STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews the facility failed to protect a resident (Resident #2) from verbal abuse from a staff member, for one of three residents reviewed for abuse. Findings included: Resident #2 was admitted to the facility on 9/19/18 with admission diagnoses which included: Generalized weakness, hemiplegia/hemiparesis (weakness/paralysis of one side of the body), lack of coordination, cognitive communication deficit (difficulty communicating), depression, and paranoid personality disorder. Resident #2's most recent Minimum Data Set (MDS) was a comprehensive admission assessment with an Assessment Reference Date	F 600	1. Corrective action has been accomplished for the alleged deficient practice in regard to F600 [483.12a(a)(1)]; facility failed to protect a resident (Resident #2) from verbal abuse from a staff member, for one of three residents reviewed for abuse. The staff member has been terminated as a result of the investigation. 2. Current facility residents have the potential to be affected by the alleged deficient practice. All current residents potentially could have been affected by the deficient practice. Director of Nursing/Nurse Management initiated in-servicing/education on	11/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/26/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 (ARD) of 9/26/18. The resident was coded as having had mild cognitive impairment. The resident had no behaviors coded for the assessment period. The resident was coded as requiring extensive or total assistance of one to two people for the following Activities of Daily Living (ADLs): bed mobility, transfer (i.e. from the bed to the chair), mobility both on and off of the unit, dressing, toilet use, personal hygiene, and bathing. The resident was coded as having had functional limitation in Range of Motion (ROM) on one side for both upper and lower extremities. Resident #2 had a care plan in place which was most recently revised on 10/31/18. The resident's care plan included the following focus areas: use of antipsychotic medication for paranoia, use of an antidepressant for depression, the diagnosis of having had a stroke, left shoulder pain, at risk for falls related to lack of coordination, paranoia, and weakness. In addition, the resident had focus areas: Resident required staff assistance with ADLs due to weakness, lack of coordination, stroke with left side hemiplegia and paralysis which a listed intervention was to provide assistance with dressing. A review of the Occupational Therapy (OT) Evaluation and Plan of Treatment for Resident #2 dated 9/19/18 was completed. The review revealed the resident had impaired Range of Motion (ROM) to the left upper extremity (her left shoulder and arm) and the resident was unable to move her left upper extremity on command. The resident was also documented as having been able to verbalize pain and the resident rated pain with movement to the left scapula (the shoulder bone) as a 9 on a 0-10 scale, with 0 being no pain	F 600	10/21/18 for all staff on the abuse policy with post test. All staff in-servicing was completed on 11/26/18 and going forward all new staff will be in-serviced at orientation. Safe surveys were conducted on all residents that had a Brief Interview for Mental Status score of 12 or higher to ensure no other residents were affected. No negative outcome occurred out of the surveys. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Executive Director/Director of Nursing Services/ Social Worker will audit five resident a day, five times a week for 4 weeks than five residents a day, three times a week for 4 weeks, then five residents a week for four weeks to ensure no verbal abuse. In servicing/education on Abuse policy will be completed on all new hires and agency personal during orientation and Annually for all staff. 4. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. 5. The Administrator will be the person responsible for implementing the	

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F 600	Continued From page 2 and 10 being intense pain. Further review revealed the resident required moderate assistance for upper body dressing. Review of the Assessment Summary Impressions revealed a clinical impression of the patient presents with increased need for caregiver assistance with ADLs and mobility with left sided hemiplegia. A review was completed of Resident #2's Progress Notes revealed a general nursing note dated 10/21/18 and timed 5:20 PM, written by Nurse #2. The note documented an allegation Resident #2 had made regarding Nursing Assistant (NA) #1. The note documented Resident #2 was alert and oriented to person, place, and situation. According to the note the resident alleged the NA had been verbally abusive to her while the NA was assisting her change her shirt. An interview was conducted with Resident #2 on 11/1/18 at 9:11 AM. The resident stated Nurse Aide (NA)#1 had been assisting her put a shirt on in the late morning of Sunday, October 21, 2018. The resident stated she had asked NA#1 to be more careful with her shirt when she had heard a sound like her shirt was going to tear. The NA responded to the resident that it did not matter because the shirt had come from a thrift store. The resident stated the NA's comment had caused her to feel like she was a lesser person. An interview was conducted with NA#1 on 11/1/18 at 10:54 AM. The NA stated the allegations which had been made against him were not true. The NA stated on 10/21/18 at about 11:00 AM he was assisting Resident #2 put on her shirt and she had complained about her arm hurting. The NA stated he had worked with	F 600	acceptable plan of correction. 6. Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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F 600	Continued From page 3	F 600		

Resident #2 in the past and had not had any problems. The NA further stated after the resident had complained about her arm hurting when he was assisting her with the shirt, he had apologized, he then finished getting the resident dressed and left the room. The NA stated he had not made any comments to the resident regarding the pain in her arm or about her clothes. The NA stated he was sent home and suspended on 10/21/18 due to the allegation. The NA stated he was later terminated due to the allegation.

