill for visitors to enter their name.

Review of the 24-hour initial report dated 2/25/24

F 600

conducted resident interviews to all residents that are able to be interviewed to see if any other residents may have been affected by the alleged suspect or anyone else and who to report to if ever affected by abuse of any kind. No other residents were noted to be affected.

On 2/25/2024 The Director of Nursing, Unit Manager, and nursing staff performed skin assessments for all residents who are unable to be interviewed to ensure that no residents have suffered and been a victim of abuse. Skin assessments revealed that no other residents were noted to be affected.

On 2/26/2024 the Administrator conducted an AD-HOC QA meeting with the interdisciplinary team to review corrective action.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 2/25/2024 the Administrator, Director of Nursing, and Unit Manager initiated re-education to all staff regarding:

- The abuse policy that includes the definition of abuse, the various types of abuse, who the abuse prevention coordinator is, timeliness of reporting along with notifying Adult Protective Services

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F 600	Continued From page 6 revealed the incident of physical abuse occurred on 2/25/24 at approximately 3:50 PM. Resident #2 had a laceration to his forehead. The employee (receptionist) (accused) was suspended pending investigation. Law enforcement was notified of the incident. Review of the 5-day investigation report dated 2/29/24 revealed the facility was made aware of the incident on 2/25/24 at approximately 3:50 PM. The incident of physical abuse occurred in the front lobby. The allegation details in the summary revealed Resident #2 was rude to the staff (Receptionist) and pushed a plastic mask container towards the staff (Receptionist). The staff (Receptionist) threw the mask container back at Resident #2 resulting in a laceration on the forehead. Law enforcement was notified, and charges related to the incident were filed. The report also indicated the incident was not reported to the County Department of Social Services. The employee was terminated, and the allegation was substantiated. During an interview on 3/4/24 at 10:00 AM, Resident #2 stated on 2/25/24 (Sunday), he wanted some of his medical records to be copied. As the copier at the nurse's station was not working, he had walked to the receptionist to have them copied. Resident #2 further stated the receptionist was not making any effort to make copies for him. Resident #2 indicated he was upset and informed the receptionist that he was going to come inside her office and copy the records himself. Resident #2 stated he had no intentions of making copies himself. However, he proceeded toward the office door which was locked. The resident indicated the receptionist tried to stop him from entering and threw a box	F 600	• Tips and strategies for de-escalating aggressive, hostile, or violent residents • Tips and strategies on how to combat and prevent burnout Education completed on 3/26/2024. Any employee that has not been re-educated by this date will not work their next shift until education has been completed. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, The Director of Nursing, or designee to ensure that through the grievance process and resident interviews, no additional occurrences of abuse take place. This monitoring process will consist of 5 resident interviews weekly for 4 weeks and then 10 resident interviews monthly for 2 months. The Director of Nursing, Unit Manager, or designee will perform 5 skin assessment per week for 4 weeks to residents unable to be interviewed and then 10 skin assessment per month for 2 months. In addition, The Administrator, The Director of Nursing, or designee will conduct staff member follow up abuse interviews to ensure carry over. 5 staff member interviews will be conducted weekly for 4 weeks and the 10 staff member interviews monthly for 2 months. Any issues during monitoring will be	

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used to put masks at him. The box hit his forehead resulting in laceration and bleeding. Resident #2 stated he was sent to the hospital via Emergency Medical Services (EMS) and returned later that night with sutures on his forehead.

Review of the receptionist statement dated 2/26/24 revealed Resident #2 approached the receptionist desk rudely around 2:30 PM on 2/25/24. The statement indicated the receptionist purposely ignored the request and chose not to engage with the resident due to the resident's previous history of confrontation/harassment of the staff member. The statement also indicated Resident #2 was aggressive and yelling at the receptionist and tried to open the office door with unknown intentions. When the resident was unable to open the office door, he came back to the receptionist window and threw a plastic object (mask holder) towards the receptionist. The receptionist threw the plastic object back towards the resident without thinking and as an instinct. The box struck the resident resulting in an injury to his forehead. The statement was signed and dated by the receptionist.

During a telephone interview on 3/4/24 at 1:19 PM, the receptionist stated she had multiple "run-ins" (when the resident used inappropriate language at her) with Resident #2 prior to this incident. Resident #2 would be rude and use inappropriate language towards her. She indicated she had reported these run-ins multiple times to the Administrator and her supervisor (Business office Manager). The receptionist stated she avoided all interactions with Resident #2 to prevent any issues. The receptionist stated on 2/25/24 (Sunday), Resident #2 walked up to the receptionist window and asked her to do

F 600

addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 3/27/2024

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something for him. The receptionist stated she ignored the resident as there was no one in the front lobby and if there was any interaction between the resident and the employee, there would be no witness to the incident. The receptionist stated the resident tried to enter her office, but she locked the door. The resident later tried to assault her from the window by throwing something (mask holder) at her. The receptionist further stated as an instinct, she threw it back at the resident. Unfortunately, it hit the resident on his head, The receptionist stated she did not intentionally try to harm the resident, but it was a reflex action to protect herself. The receptionist stated she was sent home after the incident and was later informed that she was terminated. The receptionist stated she received abuse/neglect education/training in January 2024. The receptionist stated she was charged by the police for assault on the resident.

Review of the investigation details and Plan of Correction folder provided by the Administrator on 3/4/24 revealed a witness statement dated 2/26/24. The statement was written and signed by the Housekeeping Staff #1. The statement indicated Resident #2 was being disrespectful and using inappropriate language toward staff (receptionist). The resident then proceeded to grab the door handle and tried to break into the receptionist's office. The statement indicated the receptionist was ignoring the resident which made Resident #2 upset. Resident #2 was yelling inappropriate (racist) comments at the receptionist. The witness statement explained a container (mask holder) came flying out of the receptionist window and hitting the resident on his head. Both the resident and the receptionist called 911.

