STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0638	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

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D 000	Initial Comments A complaint investigation was conducted from 8/14/2024 through 8/15/2024. The following intakes were investigated NC00219992, NC00219710, and NC00219683. 3 of the 3 allegations resulted in a deficiency. Event ID: TF1U11.	D 000		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an	D 482		8/15/24

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

Electronically Signed | 09/03/24

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D 482	Continued From page 1 effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to protect a resident's right to be free from physical restraints when Nurse Aide #1 held Resident #1 down and continued with incontinent care after Resident #1 became agitated and aggressive during incontinence care. This resulted in red and purple bruising to the top of both of Resident #1's forearms, from her wrists to her elbows. This deficient practice affected 1 of 1 resident reviewed for restraints. The findings included: Resident #1 was admitted to the facility on 08/11/22 with diagnoses that included unspecified dementia, anxiety disorder, and cognitive communication deficit. A review of Resident #1's service plan last updated on 07/03/24 revealed a care area for	D 482	Corrective action for affected residents. On 7/20/2024 at approximately 5:20 am, nurse aide #1 was attempting to provide incontinent care to resident #1 when resident #1 became combative and attempted to strike nurse aide #1. Nurse aide #1 stated resident #1 became combative by swinging her arm and striking her in the abdomen while she was on her side. Nurse aide #1 continued with care and placed resident#1 hand across chest to try to prevent her from striking her again. Nurse aide #1 stated that after she turned resident #1 to the other side, resident #1 swung and knocked her glasses off. Upon completion of care, at approximately 5:30am, resident #1 put self in wheelchair and propelled self to nurses' station and reported to nurse#1 that while nurse aide #1 was changing her brief "she was rough and grabbed her arms and held	

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D 482	Continued From page 2 "The resident is/has the potential to be physically aggressive related to dementia". Interventions included: to anticipate Resident #1's needs, if Resident #1 showed signs of agitation to remain calm, take a deep centering breath, stand out of reach of Resident #1. If the response to the staff member continues to be aggressive, staff were to calmly walk away and report to a nurse. A review of Resident #1s physician orders revealed Resident #1 was not prescribed any blood thinning medication. A review of Resident #1's progress notes revealed a note written by Nurse #1 and dated 07/20/24 at 7:58 AM that read: "[Nurse #1] was informed by [Nurse Aide #2] upstairs that [Resident #1] had come up there upset. [Nurse #1] went upstairs and spoke to [Resident #1] and she stated [Nurse Aide #1] was very rough with her. [Resident #1] stated [Nurse Aide #1] threw back the covers and held her hands down. [Nurse #1] noticed bruising to bilateral arms and a small amount of blood near [Resident #1's] right wrist. [Nurse #1] had not seen bruising on [Resident #1] prior to this event. [Nurse #1] spoke with [Nurse #2] and escorted [Nurse Aide #1] out of the building." Multiple attempts to reach Nurse Aide #1 by telephone were unsuccessful. Review of a transcribed telephone interview with Nurse Aide #1 completed by the facility revealed the following statement by Nurse Aide #1: "Interview completed by phone with [Nurse Aide #1] regarding allegation on 07/20/24 related to [Resident #1]. Nurse Aide [#1] stated that around 5:00 AM she was completing her rounds on 600 hall and went into [Resident #1's] room to check	D 482	her down." Resident #1 was assessed by nurse #1. Resident #1 was noted to have discoloration to bilateral posterior forearms. MD and RP notified, and order given to send resident #1 to hospital for evaluation per family request. Emergency Medical Service notified and resident #1 sent to hospital for evaluation and treatment. Police and Adult Protective Services notified. Nurse aide#1 suspended immediately pending investigation. Initial allegation report submitted to state reporting agency by Administrator. On 7/20/2024 at 12:10 pm resident #1 returned to the facility with no new orders. Corrective action for potentially affected residents. On 7/20/2024, the Director of Nursing identified residents that were potentially impacted by this practice by completing body audits on all current residents with BIMS 12 or less and interviews of residents with BIMS 13 or higher. This was completed on 7/20/2024. The results included: No other residents affected by alleged deficient practice. Additionally, on 7/23/2024, the Director of Nursing and Unit Managers completed ADL observations for 5 residents on each hall to ensure care was not being provided roughly, identify resident refusal of care and staff response to refusal of care. The observations identified no issues. Systemic changes. On 7/20/2024, the Director of Nursing began in servicing all full-time, part-time, and PRN (as needed) staff (including	

