STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CENTRAL CONTINUING CARE	**1287 NEWSOME STREET MOUNT AIRY, NC 27030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 12/05/23. Event ID # 3KLB11. The following intakes were investigated NC00209807, NC00208849, NC00210015, and NC00207721. One (1) of the 6 allegations resulted in deficiency.	F 000		
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 observations, record review, resident, staff, Psychiatric Nurse Practitioner, and Medical Director interviews the facility failed to protect a resident's right to be free from abuse when Resident #1 hit Resident #2 with a tissue box causing a very small cut to his left eyebrow with a bruise because Resident #2 was banging a tissue box on his bedside table. This affected 1 of 2 residents (Resident #1) reviewed for resident-to-resident abuse.	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/14/2023

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 The findings included: Resident #1 was readmitted to the facility on 05/06/23 with diagnoses that included: restlessness, agitation, anxiety, and cognitive communication deficit. A review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/07/23 revealed that Resident #1 was moderately cognitively impaired and had no signs of delirium and no behaviors, rejection of care, or wandering were noted. Review of 24-hour initial report dated 11/10/23 read in part, at 4:05 PM Resident #1 threw a tissue box at Resident #2 causing a laceration and discoloration to lateral left eye. Local law enforcement was notified as well as the state survey agency. The report was signed by the Director of Nursing (DON). At the time of the incident on 11/10/23 Resident #1 had no care plan in place for his restlessness or agitation. Resident #2 was admitted to the facility on 12/24/20 with diagnoses that included: hemiparesis following a stroke, major depressive disorder, anxiety, and cognitive communication deficit. Review of Resident #2's quarterly MDS dated 08/24/23 revealed that Resident #2 was cognitively intact and no behaviors, rejection of care, or wandering were noted during the assessment reference period. An observation and interview were conducted	F 600		

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with Resident #2 on 12/05/23 at 9:51 AM. Resident #2 was resting in a low bed with a fall mat to the right side of his bed. He was alert and verbal. His bedside table was next to his bed and contained a box of tissues. Resident #2 stated that he recalled the incident with Resident #1 that occurred on 11/10/23. He stated that he was banging his tissue box on the bedside table to get the staff's attention that he needed a "diaper" change. Resident #2 stated he could not get to his call bell, so he was using the tissue box to alert the staff of his needs and Resident #1 came over and hit me with the tissue box on my left eye. There was very light-yellow fading bruise still evident to Resident #2's left eyebrow area. Resident #2 stated that he had no pain at the time of the incident and still had no pain to the area and explained that he and Resident #1 had lived together for a while and never had issues before. He stated that Resident #1 had never hit him before and indicated that he was not scared of Resident #1, and he felt safe in the facility. He further explained that after the incident the facility moved Resident #1 to a different room, and he had not seen him since that day.

An observation and interview were conducted with Resident #1 on 12/05/23 at 10:00 AM. Resident #1 was resting on his bed and was dressed in pajama pants and white t-shirt. Resident #1 recalled the event that occurred on 11/10/23. He stated that Resident #2 was banging on his table, and "I hit him with the tissue box in the head because he was getting on my nerves." Resident #1 stated that he had lived with Resident #2 for some time, and they never had any issues but, on that day, "he just got on my nerves," he added that he had never hit anyone before the incident and had not hit anyone since

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the incident occurred. Resident #1 stated that they had not been arguing or anything that day but when Resident #2 began banging his table, "he just got on my nerves." Resident #1 stated that he was moved to this current room on the same day of the incident and did not have a roommate at the time.

The Social Worker was interviewed on 12/05/23 at 10:07 AM who stated that she recalled the event that occurred on 11/10/23 between Resident #1 and Resident #2. She stated that she was walking to her office when Nurse #1 called and stated that Resident #1 and Resident #2 were not getting along and were arguing. The Social Worker stated she told Nurse #1 she would be down there in just minute. The Social Worker stated maybe a minute or two later she went to the nurse's station where she saw Nurse Aide (NA) #1 talking to Nurse #1 and the Social Worker approached them and asked them what was going on as they proceeded to walk down the hallway towards Resident #1 and Resident #2's room. She stated that NA #1 stated that they were both calm at this point and were each in their own bed when she had gone to the nurse's station to tell Nurse #1 that Resident #1 and Resident #2 were not getting along. The Social Worker stated that when they reached the room, she asked Resident #1 what was going on and he replied that Resident #2 was getting on his nerves because he was banging a tissue box on his table. The privacy curtain was pulled so the Social Worker stated she pushed the curtain back to speak to Resident #2 and when she pulled the curtain back, she noted that Resident #2 had blood on his left eyebrow area. Resident #2 stated that Resident #1 had hit him. She added that she had NA #1 stay in the room while