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F 600	Continued From page 9 During as interview on 3/4/24 at 1:58 PM, Housekeeping Staff #1 stated on 2/25/24 between 2:30 - 2:45 PM, he was getting ready to clock out of his shift and was on his way towards the front lobby. Housekeeping staff #1 stated he observed Resident #2 in the hallway. The resident was yelling and using inappropriate language towards the Receptionist. Housekeeping Staff #1 indicated Resident #2 was observed jiggling the door handle of the receptionist office. The receptionist office door was closed, and Resident #2 was unable to open the door. Resident #2 walked back to the receptionist window in the front lobby and had a confrontation with the receptionist. The receptionist was inside her office, behind her desk. The Housekeeping staff #1 stated even before he knew what was happening, he noticed a container (mask holder) flying out of the window and hitting the resident on his head. The resident fell on the floor. Resident #2 got up and started proceeding to the receptionist office. The resident had blood on his forehead. The receptionist was outside her office and out the front door on her cellphone. The resident was also on his cellphone. The Housekeeping staff stated someone had notified the resident's nurse and she had come up front immediately to assess the resident. Resident #2 refused to be assessed by the nurse or get treatment. The Housekeeping Staff stated EMS arrived within minutes of the incident. Resident #2 initially refused to have EMS assess him, but later agreed and was assessed. The resident was taken to the hospital by EMS for further evaluation. The police also arrived at the facility and took a statement from the resident and the receptionist. The Housekeeping staff stated the Administrator,	F 600		

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F 600	Continued From page 10 Director of Nursing (DON), and his supervisor were all notified and came to the facility. The Housekeeping staff #1 indicated he was asked to write a statement about the incident. The receptionist was sent home after the incident. Housekeeping Staff #1 was unsure if the receptionist could see him as she was inside her office, and he had just walked from the hallway to the front lobby. Review of the nursing note written by Nurse #1, for Resident #2, dated 2/25/24 at 4:08 PM, revealed, Nurse #1 was called to the front lobby regarding the resident's emergency. The note indicated the nurse had observed blood on Resident #2's forehead. The resident was observed yelling at the receptionist. The note indicated that the resident was refusing to be assessed by the nurse. The Law enforcement and Emergency Medical Services (EMS) were notified. Resident #2 initially refused care from EMS and was yelling at EMS staff. The resident requested his phone, so that he could take pictures of the incident. The resident was given his phone, and he allowed the EMS to assess him. Resident #2 left to the hospital for further evaluation. Review of the Emergency Department Discharge Summary dated 2/25/24 revealed Resident #2 presented to the Emergency Room for evaluation of head injury with laceration. No significant blood loss. The resident had reported a fall at the facility when one of the nurses threw a plexiglass square box (mask holder) that was used to hold face masks at him. The report indicated the resident had sustained a laceration to the central and left forehead. The resident had also reported that he did fall back onto the ground but denied any	F 600		

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injuries from the fall. The resident was ambulatory after the event. The resident was presented with laceration on his forehead. The length of the Laceration was 2 cm {centimeters}. The laceration needed a total of 5 sutures and the resident tolerated the procedure well. The report also read in part "per EMS 2 X {times} ~ {about} 1 cm laceration on patient {resident} forehead. Bleeding was controlled by gauze at the time. Resident was alert and oriented and able to stand to stretcher." Resident was discharged back to the facility.

Review of a nursing note written by Nurse #8 dated 2/26/24 at 6:04 AM revealed Resident #2 returned to the facility on 2/26/24 at around 4 :00 AM. The resident was noted to have two reddened areas on the forehead, one with a steri-strip and one with sutures. The note read in part "No new orders were noted but resident does have a suture removal follow up and multiple appointments, copies of which were placed in the transportation box. Copy of the suture removal follow up was also made for the wound nurse, unit coordinator and DON {Director of Nursing} so that they are aware that resident needs a follow up in 3-5 days for suture removal. Resident is currently resting in bed; breathing is regular and unlabored. He tolerated his medication with no difficulty. {Medical Director name} was made aware of resident's return to the facility."

During an interview on 3/4/24 at 10:30 AM, Nurse #1 stated she worked the first shift (7AM - 3PM) on 2/25/24 and 2/26/24 and was assigned to Resident #2 on both days for the first shift. Nurse #1 indicated on 2/25/24 she was paged on the overhead pager to come to the front lobby due to an emergency. She was not aware what the

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emergency was. She indicated when she arrived to the front lobby, she observed Resident #2 had blood on his face and was bleeding from the forehead. Nurse #1 stated she had requested the resident to sit down on a chair so that she could assess him, but he refused. Resident #2 was very upset and yelling at the staff (receptionist). She did not recollect what he was yelling, as she was more concerned about calming the resident and putting pressure on the wound. Nurse #1 stated EMS had arrived at the facility within couple of minutes and wanted to assess the resident, which he refused. Nurse #1 stated the resident was bleeding badly and there was blood on the floor, on his face, on his glass and on his shirt. Resident #2 wanted to take pictures of his face (injury), blood on the floor and on his glass. EMS could assess the resident after he had taken these pictures. The resident was sent to the hospital for further evaluation. Nurse #1 indicated the receptionist was outside in the parking lot, in front of the building talking on her cellphone. Nurse #1 stated she received a report from the night shift nurse (11AM - 7PM), that the resident had returned to the facility later that night (early next morning) and was not in any distress. Nurse #1 indicated at the hospital the resident received sutures on his forehead. Nurse #1 stated the resident was at his baseline the next day, did not complain of any pain or distress. She explained Resident #2 was on as needed pain medication and did not request any pain medication.

During a telephone interview on 3/7/24 at 3:00 PM, the Physician stated Resident#2 was diagnosed with bipolar disorder and under psychiatric services to control his mood swings. The physician stated he was made aware of the incident and the resident was sent to the

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emergency room for further evaluation. In the hospital the resident received a few sutures on his forehead. Resident #2 tolerated the procedure well. The Physician stated the resident was assessed after he returned from the hospital. The laceration was not deep, there was no sign of any infection, and the sutures were healing well.

