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	345505	A. BUILDING _____ B. WING _____	C 03/25/2024

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CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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F 000	INITIAL COMMENTS The surveyor entered the facility on 3/19/24 to conduct a complaint survey and exited on 3/21/24. Additional information was obtained on 3/22/24 and 3/25/24 and therefore the survey exit date was changed to 3/25/24 Event ID# RD9W11. The following intakes were investigated NC00214120, NC00214572, NC00214630, and NC00214674. Four of the five complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J The tag F 600 constituted Substandard Quality of Care. A parital extended survey was conducted. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity G CFR 483.40 at tag F 744 at a scope and severity of D	F 000		
F 600 SS=J	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.	F 600		

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

Electronically Signed | 04/03/2024

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff, family, residents, the physician and the facility's psychiatric provider, the facility failed to protect a cognitively impaired and dependent resident (Resident # 3) from abuse by another cognitively impaired resident (Resident # 2). Resident # 2 was known by staff to display behaviors which included paranoia, delusions, aggression with staff, and exit seeking behaviors. Resident # 2 entered Resident # 3's room while staff were attending to other residents during an evening meal and assaulted Resident # 3 by pulling Resident # 3's wheelchair over on the floor resulting in Resident # 3 landing on the floor; hitting and kicking Resident # 3 in the head; beating Resident # 3 with a meal tray and; hitting Resident # 3 with the door by swinging a door back and forth onto Resident # 3's body while Resident # 3 was on the floor. Resident # 3 sustained a laceration near his eye, multiple areas of bruising, and fear that the incident would occur again. This was for one of three residents sampled for abuse. The findings included: Resident # 2 was admitted to the facility on 9/18/23 following a hospitalization from 8/28/23 to 9/18/23. According to the hospital discharge summary, dated 9/18/23, Resident # 2's diagnoses included hypertension, coronary artery disease, heart failure, atrial fibrillation, history of prostate cancer, failure to thrive with moderate	F 600	Past noncompliance: no plan of correction required.	

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malnutrition. The hospital discharge summary also noted the following. Prior to hospital admission on 8/28/23 Resident # 2 had resided at home and a neighbor had found Resident # 2 to be confused. He was also febrile. During hospitalization Resident # 2 was determined to have pneumonia which was treated and resolved. Also, while hospitalized Resident # 2 displayed behavioral problems. It was documented Resident # 2 had removed his clothing and barricaded himself and his wife in the hospital room with a trashcan. He was physically restrained at one point and started on antipsychotic medications during hospitalization. On the hospital discharge summary, the physician noted Resident # 2 could have "possible dementia," and his antipsychotic medications were to be continued after his hospital discharge.

According to facility room assignment reviews, Resident # 2 was admitted to a room in the facility where he resided with his wife.
Physician orders revealed Resident # 2 was prescribed Seroquel 25 mg (milligrams) at bedtime for agitation on 9/18/23. (Seroquel is an antipsychotic medication.)

Review of the facility record revealed on 9/19/23 Resident # 2 was seen by the facility medical physician who noted Resident # 2 seemed to have delirium while hospitalized, and antipsychotics were started. The physician noted he would try to wean the resident off antipsychotics over the next few days.

Resident # 2's admission Minimum Data Set assessment, dated 9/24/23, coded Resident # 2 as severely cognitively impaired.

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Resident # 2 was assessed to be ambulatory with a walker and displayed the behavior of refusing care.

Resident # 2's care plan, reviewed on 10/2/23, included information that Resident # 2 was at risk for complications related to cognitive impairment secondary to his advanced age. Staff were directed to observe for changes in his cognition over time. The care plan also noted he received antipsychotic medications, was at risk for elopement, and that psychiatric services would be provided as needed.

On 10/4/23 the physician noted in a progress note that he was following up on Resident # 2's medical issues and his psychosis. The physician further noted there had been no recent agitation issues with the resident.

Per physician orders, on 10/7/23 Resident # 2's Seroquel dosage was changed to ½ tablet (12.5 mg) at bedtime. This indicated a dose reduction.

Per physician orders on 10/16/23 the dosage was increased back to 25 mg at bedtime. (This dosage amount remaining ordered through 3/9/24).

Resident #2's physician noted in a progress note, dated 10/17/23, the following. He was seeing Resident # 2 because of severe agitation in the last couple of days. The resident had a urinalysis completed which was negative, and Resident # 2 had "known dementia." The physician directed the resident's daily Seroquel dosage be administered at 6:00 PM rather than at bedtime. On 11/6/23, the Director of Nursing (DON) noted in a nursing note Resident # 2 had stated suicidal

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ideations but had no plan or means to carry out his ideation. The DON further noted a psych referral would be sent.

Interview on 3/21/24 at 4:45 PM with the DON revealed at the time of 11/6/23 Resident # 2 refused to see a psychiatrist, and therefore the psychiatric evaluation did not take place at that time.

Resident # 2's physician noted in a progress note, dated 11/19/23, that he was seeing Resident # 2 for a two- month post hospitalization visit for senile dementia and other medical reasons. The physician noted Resident # 2 had an appropriate affect and was in no apparent distress. The physician further documented Resident # 2 would be maintained on Seroquel.

Resident # 2's physician noted in a progress note, dated 12/19/23, "In follow up of dementia, he does get agitated quite frequently and sometimes have outburst where he resists on seeing the doctor, but today he does not remember anything at all and has really no concerns or complaints while I am in the room." The physician further noted, "I will continue Seroquel at this time for agitation."
On 12/23/23 a quarterly Minimum Data Set assessment was completed showing the following assessment. Resident # 2 was moderately cognitively impaired, wandered and rejected care 1 to three days during the assessment period, and was ambulatory.
Review of physician orders revealed an order on 1/11/24 for a geriatric psychiatric consult for Resident # 2.

Review of Resident # 2's medical record revealed

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a document noting a hearing had been held and Resident # 2 had been deemed incompetent. This document was stamped as filed on 2/2/24. On 2/2/24 the facility's Social Services Director noted there had been a court appointed guardian arranged for Resident # 2.

On 2/3/24 at 1:48 AM Nurse # 1 documented in a nursing note the following about Resident # 2. "Around 2300 (11:00 PM) resident came up to the nurses' station and started yelling at another nurse and getting in her face. Resident was yelling that it was all the other nurse's fault. Writer got in between resident and nurse and was attempting to calm down the resident. Resident stated the girl he murdered was alive and her and her boyfriend are trying to murder him. Resident stated we needed to call the highway patrol to come protect him. Resident was eventually able to be redirected and clamed down. MD (Medical Doctor) was made aware and PRN (as needed) one time order for Haldol IM (intramuscular) was put in place in case of any more agitation. Resident is now resting in bed." (Haldol is an antipsychotic medication)

Nurse # 1 was interviewed on 3/20/24 at 11:00 AM and reported the following. Resident # 2 was not always agitated. "Every once in a while" he would become confused. She thought Resident # 2 had a history of being in the military police. Routinely he was pleasant around other residents. He knew where his room was and never wandered into other residents' rooms. She never feared for other residents' safety because of any of Resident # 2's behaviors, and he was typically easily redirected if he became confused. On 2/3/24 he had been yelling at another nurse while telling her it was her fault that someone was

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trying to come kill him. She intervened and gave him a snack. He calmed down and went to bed. She never had to administer the Haldol that was ordered.

On 2/11/24 at 4:21 AM Nurse # 2 documented in a nursing note the following about Resident # 2. "Resident came to nursing station to use phone to call police. 'I killed my wife.' CNA (certified nursing assistant and I checked and {resident's wife] is asleep."

On 2/12/24 at 10:19 PM Nurse # 3 noted the following in a nursing note about Resident # 2. "Resident noted with increased confusion this evening refusing medication and ranting of someone coming go kill him, and his wife. Resident was easily redirected. MD notified. Safety measures in place."

Nurse # 3 was interviewed on 3/20/24 at 7:30 PM and reported the following. She did not often care for Resident # 2. Initially when she did care for him, he seemed pleasant. One day he was ranting that someone was trying to kill him and stealing his money. She placed a note in the chart, talked to the physician who instructed to monitor Resident # 2. Resident # 2 had refused his medications that day. There was another episode which occurred during the first two weeks of March, 2024 during which he was ranting and trying to leave the facility. He was easily redirected. She would take him by his hand and walk him to his room. Based on his behaviors, she never feared he would hurt another resident. She had never witnessed him hurt or touch any resident. She was not aware of any psychiatric referrals ordered and not completed for the resident.

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On 2/13/24 at 1:53 AM Nurse # 1 noted the following in a nursing note about Resident # 2. "Resident confused said he got a emergency call that stated the jets are on the way to murder him and his wife. Able to calm resident down by talking to him. Resident calm but refusing to go back to his room or bed stated he will leave [his wife] down there alone to get murdered. Resident calm sitting nurses station eating a snack."

