STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING ______ B. WING ______	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIDSON HEALTH & REHAB CENTER	**4748 OLD SALISBURY ROAD LEXINGTON, NC 27295**

(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 survey was conducted from 10/15/24 through 10/16/24. The following intakes were investigated NC00222916, NC00222723, and NC00221469. Past-noncompliance was identified at:CFR 483.12 at tag F600. Non-noncompliance began on 10/3/24. The facility came back in compliance effective 10/7/24. 2 of the 4 allegations resulted in a deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to protect a resident's right to be free from abuse for 1 of 1 resident reviewed for abuse (Resident #2). Resident #2's cognitively intact roommate (Resident #3) stated on 10/3/24 he was in the room while the curtain was pulled and he heard Nurse Aide (NA) #1 and	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/31/2024

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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Resident #2 "fussing" back and forth. NA #1 told Resident #2 "you're not going to keep hitting me" followed by an audible "smack". After the incident, Resident #2 was identified by staff with a bright red hand mark on her right hip/thigh, she appeared agitated, and stated to NA #3 "she hurt me". Resident #2 did not have the cognitive capacity to express an adverse psychosocial outcome. A reasonable person would experience fear and intimidation from being abused in their home environment.

The findings included:

Resident #2 was admitted to the facility on 01/24/2022 with a diagnosis of Alzheimer's dementia.

Review of the care plan that was revised on 08/22/24 revealed Resident #2 had diagnoses of Alzheimer's, and she was alert with confusion and had behaviors. Behaviors included sadness, crying, resistance to redirection, physical aggression, verbal aggression, smacking lips, clicking tongue and jaws on occasion. The goal was to prevent injuries. The interventions in part, were to approach Resident #2 in a calm, unhurried manner, if able to remove her from a high stimulation area to reduce agitation. When agitated intervene before agitation escalated, guide away from source of distress, engage calmly in conversation, if response was aggressive, walk away calmly and approach later.

Review of the quarterly Minimum Data Set (MDS) dated 9/14/24 revealed Resident #2 was severely cognitively impaired and had no behavior during the assessment period. She required staff assistance with all activities of daily living (ADL).

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Record review of the progress note written by Nurse #1 on 10/4/24 at 10:00AM revealed Nurse Assistant (NA #1) removed Resident #2 to her room because she kept removing her clothes in the hallway. She placed her in bed. NA# 2 and #3 went in to change clothes and brief and within the minute reported to Nurse #2 to come and look at Resident #2. Resident #2 was lying in bed on her left side with her brief opened, there was a bright red handprint on her right buttock. NA #2 and NA #3 called Scheduler and reported the event.

Nurse #1 was not available for interview.

An interview with NA #1 via telephone on 10/15/24 at 3:15 PM indicated she was sitting at the desk doing charting and Resident #2 and Resident #4 were sitting in their wheelchairs beside one another in the hallway. Resident #4 stated that Resident #2 was taking her shirt off. NA #1 stated she came around the desk and put Resident #2's arms back in her shirt and went back to charting. A few minutes later Resident #4 said Resident #2 was taking off her shirt again. NA #1 indicated she told Resident #2, "Ah honey, you can't sit out here without your shirt on". NA #1 reported she attempted to redress Resident #2 in the hall the second time, and then took her to her room and put her to bed. NA #1 indicated Resident #2 was fussing when NA #1 took her to her room and had never been physically aggressive towards her. Resident #2 was fussing and cussing a little bit and that was normal for her. Resident #2 was no longer fussing when we entered her room, and she was assisted to bed by standing and pivoting. NA #1 reported Resident #2 did not try to hit her and she left Resident #2 lying in her bed with her day clothes

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on and she returned to the desk and finished charting. NA#1 explained a few minutes later NA #3 was looking for Resident #2 and NA #1 told her that she was in bed. NA #3 came out of the room and went back into the room with NA #2. About 15 mins later Nurse #3 told her to go home, because there was a handprint on Resident #2 and there was an investigation. NA #1 stated she did not smack or abuse Resident #2. She stated she had put Resident #2 in her bed, and they were not fussing with one another.