During a telephone interview on 3/5/24 at 4:10 PM, the Psychiatric Nurse Practitioner (NP) stated the resident was seen by psychiatric services due to his mood and bipolar disorder. The Psychiatric NP indicated the resident was assessed a few days prior to the incident. The NP stated she had assessed the resident on 3/1/24 after the incident. The resident was able to provide her details of the incident. The resident was in good spirits during the assessment. The NP stated the resident had expressed understanding that it was one staff member's behavior and that it was not a reflection of the facility. The resident did express he felt safe at the facility. NP stated during the assessment the resident was at his baseline, managing well and did not have any residual symptoms from the incident.

During an interview on 3/4/24 at 2:50 PM, the Administrator stated the mask holder was removed from the receptionist window after the incident. It was stored in a closed cabinet inside the receptionist's office. The mask holder was measured with the help of the Housekeeping/Maintenance Supervisor. It was approximately 8-inch (Width) X 4.5-inch (Height) X 5.5-inch (Diameter) and weighed approximately between 1 -2 pound (lbs.). The box also had 2 metal hinges approximately 1inch long at the back of the container.

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During an interview on 3/5/24 at 2:58 PM, Nurse #2 stated she was an agency nurse and was coming to the facility after a break. She indicated it was her first day after the break. She indicated worked the 7 AM to 3 PM (first shift) and was assigned to Resident #2. Nurse #2 indicated she did not receive any abuse/ neglect in-service prior to her shift, nor did she receive any information regarding de-escalation. She stated she was unaware of any incident that occurred in the facility with a resident. Nurse #2 stated she may receive a packet or something after her shift prior to her leaving the facility.

The Administrator was interviewed again on 3/4/24 at 4:43 PM and on 3/5/24 at 2:30 PM. The Administrator stated the facility had a zero-tolerance policy of abuse. The Administrator indicated the receptionist was in a safe area, inside her office and the office door was locked. The Administrator stated the receptionist had acted violently, by stating it was in self-defense. The resident was injured by the action of the receptionist. The Administrator further stated the receptionist was terminated from the facility. The Administrator indicated the receptionist had on 1-2 occasions reported to him about Resident #2's hostile nature but nothing abusive towards her. The Administrator further indicated that it was just a statement made by receptionist and nothing indicating any appropriate behavior from Resident #2 towards the receptionist that needed to be addressed. The Administrator indicated all employees had to deal with some hostile residents and it was a part of the job. The Administrator stated he did not think this was a staff burnout issue and no interventions were implemented. The Administrator stated after the

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F 600	Continued From page 15 incident all facility staff were provided with educational information on "Tips and strategies for de-escalating, aggressive, hostile or violent patient." All staff were also in serviced on abuse by the Unit Manager. The Administrator indicated he interviewed all residents with a BIMS (Brief Interview Mental Status) greater than 13 for any form of abuse by the receptionist (accused staff) or any other staff in the facility. Skin assessment for all residents with BIMS less than 13, and who were unable to be interviewed were performed by the Director of Nursing (DON) and Unit Manager. The Administrator stated the monitoring process consisted of 5 residents with BIMS greater than 13 interviewed weekly for 4 weeks and then 10 residents interviewed per month for 2 months. The DON and unit manager would perform 5 skin assessments per week on 5 residents with BIMS less than 13 for 4 weeks and then10 resident's skin assessment would be performed per month for 2 months. The administrator indicated follow up interviews regarding abuse and de-escalation would be conducted with the staff members. 5 staff members would be interviewed weekly for 4 weeks and later 10 staff members would be interviewed monthly for 2 months. The Administrator indicated the facility had provided an educational packet regarding abuse/ neglect and de-escalation to the contract staffing agency to ensure agency staff were also trained. The Administrator was, however, unable to state how the facility was ensuring that all agency staff were trained prior to their shifts in the facility. The Administrator stated any issues with the monitoring process would be addressed immediately. The finding of the monitoring process would be reported to the Quality Assurance and Performance Improvement Committee for any additional monitoring or any	F 600		

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F 600	Continued From page 16 modification. The Administrator indicated he expected all residents to be free from abuse and neglect and free from any retaliation. The Administrator indicated that the abuse allegation was substantiated.	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 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		3/27/24

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Based on record review and staff interview the facility failed to report an abuse allegation to Adult Protective Services (APS), failed to immediately report an allegation of abuse to the facility administration and failed to report an abuse allegation to the state survey agency for 2 of 2 residents reviewed for abuse (Resident #2 and Resident #5).

Findings included:

Review of the Abuse, Neglect and Exploitation policy (date implemented 10/1/23) read in part "The facility will have written procedures that include- Reporting of all alleged violations to the Administrator, stated agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe."

1. Review of the nursing note written by Nurse #1, for Resident #2, dated 2/25/24 at 4:08 PM, revealed, Nurse #1 was called to the front lobby regarding the resident's emergency. The note indicated the nurse had observed blood on Resident #2's forehead. The resident was observed yelling at the receptionist. The Law enforcement and Emergency Medical Services (EMS) were notified. The resident was assessed by EMS and left to the hospital for further evaluation.

Review of the 5-day investigation report dated 2/29/24 revealed the facility was made aware of the incident on 2/25/24 at approximately 3:50 PM. The incident of physical abuse occurred in the front lobby. The allegation details in the summary revealed Resident #2 was rude to the staff (Receptionist) and pushed a plastic mask

F 609

F-609

(1) How corrective action will be accomplished for resident(s) found to have been affected:
Resident #5 no longer resides in the facility and Adult Protective Services was notified by the Social Worker on 3/5/2024 for resident #2.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 3/11/2024 the Administrator, Director of Nursing, and Unit Manager initiated re-education to all staff regarding the guidelines and requirements for state reporting obligations along with the required timeline for reporting abuse that includes notifying Adult Protective Services.

On 3/21/2024 the Regional Director of Clinical Services re-educated the Administrator, Director of Nursing, and Unit Manager regarding the guidelines and requirements for state reporting

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container towards the staff. The staff (Receptionist) threw the mask container back at Resident #2 resulting in a laceration on the forehead. The law enforcement was notified, and charges related to the incident were filed. The report also indicated the incident was not reported to the County Department of Social Services / APS.