Resident # 2's physician noted in a progress note, dated 2/19/24, "Baseline, very confused and paranoid, in no apparent distress. He has times where he thinks somebody has to murder him and his wife. He can ambulate with a walker ...." Under the physician's plan for the date of 2/19/24, the physician noted he would continue the Seroquel for his behaviors and psychosis and "refer to psychiatry."

Review of Resident # 2's facility medical record revealed no documentation Resident # 2 was ever seen for a psychiatric consult.

On 2/23/24 at 9:29 AM Nurse # 4 noted the following in a nursing note about Resident # 2. "Resident complied with medication administration. Increasingly more agitated as the morning goes on. He is unable to verbalize what we can help him with. He wants to leave to find the 'hotel.' Asked how to contact police." Nurse # 4 further noted the physician was contacted and resident was being redirected. On 2/23/24 at 11:32 AM Nurse # 4 noted the physician had ordered lab work for the resident.

On 2/26/24 at 1 PM a nursing note was entered documenting the staff had talked with Resident #

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2's guardian and informed the guardian Resident # 2 was continuing to refuse lab work to be done.

On 2/26/24 at 3:16 PM Nurse # 4 noted the following in a nursing note about Resident # 2. "Resident had been exit seeking. Continuing to redirect with very little effect. Resident has continued to refuse to give a urine sample for UA (urinalysis). Change of shift report communicated that we are to re-attempt once the resident has calmed down. During last exit seeking attempt resident stated when he gets back, he will come back with a 'gun.' Resident was returned to room. Put music on for resident that seemed to calm resident. Safety measures in place."

Nurse # 4 was interviewed on 3/20/24 at 11:10 AM and reported the following. She worked part time and worked with Resident # 2 about one time per week. At times he appeared frustrated as if he could not say what he wanted to convey. When he mentioned the gun, she knew he had past military experience. He indicated he would not do anything with a gun if he had one. His confusion did not occur on a daily occurrence, and generally he was easy to redirect. She would allow him to voice concerns, deescalate and play music for him. That seemed to help. He never gave any indication he would harm anyone. She never saw him threaten anyone. He never wandered into other residents' rooms or tried to hurt them. She never thought anyone was in danger based on Resident # 2's behaviors.

On 2/27/24 at 1:11 PM Nurse # 5 noted in a nursing note that Resident # 2 had been agitated, confrontation, and had lifted his walker and attempted to throw out the glass door. Nurse # 5 further noted diversional conversation was

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provided and Ativan 1 mg per a one time order was administered and was effective. The resident became calm.

Nurse # 5 was interviewed on 3/20/24 at 12:57 PM and reported the following. Resident # 2 was not agitated on a daily basis. He was in the dayroom on 2/27/24 when he became upset on that date. He was typically redirectable. On that day, he took medication and was okay. He calmed down. She had never seen him threaten anyone or harm anyone. He never gave any indication he would hurt anyone. She was not aware of why a psychiatric evaluation had not been done for Resident # 2.

Review of physician orders revealed on 2/27/24 Resident # 2 was started on Depakote extended release 250 milligrams twice per day. (Depakote is a medication used as a mood stabilizer).

On 3/1/24 Nurse # 6 completed a SBAR communication form (a situation, backgroumd assessment, and recommendation request form). The nurse checked on the form Resident # 2 was having increased verbal and physical aggression, and a danger to self or others. According to the record, after the completion of the form Resident # 2 was sent to the hospital for evaluation.

Nurse # 6 was interviewed on 3/21/24 at 11:49 AM and reported the following. She was the staff development coordinator for the facility. Her office was on a different unit than the unit on which Resident # 2 resided. On 3/1/24 she had been in her office when Resident # 2 came walking down the unit where she worked. He was dressed in his coat and toboggan to leave, and his wife was

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following him. The nurse talked to him and he commented, "We are getting out of here." He then told his wife, "If you are not coming with me then you are going to pay for this." She knew around the date of 2/28/24 there had been an incident where he had had thrown his walker at an exit door and held his walker up towards staff who were trying to intervene. It had taken about 10 minutes to get him calmed down on that day. She was also aware he had refused lab work to be done. Therefore, she called EMS (Emergency Medical Services) to transfer him to the hospital on 3/1/24. It was her hope that they could medically find if something was causing his confusion and agitation. At the time she did not feel he posed a danger to others, but only to himself because he wanted to leave the facility. She had never seen him threaten or harm another resident when he was agitated.

Review of hospital emergency department records, dated 3/1/24, revealed the following. The physician noted Resident # 2 presented "for aggressive behavior. Patient was noted to be throwing his walker and furniture at staff attempting to take his wife and leave the facility. On exam patient is moderately confused, oriented to self, reports his wife was being attacked by hospital staff." The physician further noted during his assessment Resident # 2 was calm and cooperative, labs had been done without any significant abnormalities. According to the record, he was returned to the facility with no changes in orders or a psychiatric consult being done.

On 3/6/24 Resident # 2's care plan was updated to reflect that Resident # 2 had behaviors related to dementia with psychosis. Some of the interventions included to assign staff that were

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familiar with the resident when possible and to assure Resident # 2 he was safe if he became distressed.

Review of physician orders revealed on 3/9/24 an order for Seroquel 25 milligrams every 12 hours. This indicated an increased dosage.

Resident # 2's physician noted in a progress note, dated 3/11/24, Resident # 2 had experienced some syncope episodes. The physician noted that Seroquel was one medication that could contribute to orthostatic hypotension. He further noted Resident # 2 did not respond well to Lorazepam and he would be a good candidate for a lockdown unit. The physician further noted, "continue with a referral for psychiatry for further monitoring."

On 3/11/24 Resident # 2's Seroquel was discontinued.

On 3/12/24 at 7:40 PM Nurse # 7 noted, "Late Entry, Resident became aggressive and had an altercation with another resident. Resident was sent to local ER per MD order. RP notified."

Review of the facility's investigation into Resident # 2's altercation revealed Resident # 3 was the other Resident involved in the 3/12/24 altercation.

A review of Resident # 3's record revealed his diagnoses included in part stroke with hemiplegia/ hemiparesis, dysphagia, and intellectual disability. Resident # 3's quarterly Minimum Data Set assessment, dated 3/2/24, included the information that he was totally dependent on staff for transfers and required substantial to maximum assistance to roll in bed. He was

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assessed to reject care from staff at times but had no other behaviors on the assessment. According to the record, Resident # 3 resided in the room diagonally across from Resident # 2's room.

According to staffing sheets, Nurse # 5 had cared for Resident # 2 from 7 AM to 3 PM on 3/12/24 before the altercation occurred. Nurse # 5 was interviewed on 3/20/24 at 12:57 PM and reported the following. She had also cared for Resident # 2 on the previous day of 3/11/24 and he had been fine on 3/11/24. On 3/12/24 he was also fine all day until he had "a moment" at the end of the shift. She did not recall the incident in its entirety, and it was brief. She had been seated at the nursing station at the time. Both Resident # 2 and Resident # 3 were in the dayroom which was located adjacent to the nursing station. The dayroom could not be viewed if a staff member was seated. She had been charting and she "heard a noise." She stood up and saw that Resident # 2 had moved Resident # 3's wheelchair. Resident # 2 had also said something, but she did not recall what he had said. To her knowledge, Resident # 3 had not done anything, and Resident # 3 was okay. Resident # 3 had just been "moved up" from where his wheelchair had been. Resident # 2 did seem agitated at the time. She thought she recalled either the Activity Director or the Facility Scheduler had been present at the time and separated Resident # 2 and Resident # 3. She recalled the Activity Director saying Resident # 2 needed his walker. She had gone to Resident # 2's room, obtained his walker, and then walked with Resident # 2 back to his room. He calmed down while she walked with him back to his room. She recalled him saying, "I like you because you

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have a dog." He had not given any indication that he would hurt anyone or become volatile. That was the last time she saw him. She did not report anything to the oncoming Nurse (Nurse # 7) because she recalled Nurse # 7 was standing at the medication cart when the incident "moment" occurred.

The NA (Nurse Aide # 1), who had cared for Resident # 2 during the day shift of 3/12/24, was interviewed on 3/20/24 at 1:30 PM and reported the following. She was familiar with Resident # 2 and knew that at times he felt someone was out to get him. He had never hurt another resident or indicated he would. He never went into other residents' rooms. At times he had stopped in the doorway at the room adjacent to his own and spoken to the residents who resided there in a friendly manner to tell them hello. There were times he would say he felt trapped and would pull on the exit doors to get out. On 3/12/24 during the day shift he had been in the dayroom at one time and was trying to get out. She gave him some cookies and he calmed down. She had never witnessed any incident in the dayroom with Resident # 3.