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D 482	Continued From page 3 on resident. Nurse Aide [#1] stated she knocked on door and told the resident who she was and asked resident if she needed anything and resident stated she needed help changing her brief. Nurse Aide [#1] turned on the light and got my supplies together and went over to [the] bed and told resident what I was going to do. I told resident I was going to pull back the covers and when I pulled back the covers, resident started cursing, saying it was cold. I told resident that I would get done as quickly as possible. I unfastened resident's brief and assisted resident to roll over on [her] side. Resident's right arm was across her chest. While cleaning resident, resident stated "If you hurt me I am going to kick you, you fat, black, nigger". As I was wiping resident, she swung her arm back and hit me in the stomach. I repositioned resident's arm and continued to provide care. I asked resident to roll over on her right side and placed her left arm over her chest. While cleaning resident's bottom, she swung her left arm and knocked my glasses off. I placed a clean brief on resident and repositioned resident and as I was pulling her covers up she said "don't touch my legs that's how it got broke before them touching it." I gathered my trash and supplies and left the room. I don't remember if resident had bruises on arms or not as this was my first time working with resident. After taking my trash to soiled utility room, I was on my way to tell [Nurse #1] and she approached me and said I had to leave right now because the resident had said I abused her. I was not allowed to provide a statement regarding the incident before I was told to leave. As I told the police when they called me, at no time did I hurt that lady and just thought she had behaviors." A review of a completed police report revealed Nurse Aide #1 was interviewed via telephone by	D 482	agency) on ABUSE policy and Dealing with Challenging Behaviors to include walking away and not touching resident if displaying aggressive behaviors. As of 7/23/2024, 10% of staff members have not attended the in-service. The Administrator and Director of Nurses will ensure that any of the above identified staff member (full time, part time, and prn including agency) who do not complete the in-service training by 07/23/2024 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility and agency orientation for all staff (full time, part time, and prn including agency) by the Director of Nurses. Investigation findings were reviewed in Quality Assurance Meeting on 7/25/2024 with no additional findings. Discussed monitoring plan and QA tool for ADL Care Concerns updated to reflect staff observations during care to ensure staff are not restraining resident while care being provided. Quality Assurance. Beginning the week of 7/29/2024, the Director of Nursing or designee will monitor ADL CARE CONCERNS related to use of restraints during care using the QA Tool for ADL Care Observation. This will be completed weekly for 4 weeks and monthly for 2 months. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA	

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D 482	Continued From page 4 the police department on 07/21/24 at 9:28 PM. Per the police report: "When [Nurse Aide #1] went to say good morning to [Resident #1], she said she opened the door and said good morning and noticed that [Resident #1] has soiled her brief and needed to be changed. [Nurse Aide #1] said that she asked [Resident #1] if she could change her. She said that [Resident #1] has agreed and in quotes, said "If you hurt me, I'll kick you in the stomach, you fat, black, nigger." [Nurse Aide #1] said she continued to try and change [Resident #1]'s pull up. [Nurse Aide #1] stated she just wanted to get her cleaned up and stated she couldn't just leave her in her urine. [Nurse Aide #1] said in her mind, [Resident #1] showed signs of dementia and stated that in her mind they don't know what they are saying or making those kinds of statements. [Nurse Aide #1] said that she rolled [Resident #1] to her left side and [Resident #1] attempted to hit her. [Nurse Aide #1] said that she used her left arm to hold [Resident #1]'s arm down and used her right hand to pull her brief down. She then stated she rolled [Resident #1] over to her right side, and [Resident #1] used her left arm to hit [Nurse Aide #1]'s stomach twice. [Nurse Aide #1] said she used her right arm to hold [Resident #1]'s left arm down while using her left hand to pull her brief back up." A review of police body camera footage dated 06/20/24 revealed Resident #1 had red and dark purple bruising that started at her right wrist and continued to just below her right elbow, covering a majority of the top of her forearm. On Resident #1's left wrist, the red and dark purple bruising also began at her wrist and went from the top of her forearm towards the inside of her arm, stopping approximately in the middle of her forearm. Additional red and purple bruising was noted at the resident's elbow and just above.	D 482	Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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These bruises were approximately the size of a 50-cent piece and quarter.

An interview with Resident #1's Responsible Party via telephone on 08/14/24 at 10:15 AM revealed he was informed of an incident regarding Nurse Aide #1 and Resident #1 after Resident #1 reported to the facility that Nurse Aide #1 had hurt her during care. Resident #1's Responsible Party stated that it was his understanding that Nurse Aide had entered Resident #1's room around 5:00 AM and attempted to change her which he believed startled Resident #1 because it was her usual routine to sleep until 7:00 AM or 8:00 AM. Resident #1's Responsible Party reported he did not understand why, if Resident #1 was being resistive to care, that Nurse Aide #1 would continue to force Resident #1 to be changed. He also reported he had not seen Resident #1 since the incident but reported a family member had visited with her the day prior.