During an interview on 3/4/24 at 4:43 PM, the Administrator stated he was the Chief Abuse Investigation Personnel and was notified when the incident occurred on 2/25/24. He further stated Resident #2 was hit by the staff (receptionist), when the staff threw a plastic mask container at the resident. The resident had a laceration on his forehead and was taken to the hospital for further evaluation by the EMS. The law enforcement was notified regarding the incident and charges were filed. When the Administrator was asked if APS was notified, the Administrator indicated he was not aware APS needed to be notified about the abuse allegation. The Administrator stated he had not notified APS.

2. Resident #5 was admitted to the facility on 2/3/23 with diagnoses that included vascular dementia with psychotic disturbances and reduced mobility. Resident #5 was discharged from the facility on 11/6/23.

Review of a nursing progress note dated 10/18/23 at 3:01 P.M. written by Nurse #3 read in part "Pt (Patient) tearful and bruising noted to arm. Pt states someone with a hoodie hit her in the arms and knees about a week ago. She does not know who but thinks it was about a week ago. No markings to knees. No c/o (complaints of) pain. This was relayed to the nurse manager (Nurse # 4) who states she thinks the bruising is

F 609

obligations along with the required timeline for reporting abuse that includes notifying Adult Protective Services.

Education completed on 3/26/2024. Any employee that has not been re-educated by this date will not work their next shift until education has been completed.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, The Director of Nursing, or designee to monitor and ensure that all state reporting obligations were done within the appropriate timeline that includes notifying Adult Protective Services. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months.

The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 3/27/2024

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cellulitis. Will continue to monitor."

Review of a written statement created by the Administrator on 10/18/23 read at "approximately 3:05 P.M., Unit Manager (Nurse #6) came to Admin stating that (Resident #5) said a person in a hoodie hit her in the arms and knees about a week ago. . . asked her if anyone had been in her room and hurt her at any time. (Resident #5) stated no, not at all. I am fine and have never been abused."

Resident #5 was no longer residing at the facility and was unable to be interviewed.

An interview was attempted with Nurse #3 and was unsuccessful.

An interview was conducted on 3/5/24 at 3:48 P.M. with Nurse #4 who stated Nurse #3 reported to her Resident #5 stated someone with a hoodie had entered Resident #5 room and hit her. Nurse #4 indicated she reported this allegation to the Director of Nursing as soon as Nurse #3 told her about the incident.

An interview was conducted on 3/6/24 at 1:47 P.M. with the Director of Nursing (DON). During the interview, the DON indicated she was unable to recall staff reporting to her that Resident #5 had verbalized to the floor staff someone dressed in a hoodie had entered her room and physically harmed her. The DON stated she became aware of the incident the following morning when she reviewed the 24-hour report on Resident #5. During the interview, the DON stated per the facility policy, when the report of abuse was made, an initial report for the abuse allegation should have been submitted to the State Agency.

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F 609	Continued From page 20 The DON did not provide a reason for why a report was not submitted to the State Agency. An interview was conducted on 3/6/24 at 2:45 P.M. with the Administrator. During the interview, the Administrator stated he received a report from a staff member that Resident #5 had reported a person with a hoodie entered her room and hurt her. The Administrator was unable to recall the name of the staff that reported the allegation of abuse to him. The Administrator stated he did not submit an initial report to the State Agency because when he went to Resident #5's room after the allegation was reported to him, Resident #5 verbalized no one had harmed her.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents, staff, and the Medical Doctor (MD), and record reviews, the facility failed to safely transfer a resident using a total mechanical lift for 1 of 1 resident (Resident #1) reviewed for accidents. The resident was lowered to the floor by two staff members without injury as the mechanical lift tipped to one side. The findings included:	F 689	F-689 (1) How corrective action will be accomplished for resident(s) found to have been affected: The nurse completed a head-to-toe skin assessment for resident #1 and no cuts or bruises were noted. Neuro checks were initiated and vital signs were taken and within normal limits. Range of motion was	3/27/24

F 689

Continued From page 21

Resident #1 was admitted from a hospital to the facility on 4/14/23. His cumulative diagnoses included paraplegia, chronic pain, and neuropathy (peripheral nerve damage that usually affects the hands and feet).

A review of the resident's medications ordered on 7/6/23 (and continued through the date of the review on 3/6/24) included, in part:
--5 milligrams (mg) apixaban (an oral anticoagulant) to be given as one tablet by mouth every 12 hours. The manufacturer's Medication Guide for apixaban (Revised September 2021) indicated that use of this medication may cause a patient to bruise more easily than usual.
--5 mg oxycodone (an opioid pain medication) to be given as one tablet by mouth every 6 hours as needed (PRN) for pain.

Resident #1's Care Plan included the following areas of focus, in part:
--The resident has an Activities of Daily Living (ADL) self-care performance deficit. The planned interventions included the resident requiring a Mechanical Aid (lift) for transfers (Revised 6/8/23);
--The resident has been noted to exaggerate events or tell untruths related to circumstances of certain events (Revision on 9/14/23);
--The resident has acute/chronic pain related to paraplegia (Created on 12/28/23).

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 1/4/24. The quarterly MDS revealed Resident #1 was cognitively intact. The resident was dependent on staff for transfers from to and from the bed to a wheelchair. His weight was reported to be 320

F 689

assessed as well and was noted to be within normal limits. Resident #1 was sent to the emergency department for evaluation. No negative findings were noted.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
All residents that utilize a Hoyer lift have the potential to be affected.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 2/14/2024, the 2 Nursing Assistants that were performing the lift were re-educated on the spot by the Unit Manager regarding proper Hoyer Lift transfers.

On 2/14/2024, The Director of Nursing, Unit Manager, and the Staff Development Coordinator initiated re-education to all direct care nursing staff regarding proper Hoyer Lift transfers with return demonstration.

Education completed on 3/26/2024. Any direct care nursing staff that has not been re-educated by this date will not work their next shift until education has been completed.

On 2/14/2024 The Maintenance Director checked all lifts to ensure proper functioning. All lifts were noted to be

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DURHAM NURSING & REHABILITATION CENTER	**411 S LASALLE STREET DURHAM, NC 27705**

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pounds (#).