The Activity Director was interviewed on 3/20/24 at 2:10 PM and reported the following. Resident # 2 participated in activities and would talk to other residents in a pleasant manner. He never showed aggression to any residents. On occasion he would say he could not go outside because there was someone out there who was going to get him and his wife. He was not agitated when he mentioned it, and the remark would just seem to come from nowhere. She did not recall an incident at the change of day shift to evening shift on 3/12/24. She did recall Resident # 2 did not

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have his walker and mentioned this to the nurse.

The Scheduler was interviewed on 3/20/24 at 2:18 PM and reported the following. She had been in an office which was near the nursing station at the change of day shift and evening shift on 3/12/24. She recalled Nurse # 5 saying Resident # 2's name and saw her stand up. She (the Scheduler) did not see anything that happened. She left her office when she heard Nurse # 5 say Resident # 2's name to check on things. Resident # 3 was in his wheelchair a couple feet away from Resident # 2 in the dayroom. They were not interacting, and she did not recall Resident # 2 not being calm.

Resident # 3's roommate (Resident # 5) was interviewed on 3/20/24 at 9 AM. According to Resident # 5's Minimum Data Set assessment, dated 3/2/24, Resident # 5 was cognitively intact. Resident # 5 reported the following about the evening of 3/12/24 during the interview. Supper meal trays had been served on 3/12/24. He (Resident # 5) was in his bed. Resident # 3 was in his wheelchair watching television when Resident # 2 came into their room. Resident # 2 grabbed Resident # 3's wheelchair and pulled it backwards onto the floor. Resident # 3 fell out of the wheelchair. The intruding resident "hit, kicked, and stomped" Resident # 3's head. Resident # 2 took Resident # 3's meal tray and "beat the heck out of him (Resident # 3)." Resident # 2 also took the door to the entrance of their room and hit Resident # 3 with it while Resident # 3 was on the floor. Resident # 2 did this by swinging the door back and forth on Resident # 3's body. Resident # 2 then used the bathroom door to do the same thing. Resident # 2 threw the lid of Resident # 3's supper plate at Resident # 5, but it had missed

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him and hit the bed. He (Resident # 5) had never seen Resident # 2 before. He (Resident # 5) could not get out of bed by himself to help. He had used his call bell. It seemed like it took 10 to 15 minutes for the staff to come. The nurses did get there and took Resident # 2 away and Resident # 3 was sent to the hospital.

On 3/20/24 at 10:00 AM the speech therapist accompanied the surveyor to interview Resident # 3, who was observed to speak in short phrases and at times had unclear words due to his stroke. According to the speech therapist, she had worked with Resident # 3 and was effectively able to communicate with him. Resident # 3 was observed at the time to have a bruised right eye and a small scar where a laceration had healed to the right of his eye. He spoke in short sentences and conveyed the following. The resident, who attacked him, had never been in his room before. He had seen him in a room across the hall from his before the incident. The resident had come in his room and started kicking and hitting him in the face. Resident # 3 pointed to his face as he spoke and to his bruised eye. The resident, who attacked him, used the door to hit his head and it hurt his head. He was afraid now because he worried it could happen again. After the interview, it was confirmed with Resident # 3 and the speech therapist that Resident # 3's comments were understood correctly by the surveyor. Both indicated they had been understood correctly.

NA # 2 had been assigned to care for both Resident # 2 and Resident # 3 on the evening shift of 3/12/24. NA # 2 was interviewed on 3/20/24 at 10:15 AM and reported the following. She usually cared for Resident # 3 and described

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him as a "very sweet man." On 3/12/24 she had worked from 7 AM to 7 PM. She had cared for Resident # 3 all during the day and at 3:00 PM assignments were changed for the evening. Resident # 2 was also added to her assignment. She did not consistently care for Resident # 2. To her knowledge Resident # 2 had never threatened or hurt another resident prior. Around 4:00 PM she had seen Resident # 2 walking around the nursing desk. At supper time on 3/12/24 she had been in another resident's room helping them eat their meal. While assisting to help this other resident eat, she thought she heard Resident # 3's voice. Then she heard a noise as if something was falling. She went to look to see what had occurred and found Resident # 2 in Resident # 3's room. Resident # 3 was on the floor curled up in a fetal position. Resident # 2 was swinging the bathroom door back and forth and using the door to hit Resident # 3 in the back. Resident # 3 was crying and there was "blood everywhere." She yelled, "stop-stop." Resident # 3 raised his arm to swing at her and then exited the room. She looked down the hall and did not see anyone, so she screamed for help. A Nurse Aide on the adjacent hall heard the scream and alerted her nurse. Then other staff came and helped.

Nurse # 7 had been assigned to care for Resident # 2 on the evening shift of 3/12/24. Nurse # 7 was interviewed on 3/20/23 at 12:38 PM and reported the following. She routinely worked with Resident # 2 and he was confused every day and would become agitated. He would talk about needing a gun and needing to protect the place where he was. He talked about being in the special military police. He would tell the Nurse Aides at night not to come into his room to care for his wife. He saw

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himself as the caregiver for his wife and that he was in charge. He had been known to say he would hurt those girls (meaning the aides) if they didn't stop coming into his room. She (Nurse # 7) would have to talk to him and convince him to allow for the staff to care for his wife. Although he would talk to staff about guns, he would not talk to residents about them, and she never knew him to hurt or threaten to hurt another resident prior to 3/12/24. She did not recall anything that had occurred happening between Resident # 2 and Resident # 3 at the beginning of the evening shift or where Resident # 2 was at the beginning of the shift. At the time of the incident, she had been in another resident's room providing care with the door closed. She heard yelling. When she got to the room, other nurses had already arrived. Resident # 2's wife was wandering, and she redirected her and then stayed with Resident # 3 until he was taken to the hospital.

NA # 3 was interviewed on 3/21/24 at 10:20 AM and reported the following. She had been working on an adjacent hall to Resident # 2's hall on the evening of 3/12/24 when she heard NA # 2 screaming. She ran to the room and saw NA # 2 trying to get Resident # 2 out of Resident # 3's room. Resident # 2 was agitated when she (NA # 3) arrived but when he saw her (NA # 3), he calmed down and said, "There's my sweet heart." She then took him calmly by the hand and led him to his room without a problem, sat him down with his meal tray before him and closed the door. She went back to help with Resident # 3 and try to stop the bleeding while NA # 2 got multiple nurses. They came right away.

Nurse # 8 was a nurse who had responded on the date of the incident of 3/12/24 and had been

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working on the adjacent unit. Nurse # 8 was interviewed on 3/21/24 at 2:30 PM and reported when she heard the call for help, she responded and found Resident # 3 crying on the floor. There was blood in his eyes and his ears . She was familiar with Resident # 2 and was "shocked" he had attacked Resident # 3. She did not think he had the strength to do what he had done.

Nurse # 9, who had been working on another unit and had responded on 3/12/24, was interviewed on 3/21/24 at 3:00 PM. Nurse # 9 reported the following. She heard that they were calling all the nurses to Resident # 2's unit. She ran to Resident # 3's room and saw he had blood in his eyes, ears, and on his arm. One of the Nurse Aides reported he had been beaten. She called 911 for the police and EMS to be dispatched. The facility Social Worker came and stayed with Resident # 2 while she was making calls and getting the paperwork ready for transfer for both residents. Then she took over staying with Resident # 2 until emergency services arrived. At the point where she started watching Resident # 2, he was agitated again and asking if she was going to shoot him while telling her she was an idiot and no good. She had worked with Resident # 2 previously and never known him to be paranoid or have behaviors when she had worked with him previously. He had always been pleasant.

Resident # 2's guardian was interviewed on 3/21/24 at 9 AM and reported the following. She had known Resident # 2 and his wife for 37 years and knew them well. He and his wife were very active prior to his September 2023 hospitalization. She described Resident # 2 as very sweet and charitable towards others. He had no history of violent behavior. Historically he had worked for

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the military police and analyzed spy photographs. In September 2023 he was hospitalized and then he and his wife were placed in the facility. It was during the hospitalization that she first became aware of any confusion. The hospital physician had talked to her and informed her that Resident # 2 was hallucinating and thinking that he and his wife were being kidnapped. She was appointed his guardian in February 2024. She visited two to three times per week. She noticed he was becoming more and more confused, and to her, it appeared to be happening rapidly. He was having a harder time completing sentences. Some days she visited, and he was completely fine. Other days he was paranoid and would talk about being under surveillance through his clock, the smoke detector, or television. She felt as if his memories were becoming mixed up in his head. He never appeared aggressive to her. He appeared fearful. On the day of the incident, she had talked to him about two hours before the altercation. He had been in a "great mood" and had given no indication he could hurt anyone. She was totally shocked and felt as if he could be placed on the right medications, then he could be helped. She did not recall anyone at the facility talking to her about a psychiatric consult until after the incident.