An in-person interview with Resident #1's Family Member was conducted on 08/14/24 at 11:23 AM. He reported he was aware of the incident and stated he had visited with Resident #1 the day prior to the incident. Resident #1's Family Member reported when he visited with Resident #1 the day before the incident, she did not have any bruising to her forearms and did not complain of any pain in that area. He also reported not understanding why Nurse Aide #1 held her down and forced her to be changed when she was being resistive.

An interview with Nurse #1 on 08/15/24 at 9:24 AM via telephone revealed she was informed of the incident by Nurse #2 who was working on another hall. She reported it was her

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understanding that after the incident, Resident #1 left her hall and went upstairs and informed the Nurse #2 of the interaction with Nurse Aide #1. Nurse #1 continued, stating that when she spoke with Resident #1, she reported that Nurse Aide #1 had grabbed her and hurt her. Nurse #1 stated she observed Resident #1's skin and noted there to be fresh bluish bruising to her bilateral forearms. Nurse #1 stated "I can't really describe the size of the bruising but it was significant, it pretty much covered both of her arms". Nurse #1 reported she had worked with Resident #1 that night and previous days and Resident #1 had not reported any pain or bruising to her arms. She stated after she spoke with Resident #1, she and Nurse #2 found Nurse Aide #1 and informed her of the allegation. They then informed Nurse Aide #1 that she needed to leave the facility until the completion of an investigation into the allegation. Nurse #1 stated Nurse Aide #1 seem surprised and reportedly stated she did not know why Resident #1 had made the allegation. Nurse #1 stated she was shocked that Nurse Aide #1 even went into Resident #1's room because Resident #1 was mostly independent with activities of daily living and would request assistance if she needed help.

An interview with Nurse #2 via telephone on 08/14/24 at 3:38 PM revealed he was working on the 100/200 halls that evening and that Resident #1 had come to him and reported Nurse Aide #1 had been mean to her and that Nurse Aide #1 had held her down and hurt her. Nurse #2 reported Resident #1 was visibly upset and frantic. Nurse #2 reported he visually assessed Resident #1 and reported he observed what appeared to be fresh bruises on Resident #1's bilateral forearms. He continued, stating that he took Resident #1 back to her hall and notified her

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nurse and then went to Nurse Aide #1, informed her of the allegation and then escorted her out of the building.

An interview with Nurse Aide #2 on 08/15/24 at 9:42 AM revealed she was assigned to Resident #1 the shift immediately before the incident. She reported Resident #1 was mostly independent with her activities of daily living and that she had the ability to notify them when she needed assistance. Nurse Aide #2 reported typically Resident #1 was continent and would let her know when she needed to go to the bathroom. She also reported when she saw Resident #1 on that shift, she did not observe her to have and bruising to her forearms and that Resident #1 did not complain to her of any pain in her arms.

An interview with the Director on Nursing on 08/15/24 at 10:03 AM revealed she was aware of the incident and that it had occurred early in the morning, around 5:00 AM on 06/20/24. The Director of Nursing stated the Administrator called her and she immediately went to the facility. She stated when she arrived to the facility, Resident #1 had already been sent to the hospital per the family's request so she started collecting body audits on residents and gathering statements from staff and residents. She stated she was told that Nurse Aide #1 had entered Resident #1's room to provide incontinence care and after it was completed, Resident #1 left her room and reported to Nurse #2 that Nurse Aide #1 had hurt her and grabbed her arms. The Director of Nursing stated she did not speak to Nurse Aide #1 about the incident but after reviewing Nurse Aide #1's statement to the police department, she stated when Resident #1 became resistive to care, she expected Nurse Aide #1 to have stepped away from Resident #1. The Director of

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Nursing reported Nurse Aide #1 should not have forced the incontinence care to continue and that she expected her to have removed herself from the room and get assistance or tried to provide the care later once Resident #1 had calmed down.

An interview with the Administrator on 08/15/24 at 10:37 AM revealed she was notified via a telephone call from Nurse #2 that Resident #1 had alleged that Nurse Aide #1 had held her down during care and hurt her. The Administrator reported she immediately went to the facility to begin an investigation. She stated when she arrived at the facility, Nurse Aide #1 had already been sent home and emergency medical services was at the facility along with the police department. She reported when she entered the facility, Resident #1 was sitting on a stretcher and informed her that Nurse Aide #1 had held her down while she tried to take off her pants. Resident #1 reported she tried to kick Nurse Aide #1 to try and stop her, but Nurse Aide #1 did not stop and held her down. The Administrator reported Resident #1 pulled up her sleeves to show the Administrator the bruising to her forearms, which the Administrator stated covered a good portion of her forearms. The Administrator stated she spoke to several staff who worked with Resident #1 prior to the incident and was told no one had any knowledge of any bruising, redness, or pain prior to the altercation with Nurse Aide #1. The Administrator stated she had tried multiple times to reach Nurse Aide #1 via telephone but was unsuccessful. She did report Nurse Aide #1 did eventually provide a written statement which was included in her investigation into the incident. The Administrator also reported she expected her staff to walk away if a resident became resistive during care and no

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staff should ever hold a resident down or cause bruising during care.