A Nursing Progress Note dated 2/14/24 at 3:16 PM was authored by Nurse #7. The note read: "Resident was being transferred from w.c. [wheelchair] to bed with [brand name of the total mechanical lift] lift by two CNAs [Certified Nurse Aides]. Resident was properly secure in the lift pad. The [brand name of the total mechanical lift] lift leaned to one side with wheels tilted to the right side. Resident stated the middle arm of the lift bumped head. No bruises, or cuts present at this time. Both CNAs assisted resident to the floor with the resident lying on back. Nurse came in assessed resident. Nurse completed head to toe skin assessment no cuts, bruises, present at this time. Neuro checks performed vital signs within normal limits. Nurse assisted resident with ROM [range of motion]. Nurse and two CNAs assisted resident from lying on the floor on back with face up worth [upwards] towards the ceiling. Resident c/o [complained of] head hurting. Nurse gave resident PRN [as needed acetaminophen]. Resident requested to be [sent to] local ED [Emergency Department] for further evaluation. Resident is own RP [Responsible Party]. MD [Medical Doctor] notified gave nurse verbal order to transfer resident to local ED. Nurse notified [family member] of resident's transfer to [name of] Hospital. Nurse MAR [Medication Administration Record] and face sheet to EMS [Emergency Medical Services] tech [technician]."

An interview was conducted with the resident on 3/5/24 at 9:30 AM. During the interview, the resident was asked to detail the incident that occurred when he was being transferred with a total mechanical lift on 2/14/24. He stated one

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functioning properly.

4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Director of Nursing, Unit Manager, or designee to ensure that through observation, Hoyer Lift transfers are performed correctly. This monitoring will take place by observing 3 Hoyer Lift transfers weekly for 4 weeks and 10 Hoyer Lift transfers Monthly for 2 months.

In addition, The Maintenance Director will check all lifts to ensure proper functioning. This monitoring will take place weekly for 12 weeks.

Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 3/27/2024

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Nurse Aide (NA) was near his head while another NA was positioned towards his feet. After being lifted up from his wheelchair, it seemed like the wheels of the lift locked up and the NAs couldn't get them to turn. As the lift began to tip over; the resident stated a "rod" on the lift hit his head. When asked, Resident #1 stated his right hip and buttocks landed on the floor first. Upon inquiry as to whether the NAs assisted with lowering him to the floor, the resident stated they may have. However, he added since it all happened so fast, he could not be sure. Resident #1 recalled someone saying the lift used was supposed to be "out of commission."

An interview was conducted on 3/5/24 at 9:40 AM with Resident #7 (Resident #1's roommate). A review of Resident #7's 12/20/24 Admission MDS revealed the resident was cognitively intact. During the interview, Resident #7 recalled the 2/14/24 incident with the lift transfer involving his roommate. He reported the curtain between the two beds was open at the time of the incident, so he was able to see what happened. Resident #7 stated "it all happened very fast." He did recall seeing a bar from the lift hitting Resident #1 in the head. When asked if he could tell whether the resident was assisted to the floor by the NAs, he stated, "it looked like that to me." The resident recalled the lift was switched out before moving the resident from the floor to the bed. When asked why another lift was used, he stated the staff said the lift used was just for weights and not transferring residents.

A telephone interview was conducted on 3/4/24 at 3:26 PM with NA #5. NA #5 was identified as the nurse aide who was assigned to care for Resident #1 on 2/14/24 and assisted in

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transferring him with a total mechanical lift on that date. During the interview, the NA was asked to describe what occurred during the transfer. NA #5 stated the lift used was stored in the hallway close to Resident #1's room and the lift rolled "just fine" when it was initially brought into the resident's room. She reported with the help of NA #6, the resident's sling straps were hooked up to the lift. Everything was fine until the NAs went to turn him towards the bed. She stated the lift's wheels seemed to lock up and instead of turning towards the bed, it just started tipping. She stated they tried to get the lift back upright but couldn't. NA #5 stated, "We assisted him to the floor." The NA reported instead of him falling and hitting the floor, she had her hand on the back of him so they could ease him down to the floor. After the resident was eased to the floor, NA #5 reported she went to get the nurse (Nurse #7) while NA #6 stayed with the resident. She stated Nurse #7 came and assessed the resident right away. While NA #5 reported she didn't see the resident hit his head on anything, but he did complain his head hurt so she got him a bag of ice. NA #5 stated the Unit Manager told the NAs they did everything correctly. However, they were told the total mechanical lift used for the transfer was a lift that was exclusively used to obtain residents' weights.

A telephone interview was conducted on 3/4/24 at 3:05 PM with NA #6. NA #6 was the second NA identified as assisting with the transfer of Resident #1 from his wheelchair to the bed on 2/14/24. During the interview, the NA recalled details of the transfer for Resident #1 on that date. NA #6 reported, "We hooked him up correctly" to the total mechanical lift. As they were moving him backwards from the wheelchair

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F 689	Continued From page 25 to the bed and getting ready to turn the lift, "for some reason it locked up and tilted." The NA stated, "He's a heavy dude ....he did not fall to the floor." NA #6 reported they grabbed onto the sling and "we did lower him down to the floor." She recalled NA #5 ran and got the nurse to come and evaluate him. After he was assessed, she reported he was transferred from the floor to his bed using a different total mechanical lift. When asked, the NA stated Resident #1 only complained of his head hurting after being lowered to the floor. He said when the lift tilted, a bar hit his head. NA #6 stated, "We did everything right." She reported they just couldn't turn the lift with the resident in the sling and it started to tip over. An interview was conducted on 3/4/24 at 12:15 PM with Nurse #7. Nurse #7 was identified by the facility's Director of Nursing (DON) as having been assigned to care for this resident on 2/14/24 at the time of the incident. The nurse recalled she was asked to come to the resident's room to assess Resident #1. She stated when she entered the room, the resident was on the floor. Apparently, he had been in the process of being transferred with a total mechanical lift from the wheelchair to his bed with the assistance of two Agency (temporary staff) Nurse Aides (NAs). The nurse stated she assessed the resident and then helped to assist the resident to his bed. She stated the resident reported he had pain everywhere. The NAs reportedly told the nurse the lift tilted over to one side, so they lowered him to the floor. The resident reported he "fell." This nurse recalled telling the resident that if he fell, he would have broken multiple bones. She recalled Resident #1 requested to go to the hospital for evaluation and	F 689		

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treatment. Nurse #7 stated since the resident was his own Responsible Party (RP), he was sent out to the hospital in accordance with his wishes.