An interview was conducted with Nurse #1 on 11/1/18 at 11:32 AM. The nurse stated she had entered Resident #2's room on 10/21/18 and the resident seemed disturbed and upset. The nurse said she asked the resident what was wrong, and the resident responded, she thought there were a lot of people who just do not need to do this kind of work. The resident further stated to the nurse, NA#1 was dressing the resident with a shirt and her shoulder was hurting. The resident stated the NA was tugging at her shirt and it started to make a sound like the shirt was going to tear and she had asked him to be careful. The resident told the nurse the NA responded to her, what difference does it make, the shirt was from a thrift store anyway. The resident told the nurse it had made her feel bad. The NA was removed from working on the floor and the nurse told the supervisor about the allegation.

A phone interview was conducted with Nurse #2 on 11/1/18 at 12:39 PM. Nurse #2 stated she was the weekend supervisor on 10/21/18. The nurse stated she interviewed Resident #2 on 10/21/18 immediately after becoming aware of the allegation made by Resident #2. During the

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F 600	Continued From page 4	F 600		

interview the nurse stated Resident #2 told her she felt she had not been treated right by a staff member. The resident proceeded to explain to the nurse NA#1 had been assisting her to put on a shirt, the shirt had started to make a sound like the shirt would tear and her shoulder was hurting. According to the resident the NA's response was you did not buy the shirt anyway and it had come from the shelter. The resident told the nurse the NA had told the resident, "Ain't shit wrong with you," regarding her complaints of her shoulder hurting. The resident proceeded to tell the nurse the NA had verbally abused her. The nurse stated she informed both the Director of Nursing (DON) and the Administrator via phone. The nurse stated she had interviewed NA#1 and he denied the allegation and provided a statement regarding his denial of the allegation. The nurse stated NA#1 was sent home and suspended pending the outcome of the investigation. The nurse further stated Resident #2's allegation remained consistent when she had revisited the resident later in the day.

A second interview was conducted with Resident #2 on 11/1/18 at 5:00 PM. The resident stated NA #1 had almost torn her shirt when he was dressing her. The resident explained the NA was pulling the shirt over her head and shoulders and it almost became torn, so she had asked him to be careful. The resident stated the NA responded it did not matter because the shirt had come from a shelter and she could buy another. The resident also stated her shoulder did hurt at the time, it was sore during the time of the interview, and it was sore all of the time. The resident stated her shoulder had hurt more when NA #1 was trying to dress her. The resident stated she told the NA her shoulder was hurting and the NA

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F 600	Continued From page 5 responded by saying, "Ain't shit wrong with you," and continued to hurt the resident's shoulder while putting the resident's shirt on. A review was completed of a written statement from Medical Records (MR), dated 10/22/18. The written statement documented the MR had spoke with Resident #2 on 10/22/18. The MR stated the resident had told her she had been receiving care from an NA on 10/21/18 and while the NA was putting a shirt on her the shirt made a sound like it would tear. The resident asked the NA to be careful and the NA responded she had received the shirt from a thrift store. The MR documented she had asked Resident #2 about her shoulder and the resident answered her shoulder was fine. Review of an investigation report faxed to the Complaint Intake and Health Care Personnel Investigations, dated 10/25/18, revealed the facility had submitted a 5-day report regarding the allegation of abuse made by Resident #2 by NA #1. The allegation details were Resident #2 alleged while NA #1 was changing her shirt he had made insulting comments and verbally abused the resident. The resident's emotional response was she stated she was verbally abused and was unhappy about what NA #1 had said to her about her clothing. Review of the Summary of the Facility Investigation revealed the resident's allegation was consistent throughout the investigation. The resident alleged NA#1 had made a comment about her clothes not having been hers and that her clothes were from a homeless shelter. The documented investigative actions from report were the allegation was substantiated, the accused employee (NA#2) was terminated on 10/25/18, and the termination was a result of the investigation.	F 600		

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F 600	Continued From page 6 An interview was conducted with NA #2 on 11/1/18 at 5:46 PM. The NA stated Resident #2 frequently complained of pain in her left shoulder. The NA stated the resident had complaints of pain in the left shoulder when attempting to dress or undress her, such as with a shirt, when repositioning the resident in bed, and when transferring her in the sling lift. The NA stated the resident had even complained of pain in her left shoulder at times when she was sitting in her chair and resting. The NA stated when the resident had complaints of pain in her shoulder she had informed the nurse regarding the resident's complaints of pain.	F 600		