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F 600	Continued From page 4 she went to get the DON. The Social Worker stated that she told the DON what had happened, and they proceeded back to the resident's room and on the way, they asked the Staff Development Coordinator to join them and they all 3 went to Resident #1 and Resident #2's room. When the 3 of them entered the room the Staff Development Coordinator went directly to Resident #2 and began administering first aid while she and the DON spoke with Resident #1. The Social Worker explained that the 2 residents had lived together for a while and never had any issues and Resident #1 was generally calm and pleasant and it was a "total" shock to the staff that he would hit someone. She further explained that they immediately moved Resident #1 to an empty room on the hall, but they quickly decided that because he was ambulatory, they did not want them on the same hall, so they chose to move Resident #2 to a different hall and put Resident #1 back in the original room. While the Staff Development Coordinator was administering first aid to Resident #2, she was able to calm him down and they asked him if he felt safe in the facility and if he was scared of Resident #1. She stated that Resident #2 denied being scared and stated he felt safe in the facility. She added that she continued to check on Resident #1 and Resident #2 often to ensure no further issues arose with either of them. The Staff Development Coordinator was interviewed on 12/05/23 at 10:24 AM who stated that she was asked by the DON on 11/10/23 to accompany her and the Social Worker to Resident #1 and Resident #2's room and was made aware of what had occurred. The Staff Development Coordinator stated that when she entered the room, she immediately went to	F 600		

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Resident #2 and began administering first aid and attempting to calm Resident #2 down. She stated that he was "flustered initially and used profanity" but as they talked about it Resident #2 calmed down and indicated he was not having any pain and felt safe in the facility. She added that she cleaned the area to Resident #2 left eyebrow area with normal saline and applied triple antibiotic ointment and covered it with dry dressing and the direct care staff initiated neurologic checks on Resident #2 and began every 15-minute checks on Resident #1. The Staff Development Coordinator indicated that following the incident she and the other administrative nurses did a lot of staff education on abuse and reporting and that all staff were required to have the education prior to the start of their next scheduled shift.

NA #2 was interviewed on 12/05/23 at 11:36 AM who stated that on 11/10/23 she was working the unit where Resident #1 and #2 resided. She stated that she was providing incontinent care in another room on the unit when she stepped out of that room to get something off the linen cart, and she heard Resident #2 yell you motherf .... and saw Resident #1 walking back to his side of the room and sat down on his bed. She explained that NA #1 was coming down the hall and was asked her to go in and check on Resident #1 and #2 while she finished providing care in the room, she was in.

NA #1 was interviewed on 12/05/23 at 3:18 PM who stated that she recalled the event that occurred on 11/10/23 between Resident #1 and #2. She stated that she heard Resident #2 banging his tissue box on his table which was his normal behavior even with his call bell directly in his reach he would bang on his table to get the

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F 600	Continued From page 6 staff's attention. NA #1 was headed to their room when NA #2 stepped out of another room to get something off the linen cart and asked me to go and check on Resident #1 and #2. She stated she entered their room, and both residents were in their beds and appeared calm. She stated that she asked Resident #2 what was wrong, and he said that Resident #1 had threatened to hit him, and NA #1 stated she asked Resident #1 if he had said that and he stated, "yes because he kept beating the table." NA #1 told Resident #1 that she was going to have to report that to the nurse and she left the room to go tell Nurse #1 about what had been said. She further stated that the Social Worker came to the desk, and they all began down the hallway back Resident #1 and #2's room. NA #1 stated that when they reached the room she did not go back in because she knew the Social Worker would talk to the residents in private. She stated a few minutes later the Social Worker came out and stated that Resident #1 had hit Resident #2 and he was bleeding, and the DON was immediately notified. NA #1 stated that Resident #1 and #2 had lived together for awhile and never had any issues like this before and it was very unlike Resident #1 to act out like that. NA #1 confirmed that she had received the packet of abuse training that the facility gave after the incident and was aware of the different types of abuse, who to report to, and the signs of potential abuse. Nurse #1 was interviewed on 12/05/23 at 3:27 PM who confirmed that she was working on 11/10/23 when the incident between Resident #1 and #2 occurred. Apparently Resident #1 had told Resident #2 that if he did not quite banging on his table, he was going to hit him. The NAs on the unit came to the desk to report what had been	F 600		