Review of quarterly MDS dated 10/3/24 revealed Resident #4 was cognitively intact. An interview was conducted with Resident #4 on 10/16/24 at 10:35 AM and he denied any abuse to him personally since his admission. He reported that on the evening of 10/3/24 he and Resident #2 were sitting next to one another in their wheelchairs on the hall. Resident #2 removed her arms from her shirt. He notified Nurse Aide (NA) 1, who was sitting at the desk charting. NA #1 came over and put Resident #2's shirt back on and told her, "No one wants to see your sick puppies, leave your shirt on or you are going to have to go to your room". A few minutes later, Resident #2 began to remove her shirt again. He notified NA #1 and this time she came over and bent Resident #2's arm behind her back, trying to put her arm back in her shirt. Resident #2 was yelling, "You're hurting me, stop it". NA #1 let Resident #2 go, grabbed her wheelchair, "spun it around" and pushed her down the hall to her room and shut the door.

Review of the MDS dated 9/10/24 revealed Resident #3 (Resident #2's roommate) was cognitively intact. An interview was conducted on 10/16/24 at 10:37 AM. On the evening of 10/3/24

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she stated she was in her bed and saw NA #1 enter the room with Resident #2. They were "fussing" back and forth. NA #1 pulled the curtain between the beds. NA#1 said, "You're not going to keep hitting me" and then she heard a smack and Resident #2 stopped fussing and NA #1 left the room. Resident #3 reported that a few minutes later, NA # 3 came into the room, but went back out very quickly.

An interview with NA #3 on 10/16/24 at 09:30AM revealed she went into Resident #2's room on 10/3/24 around 9:00 PM and Resident #2 was in bed in her day clothes. NA #3 removed Resident #2's pants and NA #3 observed a red handprint on Resident #2's right hip/thigh area. Resident #2 was not able to tell NA #3 what happened. NA #3 reported Resident #2 was agitated and stated "She hurt me" but was not able to say who hurt her. NA #3 indicated she immediately left the room and reported the incident to Nurse #1. She then telephoned and reported the incident to the Scheduler and Nurse #2. NA#3 returned to Resident #2's room and finished providing care. Resident #2 was not crying or upset when NA #3 returned to the room. NA #3 had never observed NA #1 be aggressive towards Resident #2 or any other resident. NA #3 reported working with Resident #2 regularly and there was no change in Resident #2's behavior or demeanor. Resident #2 was back to her baseline within an hour of the incident and had remained since.

NA #2 was not available for interview.

Interview with Scheduler 10/16/24 at 9:34 AM indicated on 10/3/24 at 9:30 PM, NA #3 reported by telephone she saw a red handprint on Resident #2's right hip. NA #3 reported that she

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F 600	Continued From page 5 had told Nurse #1 and Nurse #2. The Scheduler stated she telephoned the facility and spoke to Nurse #2, and she asked her to assess the situation and to ask NA #1 to clock out and leave the premises. The Scheduler explained, she and the Unit Manager came to the facility, arriving around 10:00 PM. The Scheduler stated, Resident #2 was asleep in her bed and had reddened lines pointing downward, on the right hip at the brief line. The Scheduler called the police department to make the report of the abuse incident. The scheduler reported she had never seen any instances of abuse or suspected abuse from NA #1 or any of their current staff. Interview with Nurse #2 on 10/15/24 at 8:20PM revealed on 10/3/24 around 9:10 PM the Scheduler had called and asked her and Nurse #1 to escort NA #1 out of the building, immediately. Once NA #1 had left, Nurse #2 assessed Resident #2 for injury. Nurse #2 stated Resident #2 was lying in bed with her baby doll, she was calm and was not agitated. Resident #2 agreed for Nurse #2 to look at her legs and a red handprint was found on her right hip at the brief line. Resident #2 was unable to tell Nurse #2 what happened. Nurse #2 indicated Resident #3 was alert and oriented and stated she heard Resident #2 and the NA #1 fussing. Resident #3 was in the room, in her bed and the curtain was pulled between the resident's beds. NA #1 told Resident #1 she was not going to hit her (NA #1) and then Resident #3 heard what sounded like a smack. The Scheduler and the Unit Manager had already been made aware of the incident and they both came to the building the night of the incident. The Administrator was also made aware. Nurse #2 reported she has never witnessed or been made aware of NA #1 having abused any	F 600		

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resident.