An interview with the Corporate Nurse Consultant on 08/14/24 at 2:21 PM, she reported she was aware of the incident and that she was the person who took a statement from Nurse Aide #1 regarding the incident between herself and Resident #1. She started Nurse Aide #1 reported she had entered Resident #1's room to provide incontinence care and resident became combative and hit Nurse Aide #1 multiple times while she provided care. The Corporate Nurse Consultant reported per the facility's training on difficult behaviors, Nurse Aide #1 should not have forced incontinence care but rather stepped away and reapproached Resident #1 at a later time.

An interview with the Medical Director on 08/15/24 at 10:18 AM revealed he was aware of the incident between Resident #1 and Nurse Aide #1. He stated he had monitored Resident #1 after the incident and had visualized her arms. The Medial Director reported he was aware of some instances where Resident #1 had rubbed her forearms and had previously picked at them and stated he was unable to determine if the bruising he observed on Resident #1's forearms were from being held down or if they were from her rubbing or picking at them. The Medical Director did report he had not read Nurse Aide #1's statement she made to the police department and stated she should have walked away when Resident #1 became agitated and no have forced the care to be completed.

The facility provided the following plan of care:

Corrective action for affected residents.

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D 482	Continued From page 10 On 7/20/2024 at approximately 5:20 am, nurse aide #1 was attempting to provide incontinent care to resident #1 when resident #1 became combative and attempted to strike nurse aide #1. Nurse aide #1 stated resident #1 became combative by swinging her arm and striking her in the abdomen while she was on her side. Nurse aide #1 continued with care and placed resident#1 hand across chest to try to prevent her from striking her again. Nurse aide #1 stated that after she turned resident #1 to the other side, resident #1 swung and knocked her glasses off. Upon completion of care, at approximately 5:30am, resident #1 put self in wheelchair and propelled self to nurses' station and reported to nurse#1 that while nurse aide #1 was changing her brief "she was rough and grabbed her arms and held her down." Resident #1 was assessed by nurse #1. Resident #1 was noted to have discoloration to bilateral posterior forearms. MD and RP notified, and order given to send resident #1 to hospital for evaluation per family request. Emergency Medical Service notified and resident #1 sent to hospital for evaluation and treatment. Police and Adult Protective Services notified. Nurse aide#1 suspended immediately pending investigation. Initial allegation report submitted to state reporting agency by Administrator. On 7/20/2024 at 12:10 pm resident #1 returned to the facility with no new orders. Corrective action for potentially affected residents. On 7/20/2024, the Director of Nursing identified residents that were potentially impacted by this practice by completing body audits on all current residents with BIMS 12 or less and interviews of residents with BIMS 13 or higher. This was completed on 7/20/2024. The results included: No	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0638	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

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D 482	Continued From page 11	D 482		

other residents affected by alleged deficient practice. Additionally, on 7/23/2024, the Director of Nursing and Unit Managers completed ADL observations for 5 residents on each hall to ensure care was not being provided roughly, identify resident refusal of care and staff response to refusal of care. The observations identified no issues.

Systemic changes.

On 7/20/2024, the Director of Nursing began in servicing all full-time, part-time, and PRN (as needed) staff (including agency) on ABUSE policy and Dealing with Challenging Behaviors to include walking away and not touching resident if displaying aggressive behaviors. As of 7/23/2024, 10% of staff members have not attended the in-service. The Administrator and Director of Nurses will ensure that any of the above identified staff member (full time, part time, and prn including agency) who do not complete the in-service training by 07/23/2024 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility and agency orientation for all staff (full time, part time, and prn including agency) by the Director of Nurses. Investigation findings were reviewed in Quality Assurance Meeting on 7/25/2024 with no additional findings.

Quality Assurance.

Beginning the week of 7/29/2024, the Director of Nursing or designee will monitor ADL CARE CONCERNS related to use of restraints during care using the QA Tool for ADL care Observation. This will be completed weekly for 4 weeks and monthly for 2 months. Reports will be presented to the weekly QA committee by the Administrator

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D 482	Continued From page 12 or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. On 08/15/24 the facility plan of correction was validated. Nursing staff and other department interviews revealed that had received education on restraint and the abuse, neglect and exploitation policies and procedures. This training also included managing and working with residents who had difficult behaviors. Administrative staff interviews revealed they had completed the education for all staff and an interview with the staff revealed that they had been educated on the topic.	D 482		