Review of hospital records for Resident # 2 revealed he had a psychiatry consult on 3/13/24 after he was hospitalized. The psychiatric NP (Nurse Practitioner) noted, "Patient currently reports he doesn't know where he is or why he is not home. He states they took him out after he had to beat somebody up ....."He appears confused discussing enemies, traitors, and enemy cots." At the time of the survey, Resident # 2 remained hospitalized.

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Review of Resident # 3's 3/12/24 emergency department records revealed he was assessed to have a small laceration lateral to the right eye which was closed with skin glue and steri- strips, a skin tear to the elbow, and several abrasions and bruises to the forehead. A CT of Resident # 3's head revealed no fracture or hemorrhage. After treatment, he returned to the facility.

The facility Social Service Director was interviewed on 3/20/24 at 4:50 PM and reported the following. She had never witnessed Resident # 2 be aggressive with another resident prior to 3/12/24 or wander into another resident's room. She confirmed a psychiatric consult had never been obtained for Resident # 2 and the referral had been inadvertently missed, but she was unsure how it had been missed.

Resident # 2's physician was interviewed on 3/21/24 at 9:45 AM and reported the following. From Resident # 2's initial entry into the facility he had made "crazy statements." Although Resident # 2 never received a psychiatric consultation, he (the medical physician) was seeing him and overseeing his medications. The highest likelihood of his psychosis was from dementia. "Maybe" in the last month his behaviors had increased some, but he always had some behaviors. They had sent Resident # 2 to the hospital on 3/1/24 and the hospital had not given any new orders, which validated to the physician that the facility's treatment was okay. He (the physician) had never witnessed any aggression or violence towards others from Resident # 2, and he was "100% shocked" about the incident that had occurred. From his evaluation he had never seen that Resident # 2 posed a danger to others.

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The Administrator was interviewed on 3/20/24 at 3:20 PM and reported the following. They had thoroughly investigated the incident. None of the staff had any indication that the altercation was going to occur. She (the Administrator) had validated with the guardian that Resident # 2 had no history of active combat in the military or a diagnosis of post-traumatic stress disorder. She had found no history of mental illness. All of her staff truly cared for both of the residents, and it had been very sad for all of them who cared for them to see what had happened. A follow up interview was conducted with the Administrator on 3/21/24 at 6:30 PM. According to the Administrator although they could not change what had occurred to Resident # 3, they were monitoring and assuring that he was not withdrawing or his fears affected his interactions with others. The Administrator further reported that Resident # 3 had no long- term effects from the head injury and was continuing to interact with staff and activities per his norm following the incident. The Administrator stated that following the incident the facility had completed a plan of correction.

The Administrator was notified of Immediate Jeopardy on 3/21/24 at 3:15 PM. The Administrator presented the following corrective plan.
How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
" Resident #2 was transferred to the hospital on 3/12/2024 and has remained hospitalized
" Resident #3 was transferred to the hospital on 3/12/2024 and received treatment for his injuries and returned to the center on 3/13/2024
" A 24 hour report was submitted on 3/12/2024

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at 6:50pm and a 5-day investigation report was submitted on 3/19/2024 at 11:57am.

" Resident #3 received a trauma screen assessment following the incident on 3/14/2024 and again on 3/20/2024 by Social Work staff and results on 3/14/2024 screen were that resident was fearful following trauma and was seen by psychiatrist on 3/14/2024. The 3/20/2024 trauma screen indicated he was not fearful, in good spirits and not affected by the trauma. The trauma screen assessment recognizes Trauma Informed Care and acknowledges that residents who are trauma survivors may experience emotional, physical, and/or psychological difficulties that should be addressed immediately upon admission and throughout their stay in the Center. Through available medical records review and by interviewing the patient, indicate any diagnosis of Post traumatic stress disorder or any history of trauma on the Trauma Informed Screen Assessment.

" Resident # 3 received a psychiatric visit on 3/14/2024 following the incident. Psychiatrist recommended increasing Paxil from 20 milligrams to 30 milligrams temporarily for grief. Grief is related to recent passing of spouse. No recommendation in current treatment plan related to incident.

" The facility failed to implement effective measures and interventions to protect cognitively impaired Resident # 3 from physical abuse by Resident # 2 who had cognitive impairment.

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

" Current residents are at risk for the deficient practice.

" The last seven days of progress notes of

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F 600	Continued From page 23 current residents were reviewed for dementia behaviors including aggression, wandering, yelling, delusions, hallucinations, paranoia to ensure interventions are in place including psychiatric services as appropriate on 3/15/2024 by Assistant Administrator. " Current resident MD notes were reviewed in the last 14 days for order of psychiatric consult and referrals made if appropriate. This was completed 3/15/2024 by Assistant Administrator. The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur. " Administrator or designee provided training to all staff in all departments utilizing online learning education modules on dementia care and managing aggressive behaviors. This education includes examples of dementia and aggressive behaviors and ways to prevent and manage these behaviors. This was completed 3/15/2024. No agency staffing at this time. " All staff in all departments were educated by Administrator or designee that when a resident exhibits aggressive behavior, they will stay with them to provide one-on-one supervision and immediately notify a supervisor. This was completed 3/15/2024 " The Administrator or Director of Nursing will make the decision how long the resident will continue to receive one on one based on investigation. " Social Work staff are responsible for initiation of psychiatric services when a consult is placed. Administrator or designee provided training to current social work staff to ensure psychiatric services referral are initiated following dementia behaviors including aggression. This was completed 3/15/2024.	F 600		

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" The Administrator or designee provided training to all current Social Work staff on 3/15/2024 to ensure they will notify Medical Provider and Administrator when a resident or responsible party refuses psychiatric services.
" The Administrator or designee provided education to all current Medical Providers on 3/15/2024 that they will discuss on a case-by-case basis with the Administrator if services for psychiatry can be managed by the Medical Provider in house or if involuntary commitment is needed to provide psychiatric services. This is for resident or responsible parties who refuse psychiatry services.
" Any staff who did not receive the educations by the compliance date was removed from the schedule until completed this will be completed by Staff Development Coordinator.
" All new staff will receive education during the orientation process prior to floor training. This will be completed by the Staff Development Coordinator.
" Director of Nursing or designee will educate all staff on abuse and neglect policy related to what abuse is, the types of abuse and reporting. This was completed by 3/15/2024.
" All Nurses are responsible for notifying Medical Providers of each instance of change in condition which includes dementia behaviors and aggression. This practice is a current process.
" In reviewing a resident for potential admission, the facility Admission staff reviews their history and physical and current hospital documentation including diagnosis and medication management. This process is currently in place.
" Administrator or designee educated Admissions staff on 3/15/2024 that when admitting a resident that has behaviors such as

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delusions/paranoia they will interview potential resident responsible party for information regarding current triggers and history of behaviors. This information will be communicated to the Director of Nursing.
" Administrator or designee educated the Director of Nursing on 3/15/2024 that they will initiate interventions as appropriate at time of admission based on the interview conducted by Admissions staff.
" The Social Work staff will obtain psychiatric consent and evaluation upon admission. This is a current process.

How the facility plans to monitor its performance to make sure that solutions are sustained.

" On 3/14/2024 the quality assurance committee to include Director of Nursing, Assistant Director of Nursing, Director of Admissions, Unit Coordinator, Staff Development Coordinator, Maintenance Director, Medical Records, Director of Social Work, Activities Director, Business Office Manager, Human Resources, Administrator, Assistant Administrator, Director of Rehabilitation Services, Medical Director met and initiated the following monitoring plan.