Review of Administrators' note written on 10/04/24 at 10:00 AM indicated in part, on 10/03/24 Unit Manager (UM) was notified of the abuse of Resident #2. The Police and Adult Protective Services (APS) were notified. NA #1 was immediately escorted out of the building. The resident was not fearful and was sleeping when UM checked on her.

Record review of UM note dated 10/04/24 indicated in part, an Interdisciplinary Team meeting was held, and Resident #2 was discussed, and skin evaluated. Resident #2 had no pain and no redness or bruise to skin. Resident #2 did not exhibit distress and was baseline alert with confusion.

Record review of Social Worker note dated 10/07/24 indicated Resident #2 had no changes in mood or behavior.

Interview with the Social Worker on 10/16/24 at 9:28 AM indicated she was made aware of the abuse incident involving Resident #2 on 10/03/24 around 9:30 PM by the Scheduler. She came to the facility the night of the incident and witnessed a red mark and what she thought looked like fingers pointing down on the right hip of Resident #2. NA #1 had already been removed from the building. She stated she called Adult Protective Services (APS) at 9:52 PM on 10/03/24 and left a message on voicemail system. APS returned her call at 9:58 PM, the same night. The Social Worker reported Resident #2 was asleep in her bed when she observed the red mark.

The interview with the Unit Manager (UM) on

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10/16/24 at 9:51 AM revealed Resident #2 had a history of being combative towards staff, mostly during ADL care and she did take her arms out of her shirt on occasion. On 10/03/24 around 9:30 PM, the Scheduler called to report a handprint that had been found on the right hip of Resident #2 and NA #1 was the last person to provide care before NA #3 discovered the handprint. The UM reported that the Scheduler had asked Nurse #2 to remove NA #1 from the building. The UM stated she assessed Resident #2 on 10/03/24 around 10:00 PM and observed a red mark, in the shape of a hand and fingers on her right hip. Resident and staff interviews were conducted that night, and it was concluded that NA #1 was the accused. The Unit Manager reported she had not seen any instances of abuse by NA#1 in the past.

An interview on 10/16/24 at 3:00PM with the Administrator revealed she reviewed the camera footage, from the night of the incident. The footage revealed Resident #2 and Resident #4 were sitting in the hall in their wheelchairs near the nursing station. Resident #2 began to remove her shirt. NA #1 got up and came around the desk and put Resident #2's shirt back on. Resident #2 took her shirt back off a second time, at this time NA #1 took Resident #2 to her room. The footage did not show NA #1 acting in an aggressive manner toward Resident #2. The camera footage then showed NA #3 coming to the desk and speaking with NA #1, and then heading to Resident #2's room. Administrator reported she interviewed NA #1 on Monday 10/5/24 and NA #1 stated, "Resident #2 didn't hit me and I didn't hit her." The Administrator stated that the video of the incident in the hall was no longer available but when she had viewed the video and observed NA #1's attempt to redress

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Resident # 2 it did not look aggressive and when NA #1 turned Resident #2 in the wheelchair to go to the room it was not aggressive. The Administrator reported that interviews with staff and residents and observation of Resident #2 did reveal abuse by NA #1. Observation of Resident #2 immediately after the incident and for three days following that showed the red mark on her hip had disappeared and she was at baseline.

The facility provided the following corrective action plan with a compliance date of 10/07/24.