A review of the EMS Report dated 2/14/24 revealed a call was received from the facility requesting EMS services on 2/14/24 at 2:49 PM. EMS arrived at the facility on 2/14/24 at 3:03 PM. A narrative within the EMS Report indicated upon arrival to the resident's room, Resident #1 was sitting in his bed and in no acute distress. His vital signs were noted to include blood pressure 124/61, pulse rate 89, respiration rate 14, and oxygen saturation rate of 96 percent (%) on room air. The resident complained of a headache, stating the "handlebar" from the total mechanical lift struck his head while the staff were transferring him. The EMS Report indicated, "Pt [Patient] has no signs of trauma/injury noted." Resident #1 was transferred to the hospital ED for further evaluation.

The hospital ED records included a Triage Note dated 2/14/24 at 3:38 PM. The note indicated the facility staff reported during a total mechanical lift transfer from a wheelchair to the bed, Resident #1 "gently knocked head on bar and was assisted to the ground lowered by staff and lift." No obvious injury or trauma was noted. An ED Provider note dated 2/14/24 at 4:38 PM indicated Resident #1 presented to the ED for evaluation after a fall. The resident reported he was being transferred form his wheelchair to the bed when the lift broke and he fell approximately 5 feet hitting his head on a bar and landing on his right side. He reported pain to his right arm and forehead. Additionally, the resident stated he experienced a burning sensation in the right lower quadrant of his abdomen for the last 3 days. The

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provider note reported Resident #1's trauma workup was largely reassuring with the results of his tests showing no acute abnormalities. Resident #1's tests included a computerized tomography (CT) of the brain and cervical spine (the neck region), and x-rays of the chest, right shoulder, pelvis, right femur, and right knee. The resident was found to have cystitis (an infection of the urinary bladder) with a course of an oral antibiotic initiated for treatment. Resident #1 was discharged from the ED on 2/14/24 at 10:19 PM back to the facility.

Resident #1 was seen by his MD at the facility on 2/16/24. A Provider Progress Note dated 2/16/24 at 11:56 AM reported the resident requested to be seen and examined due to his recent fall, ED visit, and urinary tract infection. Resident #1 appeared to be in no acute distress at that time. The MD reported the resident was being lifted from his chair to bed when he had a fall on 2/14/24 and was assisted to the floor with his back to the floor. The MD noted, "Patient without any head injury or bruises. Patient was sent to the ER [Emergency Room] as requested by himself however CT of the brain, C-spine [cervical spine], abdomen and x-rays of multiple joints came back unremarkable for any evidence of fractures. Patient was started on Augmentin for possible UTI [urinary tract infection] as well. Patient's complaining of increased pain we will increase the patient's oxycodone to 10 mg for 1 week."

An interview was conducted on 3/4/24 at 4:40 PM with the facility's Director of Nursing (DON). The DON recalled Resident #1 was on his bed when she came into his room. When asked about the total mechanical lift used for Resident #1's

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transfer on 2/14/24, the DON stated that lift was generally only used to obtain residents' weights. When asked why this lift was not used for transfers, she stated, "it is a working lift" and there was no issue with it. Upon further inquiry as to what made the lift tilt or tip, the DON stated there may have been a problem with the flooring which prevented it from turning. The DON reported if there was a problem with a lift, there would have been a tag put on it and the lift would have been stored in the back behind the double doors to put it out of service. During a follow-up interview conducted with the facility's DON on 3/5/24 at 8:24 AM, the DON reported the maximum weight for the total mechanical lift used for Resident #1 on 2/14/24 was 600 pounds.

A review of the specifications for the brand and model number of the total mechanical lift used to transfer Resident #1 on 2/14/24 confirmed the weight limit for the lift was 600 pounds.

An interview was conducted on 3/5/24 at 8:26 AM with NA #7. NA #7 was identified as the nurse aide who assumed responsibility for weighing residents with the total mechanical lift used to transfer Resident #1 on 2/14/24. When asked, NA #7 confirmed she was working in the facility on 2/14/24 when NA #5 and NA #6 attempted to transfer Resident #1. She recalled going into the resident's room after he had been lowered to the floor and confirmed the lift used for the transfer was the "weight lift." NA #7 stated when the facility purchased their 4th total mechanical lift approximately 6 months ago, the NAs were educated to only use the "weight lift" for obtaining weights and to use the other 3 lifts for transfers. When asked why this lift was not supposed to be used for transfers, she stated, "It's not broken,

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F 689	Continued From page 29 that's my [brand name] lift and I prefer to only use it to do weights." Accompanied by the DON and the facility's Maintenance/Housekeeping Director, an observation was made on 3/4/24 at 4:45 PM of the total mechanical lift identified as having been used to transfer Resident #1 on 2/14/24. The lift was observed to be stored in the back behind the double doors at the end of a hallway. An interview conducted with the Maintenance / Housekeeping Director at the time of the observation revealed a service company came out to inspect and maintain the facility's lifts on a quarterly basis. A sticker from the service company was observed to be placed on the lift. The sticker indicated the lift was last inspected on 2/21/24 and was due for another inspection in May 2024. Additionally, the Maintenance / Housekeeping Director reported he checked all lifts twice a week. During a follow-up interview conducted on 3/5/24 at 9:48 AM, the Director reported his twice weekly checks was preventative maintenance and included a visual inspection, lubrication, a check on the up/down motion of the lift, a check to be sure the lift legs opened, closed and turned appropriately, a check to be sure the hand control worked properly, and a check to ensure the battery was charged. Both the DON and the Maintenance / Housekeeping Director reiterated that the lift used to transfer Resident #1 on 2/14/24 was in good working condition with no problems identified either before it was used or after the incident. A telephone interview was conducted on 3/6/24 at 8:52 AM with a representative from the medical equipment service company who came out quarterly to calibrate and safety test the facility's	F 689		

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mechanical lifts. During the telephone interview, the representative of this company reviewed the details of the technician's visit to the facility on 2/21/24. She reported no repairs nor problems were identified with the make/model total mechanical lift used to transfer Resident #1 on 2/14/24.