" Director of Nursing or designee will review current resident progress notes for dementia behaviors including aggression and ensure interventions are in place daily Monday- Friday x 4 weeks then 3x a week x 4 weeks and then weekly x 4 weeks. Monday audits will include the prior Friday, Saturday and Sunday.
" Director of Nursing or designee will audit physician progress notes and ensure that any psychiatric referrals have been consented and

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F 600	Continued From page 26 sent to psychiatric services Monday- Friday x 4 weeks then 3x a week x 4 weeks and then weekly x 4 weeks. Monday audits will include the prior Friday, Saturday and Sunday. " Activity Director or designee will monitor Resident # 3 for changes in activity participation and will notify administrator of any changes for psychiatric intervention. This will occur 5 x weekly x 4 weeks then 3x a week x 4 weeks and then weekly x 4 weeks. " Social Worker or designee will complete psychosocial visits on Resident # 3 for changes in current psychosocial state such as depression and/or anxiety 3x weekly x 8 weeks, then weekly x 4 weeks. Any changes will be reported to the administrator for psychiatric intervention. The results of the audits will be reported to the Quality Assurance Performance Improvement Committee quarterly x 2 by the administrator for analysis of patterns, trends, or need for further systemic changes. Date of compliance is March 16th 2024 The facility's corrective action plan was validated by the following. On 3/20/24 at 9:55 AM (prior to the interview with Resident # 3), Resident # 3 was observed in a group activity and engaged with others. He did not appear withdrawn. During the interview with Resident # 3 at 10:00 AM on 3/20/23, Resident # 3 was interviewed regarding whether he thought the facility staff were watching and monitoring residents. Resident # 3 stated he did think that the staff were monitoring residents. During the initial tour of the facility which began	F 600		

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on 3/19/24 at 9:42 AM, there were no residents displaying behaviors of aggression or outbursts. Multiple residents were interviewed. Interviewed residents did not report any social interaction problems with dementia residents. Interviewed residents on tour reported they had not been mistreated or abused.

The facility Social Services Director was interviewed on 3/20/24 at 4:50 PM and reported the following. The facility had caught their mistake of not referring Resident # 2 for psychological services and implemented a plan of correction. She validated she had been involved in the plan of correction by reviewing other residents' charts to assure dementia residents with psychological needs were referred. When the lack of referral was caught as an error by the facility, the facility sent the referral for Resident # 2 after the altercation occurred.

The facility's provider of psychological services was contacted on 3/20/24 at 3:30 PM and validated they had received the referral for Resident # 2 on 3/13/24 (the day after the altercation had occurred). The provider indicated they would evaluate Resident # 2 when and if he returned to the facility.

The facility's inservice education modules were reviewed and revealed multiple topics were covered related to caring for residents with dementia, behavioral problems, and abuse. Multiple staff members were interviewed and validated they had undergone training since the incident date of 3/12/24. Staff members were able to state points of the inservice material that had been covered.

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F 600	Continued From page 28 The facility presented documentation that audits and inservices had been conducted per their plan of correction. The Admission Coordinator was interviewed on 3/22/24 at 11:50 AM and validated she had been involved in the new procedure of reviewing possible new admissions for behavioral issues and then talking to the responsible party about behaviors if the hospital records indicated there were behavioral issues and needs. Thus far, the Admissions Coordinator reported since the new procedure had been implemented, the facility had not admitted any dementia residents with behaviors. Her plan was to discuss with the Director of Nursing when a dementia resident with behaviors was asking for admission so that it could be determined if they could care for the resident and meet their needs. On 3/22/24 the facility's corrective action plan date of 3/16/24 was validated.	F 600		
F 689 SS=G	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 observation, record review, resident interview, and staff interview the facility failed to ensure a resident was transferred safely.	F 689	Past noncompliance: no plan of correction required.	

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Resident # 1 sustained a fractured leg when two nursing staff members transferred Resident # 1 using a sliding board after therapy had determined Resident # 1 did not have the functional ability to use the sliding board safely. This was for one (Resident # 1) of three sampled residents reviewed for supervision to prevent accidents. The findings included:

Resident # 1 was admitted to the facility on 11/2/23 and had a diagnosis of paraplegia and incomplete quadriplegia.

Review of a physical therapy evaluation, which was completed on 2/2/24, revealed Resident # 1 was documented to have impaired strength in all her extremities. Resident # 1's mobility function score was documented as a "2" on a scale of 1 to 12, with the therapist noting that 12 indicated the highest level of mobility functioning.

Resident # 1's quarterly Minimum Data Set assessment, dated 2/7/24, coded Resident # 1 as cognitively intact and as totally dependent on staff for transfers.

Review of physical therapy progress notes revealed the therapist attempted to work with Resident # 1 with a sliding board for transfers and it was determined not to be an appropriate transfer technique. Specifically, on 2/22/24 Physical Therapist # 1 documented, "Due to patient requiring 2-3 persons and total dependence, a slide board transfer is not appropriate at this time and should no longer be used. PT strongly recommends use of mechanical lift for patient safety."

Resident # 1's care plan, updated on 2/22/24,

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noted Resident # 1 exhibited manipulative behavior and was at risk for falls. One of the interventions added to the care plan on 2/22/24 read, "Resident often requests slide board to be used for transfer, [mechanical lift] is recommended by therapy for safety, resident aware."

On 2/23/24 at 3:22 PM the ADON (Assistant Director of Nursing) entered a nursing entry labeled as "late entry." The entry read" Resident insisted on the use of the slide board for her transfer from bed to chair, that is what she has used for the last 5 years Physical therapist was asked to come to room. Together we discussed the importance of using [mechanical lift] for safety on all transfers, resident was then transferred to chair from bed with myself and PT. Therapy also repeated the importance of the use of [mechanical lift] for safety."

The ADON was interviewed on 3/20/24 at 10:30 AM and reported the following. Around the date of 2/23/24 she was assisting Resident # 1. Resident # 1 wanted the ADON to help her use the sliding board to transfer. The ADON knew Resident # 1 needed a mechanical lift for safety purposes, and this was on Resident # 1's Kardex instructions as the mode of transfer for nursing staff to use. She (the ADON) asked a therapist to come talk to Resident # 1 about safety. The therapist explained safety concerns to Resident # 1, and Resident # 1 was agreeable to using the mechanical lift.

Physical therapist # 1 and Physical therapist # 2 were interviewed on 3/19/24 at 3:00 PM and reported the following. They had both worked with Resident # 1 in therapy. Part of their treatment

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addressed the evaluation of transfers. Resident # 1 wanted to use a sliding board, and according to the therapists, in order to use a sliding board an individual needed to have enough core body strength that he/or she could sit without leaning. The individual also needed to be able to scoot along with the transfer. Resident # 1 did not physically have this capability. In her right leg she had no movement at all. In her left leg she had a "trace" of movement and could clench/contract a muscle in her left leg only. The therapists had given her a strap for leg support when they attempted to use the sliding board, and it had taken multiple people to help with the transfer. After working with her on the sliding board, they did not think it was safe because of her limited mobility. Therefore, it had been discussed with Resident # 1 that she needed to use the mechanical lift for safety reasons. That was her established plan of care for transfers.

Review of nursing notes revealed on 2/25/24 at 10:45 PM Nurse # 10 documented a nursing entry noting the following information. "Resident states her right knee was hurting worse after transferring into the bed. Palpated knee with no signs of swelling or pain. Informed MD (Medical Doctor). New order received to obtain knee x-ray. Resident informed knee x-ray will be done tomorrow."

The results of the x-ray, completed on 2/26/24, revealed Resident # 1 had an oblique, moderately displaced fracture of the distal diaphysis of the right femur (leg bone).

Review of hospital records revealed Resident # 1 was admitted to the hospital on 2/26/24 and underwent surgery on 2/27/24 for her femur

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fracture. On 2/28/24 she was transferred back to the facility for care.

Resident # 1 was interviewed on 3/19/24 at 11:22 AM and reported the following. On the evening when she sustained the fracture, a nurse and a NA (Nuse Aide) were helping transfer her with the sliding board. Her right leg got caught between the bed and the chair. She (Resident # 1) thought she heard something make a noise when her leg caught, and she told the nurse and NA that they had broken her leg.

Nurse # 11 was the nurse who had helped with the transfer on 2/25/24. Nurse # 11 was interviewed on 3/19/24 at 3:43 PM and reported the following. She had been at the nursing desk when NA # 4 approached the nursing desk and asked for help transferring Resident # 1 from her wheelchair to the bed. She went to Resident # 1's room with NA # 4 to help. Resident # 1 was not assigned to her, and she was not familiar with what the Kardex/care plan instructions were for Resident # 1. "From looking" at Resident # 1, Nurse # 11 thought Resident # 1 would require a mechanical lift transfer. She (Nurse # 11) asked NA # 4 how they were going to do the transfer. Resident # 1 was wanting to use the sliding board, and NA # 4 positioned a sliding board, which had been in Resident # 1's room, in the position to use it for a transfer. She and NA # 4 used a draw sheet to move Resident # 1 on the sliding board from her wheelchair into the bed. NA # 4 showed her (Nurse # 11) how to do this. She (the nurse) was on the other side of the bed pulling Resident # 1 with the drawsheet along on the sliding board. NA # 4 was positioned beside Resident # 1's wheelchair. NA # 4 was pushing Resident # 1 along on the sliding board towards

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the bed and towards Nurse # 11. He was also using the drawsheet on the sliding board to do this. She (Nurse # 11) did not hear a noise or see that Resident # 1's leg got caught during the transfer. When they got Resident # 1 on the bed, they noticed her upper body was not aligned with her legs at the hip area. Resident # 1 called out "my leg." They tried to straighten her legs to see if the poor alignment would help her pain. Nurse # 11 was interviewed regarding who had been supporting Resident # 1's legs during the slide and reported her legs did not dangle and no one supported them. Nurse # 11 further reported that once they got her in bed, and the resident was complaining, then she (Nurse # 11) went to obtain Resident # 1's assigned nurse (who was Nurse # 10).