This will serve as our plan of abatement for Davidson Health and Rehab related to: allegation of Abuse

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 10/03/2024 After notification from facility and CNA #1 immediate removal from facility, Director of Nursing/Designee initiated investigation. Resident #2 provided a safe and comfortable environment. No signs/symptoms of withdrawal. No change in baseline psychosocial wellbeing. Head to toe assessment completed with -no other areas identified. Resident #2 denied pain. Statements obtained from staff and resident's roommate (Resident #3) as she witnessed the event. The roommate was alert and oriented with a reliable history. Police and (Adult Protective Services) APS notified us of the event. 10/04/2024- NC- CNA registry notified of event. NA #1 remained suspended and taken off schedule for duration of investigation. NA #l 1terminated on 10/08/2024. On 10/03/2024-10/04/24- Director of

F 600

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Nursing/Designee provided incapable affected residents with skin assessments to identify any new skin areas and to assess for psychosocial well-being. No negative findings. On 10-03/2024-10/04/2024- Director/Designee provided capable residents interviews for any concerns with abuse or concerns with care provided. No negative finding

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

To identify other residents that have the potential to be affected the Director of Nursing/designee interviewed 100% capable residents to ensure there were no concerns with abuse or care provided by staff by using questionnaire related to "feeling safe" in the facility and any concerns with care. No negative findings. Completed on 10/04/2024
To identify other residents that have the potential to be affected the Don/designee completed skin assessments on 100% incapable residents and to ensure no concerns with care provided. No signs/symptoms of withdrawal or change in behavior noted. Completed 10/04/2024.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

To prevent this from happening again the NHA/designee will educate 100% current staff on the abuse/neglect policy and procedure and providing quality of care and services to Dementia residents-to include combative residents and staff responsibilities when caring for these residents, completed 10/04/2024.

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F 600	Continued From page 10 New hires were educated during on-boarding and Agency staff will be educated before taking shift on Abuse Policy and Providing Care for Dementia Residents. An Ad Hoc was held on 10-07-2024 with the facility medical director to review the event and the QAPI plan. Completed 10/07/2024. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. To monitor and maintain compliance with psychosocial well-being and/or concerns with care by using questionnaire with questions related to concerns with care, who to report concerns to, and do they feel safe in the facility and safe to voice such concerns. Any deficits will be immediately addressed. The complete date for audits will be 12/22/2024. Results will be taken to QAPI for review and revision as needed. To monitor and maintain ongoing compliance the Director of Nursing/Designee will audit five incapable resident's weekly x's 12 weeks to assess for any signs/symptoms of withdrawal or abrupt change in baseline behavior. The complete date for audits will be 12/22/2024. Results will be taken to QAPI for review and revision as needed. To monitor and maintain compliance the NHA/Designee will assign 100% resident rooms to the Interdisciplinary Team to observe residents assigned to those rooms for signs of withdrawal or change in baseline behavior 5x's a week x's 12 weeks. The completed date for audits will be 12/22/2204. Results will be taken to QAPI for review and revision as needed. To monitor and maintain ongoing compliance the	F 600		

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F 600	Continued From page 11 NHA/designee will interview five staff members weekly x's twelve weeks on abuse/neglect using questionnaire on types of abuse, when and who to report abuse to, first step to take if suspected and/or actual abuse witnessed and caring for dementia/combative behavior. Any deficits will be immediately addressed. The completed date will be 12/22/24.Results will be taken to QAP for review and revision as needed. Alleged date of compliance 10-07-2024. The corrective action plan was validated on 10/16/2024 by reviewing the abuse investigation, and resident and staff statements. The residents' skin assessments and the evidence of education provided to the staff was reviewed. The resident psychosocial audits were reviewed. Adult Protective Services and the Police were contacted. Staff were interviewed and they confirmed that they received education on abuse and reporting. The facility had conducted an AD Hoc QA meeting on 10/7/24. The facility provided an ongoing monitoring tool. The correction date was 10/7/24.	F 600		