A telephone interview was conducted on 3/6/24 at 12:30 PM with Resident #1's MD (who also served as the facility's Medical Director). Upon inquiry, the MD recalled seeing Resident #1 on 2/16/24 after the 2/14/24 incident when the resident was lowered to the floor during a transfer with the total mechanical lift. The MD noted the resident was without any head injury or bruises. The MD reported he did increase Resident #1's pain medication "for just a few days" after the fall but also added the resident normally complained of pain at baseline.

An interview was conducted on 3/5/24 at 12:05 PM with the DON. At that time, the DON reported the facility developed a "whole plan of correction" after the 2/14/24 transfer incident involving Resident #1. A review of this Corrective Action Plan included nursing staff in-service education. The DON reported because the cause of the lift tilting during a transfer was not identified, this education was a comprehensive review of the safe use of the total mechanical lifts. A follow-up interview was conducted with the DON on 3/5/24 at 1:30 PM in the presence of the Unit Manager. Both the DON and Unit Manager confirmed the in-service sign-in sheets provided for review was up to date. The DON reported she was responsible to educate the Registered Nurses (RNs) and the Unit Manager was responsible to educate the facility's employed and Agency NAs

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and Licensed Practical Nurses (LPNs).

Interviews conducted with 4 out of the 7 nurse aides working on the first shift of 3/5/24 revealed they had not received in-service education from the facility on the safe use of a total mechanical lift. These interviews included:
--On 3/5/24 at 2:15 PM, NA #8 (an Agency NA) reported she had not received the in-service education;
--On 3/5/24 at 2:17 PM, NA #9 (an Agency NA) reported he had not received the in-service education;
--On 3/5/24 at 2:23 PM, NA #10 (an Agency NA) reported she had not received the in-service education;
--On 3/5/24 at 2:25 PM, NA #11 (an Agency NA) reported she had not received the in-service education.

An interview was conducted on 3/5/24 at 3:25 PM with the facility's Administrator. During the interview, the Administrator was informed that 4 of the 7 nurse aides working on first shift of 3/5/24 confirmed they did not receive in-service education on the safe use of a total mechanical lift. A review of the nursing staff in-service education sheet for the safe use of mechanical lifts also confirmed these NAs had not signed the in-service sheet to indicate he/she had received the education.

On 3/6/24 at 11:45 AM, a follow-up interview was conducted with the DON. During the interview, the DON stated it was "a mistake on our part" that the four nurse aides working and interviewed on the first shift of 3/5/24 were missed and not educated on the safe use of the total mechanical lifts. The DON noted there were several Agency

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F 689	Continued From page 32 NAs working on 3/5/24 who did not regularly come to the facility, and they were simply missed with the education piece on the lift. When asked if all NAs who were working on the floor were expected to be able to safely use a total mechanical lift during their shift, the DON stated, "Yes."	F 689		
F 867 SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		3/27/24

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F 867	Continued From page 33 development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity	F 867		

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(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 867	Continued From page 34 of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including	F 867		

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	345070	A. BUILDING ____ B. WING ____	C 03/06/2024

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F 867	Continued From page 35 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee after each of the following surveys with citations that were recited on the current complaint survey of 3/6/24: 1) A complaint investigation survey of 1/14/22. This was evident for one recited deficiency in the area of Freedom from Abuse and Neglect (F600). 2) The annual recertification / complaint investigation survey of 8/18/22. This was for one recited deficiency in the area of Request / Refuse / Discontinue Treatment; Formulate Advance Directives (F578). 3) A complaint investigation survey of 3/16/23. This was evident for recited deficiency in the area of Reporting Alleged Violations (F609). 4) A follow-up, focused infection control, and complaint investigation survey of 4/13/23. This was also for one recited deficiency in the area of Reporting Alleged Violations (F609). 5) The annual recertification / complaint investigation survey of 9/14/23. This was for one recited deficiency in the area of Request / Refuse / Discontinue Treatment; Formulate Advance Directive (F578). The continued failure of the facility during six federal surveys of record show a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to:	F 867	F-867 (1) How corrective action will be accomplished for resident(s) found to have been affected: F-578- Resident #8 no longer resides in the facility. F-600- The police and EMS were notified by the facility on 2/25/2024 and resident #2 was taken to the hospital for laceration sustained to forehead by object thrown by employee. Medical Director and emergency contact were notified. Psyche services notified for follow up to ensure psychosocial well-being. Accused employee was sent home and suspended per investigation results. A 24-hour initial allegation of abuse was sent in by the administrator on 2/25/2024. Adult Protective Services was notified by the Social Worker on 3/5/2024 for resident #2. F-609- Resident #5 no longer resides in the facility and Adult Protective Services was notified by the Social Worker on 3/5/2024 for resident #2. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: F-578- On 3/8/2024 an audit was	