NA # 4 was interviewed on 3/19/24 at 5:05 PM and reported the following. He had taken care of Resident # 1 before the date of 2/25/24 and she always wanted to use the sliding board. He did not think "it was the greatest idea," but she did not like the mechanical lift. If they did not use the sliding board then Resident # 1 would "put up a big fuss" about it. He was not aware physical therapy thought the sliding board was unsafe to use or what the instructions were on the Kardex. Resident # 1 directed her care. On 2/25/24 he and Nurse # 11 used a draw sheet and the sliding board to place Resident # 1 back in the bed from her wheelchair. He had been at the side of the wheelchair pushing Resident # 1 along on the sliding board towards the bed with the draw sheet. Nurse # 11, who was standing on the other side of the bed, was pulling Resident # 1 along on the board using the draw sheet. When Resident # 1 was in the bed, Resident # 1 said she believed her knee was broken. NA # 4 was

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interviewed regarding who had been supporting Resident # 1's legs as the resident was being slid on the board. NA # 4 reported her legs had not dangled. She was in a wheelchair, which could be put in a reclining position about the same level of the bed. Therefore, they had just scooted her whole body on the draw sheet. NA # 4 further reported that after the transfer, then Nurse # 10 came to check Resident # 1.

Nurse # 10 was interviewed on 3/19/24 at 4:30 PM and reported the following. On the night of the incident, NA # 4 and Nurse # 11 had informed her Resident # 1 was in pain after they had transferred her to the bed. She had not been in the room and did not know what had occurred during the transfer. She was not aware physical therapy thought the sliding board was not safe for Resident # 1 to use. After she (Nurse # 10) was informed Resident # 1 was hurting, she went to assess Resident # 1. She palpated Resident # 1's leg, and the resident did not flinch. She saw no physical abnormalities. Resident # 1 normally complained of some pain and muscle spasms, and the resident was ordered PRN (as needed) pain medications. Resident # 1's pain did not seem worse than her usual complaints. Nurse # 10 medicated Resident # 1 per the PRN order as she usually did, and the pain medication was effective.

Nurse # 12 had cared for Resident # 1 on the day shift of 2/26/24. Nurse # 12 was interviewed on 3/19/24 at 4:44 PM and reported the following. On 2/26/24 during morning shift, she had been told Resident # 1's leg was hurting, and a mobile x-ray was scheduled. She medicated Resident # 1 for pain. The pain medication seemed to help, and she slept part of the day. She talked to Resident

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1 about the option of going to the hospital or waiting for the mobile x-ray. Resident # 1 opted to wait for the x-ray. When the x-ray was performed, it showed Resident #1 had a fracture. The technician let them know onsite when the x-ray was done that the fracture could be seen, and they transferred Resident # 1 to the hospital. Nurse # 12 further reported the following. The day shift staff nursing staff used a mechanical lift to transfer Resident # 1. Resident # 1 could be manipulative and try to get the staff to use a sliding board, but she (Nurse # 12) was aware that therapy did not allow them to do use it. Nurse # 12 stated a sliding board had not been in her care plan.

The Administrator was interviewed on 3/20/24 at 3:20 PM and confirmed that Resident # 1 was to always have been a mechanical lift transfer for safety reasons. That had always been on the Kardex. The Administrator further reported the following. Resident # 1 was alert and oriented, and her staff always considered residents rights when caring for residents. She thought that had contributed to the incident occurring because her staff members were trying to do what the resident wanted although it was not safe. Following the incident, the facility had implemented a plan of correction. Part of their plan was to educate staff that if a resident insisted on a transfer that was not part of their Kardex/plan of care, then the staff member was to notify a supervisor.

On 3/20/24 the Administrator presented the facility had completed a corrective action plan. The corrective action plan included the following:

How corrective action will be accomplished for those residents found to have been affected by

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the deficient practice;
" On 2/25/2024 Resident # 1 convinced nursing staff to assist with an unsafe transfer from powerchair to bed using a slide board resulting in a fractured femur. Per resident care plan and Kardex resident is a two person assist via mechanical lift for transfers. Resident transferred to hospital on 2/26/2024.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
" All residents have the potential to be affected due to staff not following the Kardex.
" Care Plans and Kardex were reviewed for accuracy of how to transfer a resident including mode of transfer and how many staff members it requires for transfers on all current residents 2/28/2024. This was completed by the unit manager with the input of the therapy manager.

The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur;
" DON or designee will provide education to all nursing staff to review the Kardex for appropriate transfer status and to notify a supervisor if a resident insists on transferring in a route other than what is on the Kardex by 3/1/2024
" Regional Director of Clinical services, Administrator, Therapy Manager and Director of Nursing met on 3/1/2024 and decided to implement QI safe transfer monitoring tool. Nurse managers or designee will perform observation of staff transfers to ensure accuracy according to the Kardex; this began on 3/4/2024 with 3 transfers 3x per week for x4 weeks, 3 transfers per week x 4 weeks and monthly x 1 month.

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" All new hires after 3/1/2024 will receive training during orientation by the Staff Development Coordinator.

How the facility plans to monitor its performance to make sure that solutions are sustained;
" Part of the Quality Assurance Plan Improvement Committee (Regional Director of Clinical Services, Administrator, Therapy Manager and Director of Nursing) met on 3/1/2024 and decided to audit and monitor transfers as part of Quality Assurance. This Quality Assurance subcommittee introduced the plan to the entire Quality Assurance Committee on 3/5/2024.
" Results of audits will be reviewed at Quality Assurance Plan Improvement Committee meeting x2 for analysis of patterns, trends or need for further systemic changes.

Date of Compliance: 3/2/2024

The following was done to validate the facility's corrective action plan.

During an initial tour of the facility, which began on 3/19/24 at 9:42 AM, multiple residents were interviewed. Residents did not report any problems with accidents occurring during care.

A sampled dependent resident was observed as two staff members completed a transfer via a mechanical lift on 3/21/24 at 10:10 AM. Prior to the transfer the Nurse Aide located the Kardex and validated the type of transfer needed. The Nurse Aide validated there had been recent training about transferring residents. The Nurse Aide was interviewed about what she would do if a resident insisted on a transfer other than noted

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CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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F 689	Continued From page 38 in a resident's plan of care. The Nurse Aide stated she would never do a transfer that was not included in a resident's plan of care. The sampled dependent resident was observed to be safely transferred by use of a mechanical lift per his plan of care. NA # 4 validated during his interview on 3/19/24 at 5:05 PM that following the incident he had received training about transfers. The facility presented documentation of staff inservice education and audits per their plan of correction. On 3/21/24 the facility's plan of correction date of 3/2/24 was validated.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, family interview, physician interview, and Psychiatric Nurse Practitioner interview, the facility failed to obtain a psychiatric referral as ordered when a dementia resident exhibited signs of psychosis. This was for one (Resident # 2) of one sampled dementia resident who exhibited behavioral disturbances related to psychosis. The findings included: Resident # 2 was admitted to the facility on	F 744	Past noncompliance: no plan of correction required.	

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9/18/23 following a hospitalization from 8/28/23 to 9/18/23. According to the hospital discharge summary, dated 9/18/23, Resident # 2's diagnoses included hypertension, coronary artery disease, heart failure, atrial fibrillation, history of prostate cancer, failure to thrive with moderate malnutrition. The hospital discharge summary also noted the following. Resident # 2, who had resided at home prior to hospitalization, had "possible dementia" and had barricaded himself and his wife in the hospital room at one point during his stay. He had required physical restraints and initiation of antipsychotic medication while hospitalized.

Physician orders revealed Resident # 2 was prescribed Seroquel 25 mg (milligrams) at bedtime for agitation on 9/18/23 when he was admitted to the facility. (Seroquel is an antipsychotic medication.)

Review of the facility record revealed on 9/19/23 Resident # 2 was seen by the facility medical physician who noted Resident # 2 seemed to have delirium while hospitalized, and antipsychotics were started. The physician noted he would try to wean the resident off antipsychotics over the next few days.

Resident # 2's admission Minimum Data Set assessment, dated 9/24/23, coded Resident # 2 as severely cognitively impaired.
Resident # 2 was assessed to be ambulatory with a walker and displayed the behavior of refusing care.

Resident # 2's care plan, reviewed on 10/2/23, included information that Resident # 2 was at risk for complications related to cognitive impairment

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secondary to his advanced age. Staff were directed to observe for changes in his cognition over time. The care plan also noted he received antipsychotic medications, was at risk for elopement, and that psych services would be provided as needed.

On 10/4/23 the physician noted in a progress note that he was following up on both the resident's medical issues and the resident's psychosis. The physician further noted there had been no recent agitation issues with the resident.

Per physician orders, on 10/7/23 Resident # 2's Seroquel dosage was changed to ½ tablet (12.5 mg) at bedtime. This indicated a dose reduction.

Per physician orders on 10/16/23 the dosage was increased back to 25 mg at bedtime. (This dosage amount remaining ordered through 3/9/24).

Resident #2's physician noted in a progress note, dated 10/17/23, the following. He was seeing Resident # 2 because of severe agitation in the last couple of days. The resident had a urinalysis completed which was negative, and Resident # 2 had "known dementia." The physician directed the resident's daily Seroquel dosage be administered at 6:00 PM rather than at bedtime. On 11/6/23, the DON (Director of Nursing) noted in a nursing note Resident # 2 had stated suicidal ideations but had no plan or means to carry out his ideation. The DON further noted a psych referral would be sent.

Interview on 3/21/24 at 4:45 PM with the DON revealed at the time of 11/6/23, Resident # 2 refused to see a psychiatrist, and therefore the

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psychiatric evaluation did not take place at that time.

Resident # 2's physician noted in a progress note, dated 12/19/23, "In follow up of dementia, he does get agitated quite frequently and sometimes have outburst where he resists to seeing the doctor, but today he does not remember anything at all and has really no concerns or complaints while I am in the room." The physician further noted, "I will continue Seroquel at this time for agitation."

On 12/23/23 a quarterly Minimum Data Set assessment was completed showing the following assessment. Resident # 2 was moderately cognitively impaired, wandered and rejected care 1 to three days during the assessment period, and was ambulatory.

Review of physician orders revealed an order on 1/11/24 for a geriatric psychiatric consult.

Review of Resident # 2's medical record revealed a document noting a hearing had been held and Resident # 2 had been deemed incompetent. This document was stamped as filed on 2/2/24. On 2/2/24 the facility's Social Services Director noted there had been a court appointed guardian arranged for Resident # 2.

On 2/3/24 at 1:48 AM Nurse # 1 documented in a nursing note Resident # 2 was yelling at a nurse that someone was trying to murder him and that a girl he had murdered was still alive.

On 2/11/24 at 4:21 AM Nurse # 2 documented in a nursing note that Resident # 2 thought he had killed his wife.

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On 2/12/24 at 10:19 PM Nurse # 3 noted Resident # 2 was ranting someone was coming to kill him and his wife .

On 2/13/24 at 1:53 AM Nurse # 1 noted Resident # 2 thought jets were coming to murder him and his wife.

Resident # 2's physician noted in a progress note, dated 2/19/24, "Baseline, very confused and paranoid, in no apparent distress. He has times where he thinks somebody has to murder him and his wife. He can ambulate with a walker ...." Under the physician's plan for the date of 2/19/24, the physician noted he would continue the Seroquel for his behaviors and psychosis and "refer to psychiatry."

Review of Resident # 2's facility medical record revealed Resident # 2 was never seen for a psychiatric consult.

On 2/23/24 at 9:29 AM Nurse # 4 noted Resident # 2 was asking how to contact the police and verbalizing he needed to leave to find a hotel.

On 2/26/24 at 3:16 PM Nurse # 4 noted Resident # 2 was exit seeking.

On 2/27/24 at 1:11 PM Nurse # 5 noted in a nursing note that Resident # 2 had been agitated, confrontational, and had lifted his walker and attempted to throw out the glass door.

Review of physician orders revealed on 2/27/24 Resident # 2 was started on Depakote extended release 250 milligrams twice per day. (Depakote is a medication used as a mood stabilizer).

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On 3/1/24 Nurse # 6 completed a SBAR communication form (a situation, backgroumd assessment, and recommendation request form). The nurse checked on the form Resident # 2 was having increased verbal and physical aggression, and a danger to self or others. According to the record, after the completion of the form Resident # 2 was sent to the hospital.

Nurse # 6 was interviewed on 3/21/24 at 11:49 AM and reported the following. She was the staff development coordinator for the facility. Her office was on a different unit than the unit on which Resident # 2 resided. On 3/1/24 she had been in her office when she saw Resident # 2 was trying to leave the facility. She knew that he had refused lab work a few days before and felt his continued attempts to leave might pose a danger to himself. Therefore, the resident was transferred to the hospital by 911 services.

Review of hospital emergency department records, dated 3/1/24, revealed the following. The physician noted Resident # 2 presented "for aggressive behavior. Patient was noted to be throwing his walker and furniture at staff attempting to take his wife and leave the facility. On exam patient is moderately confused, oriented to self, reports his wife was being attacked by hospital staff." The physician further noted during his assessment Resident # 2 was calm and cooperative, labs had been done without any significant abnormalities. According to the record, he was returned to the facility with no changes in orders. There was no indication a psychiatric consult was obtained while Resident # 2 was at the hospital.

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Review of physician orders revealed on 3/9/24 an order for Seroquel 25 milligrams every 12 hours. This indicated an increased dosage.

Resident # 2's physician noted in a progress note, dated 3/11/24, Resident # 2 had experienced some syncope episodes. The physician noted that Seroquel was one medication that could contribute to orthostatic hypotension. He further noted Resident # 2 did not respond well to Lorazepam and he would be a good candidate for a lockdown unit. The physician further noted, "continue with a referral for psychiatry for further monitoring."

On 3/11/24 Resident # 2's Seroquel was discontinued.

On 3/12/24 at 7:40 PM Nurse # 7 noted Resident # 2 had been involved in an altercation with another resident and wase sent to the emergency room for evaluation secondary to a physician's order.

Review of the facility's investigation into Resident # 2's altercation revealed Resident # 3 was the other resident involved in the 3/12/24 altercation. According to the facility's investigation, Resident # 2 had initiated the altercation without provocation from Resident # 3.

Review of hospital records for Resident # 2 revealed he had a psychiatry consult on 3/13/24 after he was hospitalized. The psychiatric NP (Nurse Practitioner) noted Resident # 2 was confused and was discussing traitors and enemies. At the time of the survey, Resident # 2 remained hospitalized.

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The facility Social Service Director was interviewed on 3/20/24 at 4:50 PM and reported the following. She had never witnessed Resident # 2 be aggressive with another resident prior to 3/12/24 or wander into another resident's room. She confirmed a psychiatric consult had never been obtained for Resident # 2 and the referral had been inadvertently missed, but she was unsure how it had been missed.

Resident # 2's guardian was interviewed on 3/21/24 at 9 AM and reported the following. She had known Resident # 2 for 37 years and knew him well. He was very active prior to his September 2023 hospitalization. She described Resident # 2 as very sweet and charitable towards others. He had no history of violent behavior. Historically he had worked for the military police and analyzed spy photographs. In September 2023 he was hospitalized and then he and his wife were placed in the facility. It was during the hospitalization that she first became aware of any confusion. The hospital physician had talked to her and informed her that Resident # 2 was hallucinating and thinking that he and his wife were being kidnapped. She was appointed his guardian in February 2024. She visited two to three times per week. She noticed he was becoming more and more confused, and to her, it appeared to be happening rapidly. He was having a harder time completing sentences. Some days she visited, and he was completely fine. Other days he was paranoid and would talk about being under surveillance through his clock, the smoke detector, or television. She felt as if his memories were becoming mixed up in his head. He appeared fearful. He never appeared aggressive to her, and she was shocked that he had been in an altercation with another resident. She did not

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recall anyone at the facility talking to her about a psychiatric consult until after the incident.

Resident # 2's physician was interviewed on 3/21/24 at 9:45 AM and reported the following. From Resident # 2's initial entry into the facility he had made "crazy statements." Although Resident # 2 never received a psychiatric consultation, he (the medical physician) was seeing him and overseeing his medications. The highest likelihood of his psychosis was from dementia. He (the physician) had never witnessed any aggression or violence towards others from Resident # 2, and he was "100% shocked" that he had initiated an altercation with another resident. From his evaluation he had never seen that Resident # 2 posed a danger to others.

The Psychiatric Nurse Practitioner was interviewed on 3/21/24 at 4:50 PM and reported the following. Given Resident # 2's advanced age, if she had received a psychiatric referral for Resident # 2, she would not have referred him for imaging and studies to determine the cause of his dementia. Varying dementia disorders that cause behavioral disturbances are treated with similar medications to help stabilize a resident's mood. There were times that dementia residents had outbursts that could not be predicted by caregivers, and therefore Resident # 2's altercation may have still occurred even if she had evaluated and started treating him.