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F 867	Continued From page 36 F578: Based on record review and staff interviews, the facility failed to ensure advanced directive information was up to date in the resident's electronic medical record for 1 of 1 resident (Resident #8) reviewed for advanced directives. During the recertification / complaint investigation survey of 8/18/22, the facility was cited for failing to determine code status on admission for 1 of 5 residents reviewed for advance directives. During the recertification / complaint investigation survey of 9/14/23, the facility was also cited for failing to have Advance Directives (code status) in the residents' records for 1 of 1 resident reviewed for Advance Directives. F600: Based on record review, resident, staff, Physician, Psychiatric Nurse Practitioner, and Administrator interviews the facility failed to protect a resident's right to be free from employee to resident physical abuse, when an employee (receptionist) threw a plexiglass (acrylic) mask holder hitting Resident #2 on his forehead. The resident had a fall, and a laceration on his forehead. The resident was angry and upset when he was hit by the object thrown by the staff member. Resident #2 was sent to the emergency room and had undergone a procedure for 5 sutures on his forehead. This was for 1 of 2 residents reviewed for abuse (Resident #2). During the complaint investigation survey of 1/14/22, the facility was cited for neglecting to monitor, assess and identify a resident's skin that was irritated and bleeding behind the ears from a surgical face mask strap that resulted in a partial thickness injury of one ear and a full thickness	F 867	completed by the Director of Nursing and the Social Worker to ensure that all residents had an Advanced Directive (code status) in their medical record. Audit revealed that no other residents were affected. F-600- On 2/25/2024 The Administrator conducted resident interviews to all residents that are able to be interviewed to see if any other residents may have been affected by the alleged suspect or anyone else and who to report to if ever affected by abuse of any kind. No other residents were noted to be affected. On 2/25/2024 The Director of Nursing, Unit Manager, and nursing staff performed skin assessments for all residents who are unable to be interviewed to ensure that no residents have suffered and been a victim of abuse. Skin assessments revealed that no other residents were noted to be affected. On 2/26/2024 the Administrator conducted an AD-HOC QA with the interdisciplinary team to review corrective action. F-609- All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in	

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injury and partial amputation of the other ear for 1 of 2 sampled residents reviewed for injury.

F609: Based on record review and staff interview the facility failed to report an abuse allegation to Adult Protective Services (APS), failed to immediately report an allegation of abuse to the facility administration and failed to report an abuse allegation to the state survey agency for 2 of 2 residents reviewed for abuse (Resident #2 and Resident #5).

During the complaint investigation survey of 3/16/23, the facility was cited for failure to report an allegation of abuse to the State Agency within two hours of becoming aware of the allegation for 1 of 2 allegations of abuse reviewed.

During the follow-up / focused infection control, and complaint investigation survey of 4/13/23, the facility was also cited for failure to report an allegation that a resident's financial information from a debit card was used fraudulently due to suspicious charges to the account by failing to submit a 24 hour and 5 day report within the required time frame to the State Agency of North Carolina for 1 of 1 resident reviewed for abuse.

An interview was conducted on 3/6/24 at 3:18 PM with the facility's Administrator to discuss the facility's Quality Assurance and Performance Improvement (QAPI)/QAA Improvement Activities. The Administrator reported the QAA Committee included himself, the Medical Director, Director of Nursing (DON), Unit Manager, Therapy Director, Maintenance Director, Dietary Manager, and Social Worker. The committee was scheduled to meet at least quarterly. However, the Administrator noted the committee

F 867

the future:
F-578- On 3/7/2024 the Administrator re-educated the Social Worker regarding the requirement that all residents are to have an Advance Directive (code status) in their medical record.

F-600- To protect residents from similar occurrences, on 2/25/2024 the Administrator, Director of Nursing, and Unit Manager initiated re-education to all staff regarding:

- The abuse policy that includes the definition of abuse, the various types of abuse, who the abuse prevention coordinator is, timeliness of reporting along with notifying Adult Protective Services

- Tips and strategies for de-escalating aggressive, hostile, or violent residents

- Tips and strategies on how to combat and prevent burnout

Education completed on 3/26/2024. Any employee that has not been re-educated by this date will not work their next shift until education has been completed.

F-609- On 3/11/2024 the Administrator, Director of Nursing, and Unit Manager initiated re-education to all staff regarding the guidelines and requirements for state reporting obligations along with the required timeline for reporting abuse that includes notifying Adult Protective Services.

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F 867	Continued From page 38 typically meets about once a month (with the last ad hoc committee meeting held on 2/26/24). When asked how the committee decided on which opportunities they would become involved in, the Administrator stated that they would review open citations and any type of quality measure where the facility did not obtain their desired goal. When asked how repeat citations were handled, the Administrator reported the QAA Committee would typically do a root cause analysis for these opportunities, pull out the facility's old plan of correction (POC) to see what had been done in the past, develop a new POC, and then adjust the new POC as needed.	F 867	On 3/21/2024 the Regional Director of Clinical Services re-educated the Administrator, Director of Nursing, and Unit Manager regarding the guidelines and requirements for state reporting obligations along with the required timeline for reporting abuse that includes notifying Adult Protective Services. Education completed on 3/26/2024. Any employee that has not been re-educated by this date will not work their next shift until education has been completed. F-867- To protect residents from similar occurrences, on 3/21/2024 the Regional Director of Clinical Services re-educated the Quality Assurance and Performance Improvement Committee on maintaining implemented procedures and monitoring interventions that the committee puts into place. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: F-578- Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that by reviewing on admission with the clinical team that the Advance Directive (code status) is listed and in the medical record along with care plan meeting review to ensure that any changes in the Advance Directive (code status) were updated and in the medical record. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months.	

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F 867	Continued From page 39	F 867	Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. F-600- Monitoring will be done by the Administrator, The Director of Nursing, or designee to ensure that through the grievance process and resident interviews, no additional occurrences of abuse take place. This monitoring process will consist of 5 resident interviews weekly for 4 weeks and then 10 resident interviews monthly for 2 months. The Director of Nursing, Unit Manager, or designee will perform 5 skin assessment per week for 4 weeks to residents unable to be interviewed and then 10 skin assessment per month for 2 months. In addition, The Administrator, The Director of Nursing, or designee will conduct staff member follow up abuse interviews to ensure carry over. 5 staff member interviews will be conducted weekly for 4 weeks and the 10 staff member interviews monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report	

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F 867	Continued From page 40	F 867	findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. F-609- Monitoring will be done by the Administrator, The Director of Nursing, or designee to monitor and ensure that all state reporting obligations were done within the appropriate timeline that includes notifying Adult Protective Services. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. F-867- Monitoring will be done by the Administrator and/or the Director of Nursing to ensure that through observation and review, all implemented QAPI plans that were put into place are maintained. This monitoring process will take place weekly for 4 weeks then monthly for 6 months. Any issues during monitoring will be	

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F 867	Continued From page 41	F 867	addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 3/27/2024	