The Administrator was interviewed on 3/20/24 at 3:20 PM and reported the following. They had thoroughly investigated the incident. None of the staff had any indication that the altercation was going to occur. She (the Administrator) had validated with the guardian that Resident # 2 had

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no history of active combat in the military or a diagnosis of post-traumatic stress disorder. She had found no history of mental illness. The facility had identified the psychiatric referral had not taken place before the altercation and completed a corrective action plan.

On 3/22/24 the Administrator presented the facility had completed a corrective action plan. The corrective action plan included the following:

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
" The facility failed to provide behavioral services to resident #2 to maintain the highest practical wellbeing.
" Resident # 2 was hospitalized on 3/12/2024 and has not returned.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
" All residents identified as per their comprehensive assessment and care plan are at risk for the deficient practice.
" 100% audit of all comprehensive assessments and care plans were completed 3/15/2024 to identify the need for behavioral health services by the Regional MDS Consultant.
" All residents who receive an order for behavioral health service consult are at risk. All Medical Provider notes were reviewed in the last 14 days for order for behavioral health services and referrals made if needed by the Assistant Administrator. This was completed 3/15/2024.

The measures that will be put into place or systemic changes made to ensure that the

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deficient practice will not recur.
" All social work staff were educated by administrator or designee to review all medical provider progress notes to ensure any behavioral health service consults are addressed and will ensure behavioral health services are in place based on comprehensive assessment. This was completed 3/15/2024 .
" The Administrator or designee provided training to all current Social Work staff on 3/15/2024 to ensure they will notify Medical Provider and Administrator when a resident or responsible party refuses behavioral health services.
" The Administrator or designee provided education to all current Medical Providers that they will discuss on a case-by-case basis with the Administrator if services for behavioral health can be managed by the Medical Provider in house or if involuntary commitment is needed to provide behavioral health services. This is for resident or responsible parties who refuse behavioral health services. All Nurses are responsible for notifying Medical Providers of each instance of change in condition which includes dementia behaviors and aggression. This practice is a current process.
" In reviewing a resident for potential admission, the facility Admission staff reviews their history and physical and current hospital documentation including diagnosis and medication management. This process is currently in place.
" Administrator or designee educated Admissions staff on 3/15/2024 that when admitting a resident that has behaviors such as delusions/paranoia they will interview potential resident responsible party for information regarding current triggers and history of behaviors. This information will be communicated

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to the Director of Nursing.
" Administrator or designee educated The Director of Nursing on 3/15/2024 that they will initiate interventions as appropriate at time of admission based on the interview conducted by Admissions staff.

How the facility plans to monitor its performance to make sure that solutions are sustained.

" The results of the audits will be reported to the QAPI committee by the Director of Nursing quarterly x 2 meetings for analysis of patterns, trends, or need for further systemic changes. Any staff found to be non-compliant with the procedure will receive progressive discipline.

" On 3/14/2024 the quality assurance committee to include Director of Nursing, Assistant Director of Nursing, Director of Admissions, Unit Coordinator, Staff Development Coordinator, Maintenance Director, Medical Records, Director of Social Work, Activities Director, Business Office Manager, Human Resources, Administrator, Assistant Administrator, Director of Rehabilitation Services, Medical Director met and initiated the above monitoring plan.

" Director of Nursing or designee will audit all medical provider progress notes and ensure that any behavioral health referrals have been consented and sent to behavioral health provider 5x weekly x 4 weeks, then 3x weekly x 4 weeks and then weekly x 4 weeks.
" Regional Consultant or designee will audit 5 comprehensive assessments for identification of need for behavioral health services based on the assessment and ensure referral has been

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completed weekly x 4 weeks, 3x weekly x 4 weeks, then weekly x 4 weeks.
Date of compliance is March 16th 2024

The facility's corrective action plan was validated by the following.
During the initial tour of the facility which began on 3/19/24 at 9:42 AM, there were no residents displaying behaviors of aggression or outbursts. Multiple residents were interviewed. Interviewed residents did not report any social interaction problems with dementia residents.

The facility Social Services Director was interviewed on 3/20/24 at 4:50 PM and reported the following. The facility had caught their mistake of not referring Resident # 2 for psychological services and implemented a plan of correction. She validated she had been involved in the plan of correction by reviewing other residents' charts to assure dementia residents with psychological needs were referred. When the lack of referral was caught as an error by the facility, the facility sent the referral for Resident # 2 after the altercation occurred.

The facility's provider of psychological services was contacted on 3/20/24 at 3:30 PM and validated they had received the referral for Resident # 2 on 3/13/24 (the day after the altercation had occurred). The provider indicated they would evaluate Resident # 2 when and if he returned to the facility.

The facility presented documentation that audits and inservices had been conducted per their plan of correction.

The Admission Coordinator was interviewed on

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F 744	Continued From page 51 3/22/24 at 11:50 AM and validated she had been involved in the new procedure of reviewing possible new admissions for behavioral issues and then talking to the responsible party about behaviors if the hospital records indicated there were behavioral issues and needs. Thus far, the Admissions Coordinator reported since the new procedure had been implemented, the facility had not admitted any dementia residents with behaviors. Her plan was to discuss with the Director of Nursing when a dementia resident with behaviors was asking for admission so that it could be determined if they could care for the resident and meet their needs. On 3/22/24 the facility's corrective action plan date of 3/16/24 was validated.	F 744		
F 867 SS=D	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	F 867		4/3/24

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	345505	A. BUILDING _____ B. WING _____	C 03/25/2024

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F 867	Continued From page 52	F 867		

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 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

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(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 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

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F 867	Continued From page 54 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 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 record review, resident interview, and staff interview the facilities Quality Assurance/Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint survey of 6/11/21 and the complaint survey of 11/10/21. This was for one repeat deficiency. The area of deficiency dealt with failure to provide supervision to prevent accidents. The continued failure of the facility during three federal surveys over the course of three years showed a pattern of the facility's inability to sustain an effective Quality Assurance/Performance Improvement program. The findings included: This citation is cross referred to: F 689 During the complaint survey of 3/25/24 the facility failed to ensure a resident was transferred safely. Resident # 1 sustained a fractured leg when two nursing staff members transferred	F 867	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F 867 QAPI QAPI/QAA Improvement Activities 1. The facility failed to maintain implemented procedures and monitor previous interventions set in place by the Committee after each of the surveys. 2. Current residents are at risk. 3. The current Quality Assessment and Assurance Committee will be trained on the importance of development of systemic programs with sustained results to prevent further repeat deficient practices. As a team the committee will	

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F 867	Continued From page 55 Resident # 1 using a sliding board after therapy had determined Resident # 1 did not have the functional ability to use the sliding board safely. This was for one (Resident # 1) of three sampled residents reviewed for supervision to prevent accidents. F 689: During the recertification and complaint survey of 6/11/21 the facility failed to supervise and monitor a resident who was not compliant with the smoking policy and was found smoking in room with oxygen via nasal cannula on three occasions for one of five sampled residents reviewed for smoking compliance. There was also no system or interventions in place to prevent recurrent noncompliance with the smoking policy by residents. F 689 During the complaint investigation of 11/10/21 the facility failed to prevent a resident from rolling off the bed during care which resulted in a right frontal hematoma and laceration, and right periorbital swelling from a fall and hospitalization for 1 of 3 sampled residents reviewed for supervision to prevent accidents. On 3/21/24 at 6:30 PM the Administrator was interviewed regarding the facility's quality assurance program and having a repeat deficiency. The Administrator reported the following. She felt the facility had a very good quality assurance program. They had learned from their mistakes and although there was a repeat citation area, she felt the things that contributed to each of the accidents cited over the past three years were very different. Their quality assurance program had prevented the specific incidents cited in previous years being repeated. When the accident did occur with Resident # 1,	F 867	work on the process of development of a Performance improvement plans and Ad Hoc teams' meetings development. The team is also learning how to monitor current Performance improvement plans for efficacy and the importance of modifications if or when systemic changes are no longer effective. Education will be completed by the Administrator and/ or designee by 04/2/24. Any newly hired department heads or members of the QAA/QAPI team will be educated by the Administrator or Director of Nursing or designee during orientation week to ensure compliance in our facility. 4. Regional Director of Clinical Services to audit all Performance improvement plans related to the repeat tags weekly x 12 weeks then 3 times weekly. 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed 6. Date of compliance: 04-3-2024	

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F 867	Continued From page 56 their quality assurance program immediately evaluated the accident and put a corrective plan in place. Therefore, she considered that the quality assurance program was effective. She also thought that the accident which had occurred with Resident # 1 was complicated by the issue of the facility staff also wanting to respect a resident's right to have input into their care.	F 867		