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F 600	Continued From page 7 said. Nurse #1 stated she picked up the phone and called the Social Worker and we walked back down the hallway. When she entered the room Resident #1 was sitting on his bed and Resident #2 was laying in his bed and he had a very small almost like a "paper cut" to his left eyebrow area and Resident #2 stated that Resident #1 had hit him with the tissue box. Nurse #1 stated that they immediately removed Resident #1 from the room and first aid was given to Resident #2 and got him calmed down. She further explained that this type of behavior was very uncharacteristic of Resident #1 and stated that the 2 residents had never had issues like this before. Resident #1 was placed on every 15-minute checks and neurologic checks were initiated on Resident #2. Nurse #1 confirmed that she had received the education on abuse following the event and was able to recite the types of abuse and who to report to and to always protect the resident first then alert your supervisor. The Psychiatric Nurse Practitioner (NP) was interviewed via phone on 12/05/23 at 3:53 who stated that she was asked to evaluate Resident #1 on her visit on 11/28/23 and was told of the incident that had occurred on 11/10/23. The NP stated that she had previously evaluated Resident #1 in the past and this type of behavior was very unusual for him. She stated that the 2 residents had roomed together for a while with no issues that she was aware of. The NP stated that when she saw Resident #1 on 11/28/23 he recalled the event on 11/10/23 and stated that Resident #2 was getting on his nerves and was keeping him awake at night banging on his table. During the conversation the NP stated that Resident #1 also mentioned another resident across the hallway that hollered all night and he reported he had told	F 600		

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her to shut up which again was very unusual for Resident #1. The NP stated that Resident #1 denied any depression or anxiety but since he had a change in behavior, she started him some Zoloft (antidepressant) to see if that would help keep him calm and pleasant.

The Medical Director (MD) was interviewed via phone on 12/05/23 at 4:30 PM who stated that the facility had made him aware of the incident that occurred on 11/10/23 between Resident #1 and #2. The MD stated that he was shocked when they told him because it was very uncharacteristic of Resident #1, he was generally quite with a flat affect and never got excited about anything. The MD stated that he evaluated Resident #1 on 11/13/23 and the exam revealed no acute findings, he added that during that visit Resident #1 spoke to him more than he ever had in the past. The MD also stated that he did not feel like Resident #1 posed a safety risk to himself or other residents.

The DON was interviewed on 12/05/23 at 4:30 PM who stated on 11/10/23 she was in her office when the Social Worker came and notified her that Resident #1 had hit Resident #2 and he was bleeding. The DON stated on her way down the hallway she asked the Staff Development Coordinator to come with them and assist as needed. When she entered the room, the DON stated she and the Social Worker began questioning Resident #1 on what had happened while the Staff Development Coordinator administered first aid to Resident #2. The DON stated that Resident #1 just stated that Resident #2 was banging on his table, and it was getting on his nerves and that was why had hit him with the tissue box. She stated that he was started on

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F 600	Continued From page 9 every 15 minute checks and moved to an empty room on the hall but ended up returning to the original room and Resident #2 was moved to different unit and neither resident had a roommate at this time. The DON stated that neurologic checks were initiated on Resident #2 and families were notified as was the MD. She stated that they placed both residents on the book to be evaluated by the MD and the Psychiatric NP on their next visits and began performing skin sweep on all residents and interviewing alert and oriented resident to ensure that no other abuse had occurred. She further stated all staff, and all residents were educated on the abuse policy and procedures and who to report to along with the different types of abuse including resident to resident abuse prior to their next scheduled shift and the education was included in the new hire packet. The DON stated that all residents were to receive a full skin assessment weekly times 4 weeks and random residents were interviewed about abuse weekly by the Social Worker and Activities staff. The Administrator was interviewed on 12/05/23 at 5:11 PM who stated that he was notified of the incident that occurred on 11/10/23 between Resident #1 and #2 and his first reaction was shock because this was so very uncharacteristic of Resident #1. He stated that the residents were separated, and Resident #1 placed on 15-minute checks, first aid was given to Resident #2, skin sweeps were done, all alert and oriented residents and staff were interviewed to identify if any other abuse had occurred. All staff were educated on abuse prior to the start of their next shift and all families were notified along with all regulatory agencies as well. The Administrator stated that the plan of correction was on the	F 600		

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F 600	Continued From page 10 agenda to be discussed in their next quality assurance meeting which was scheduled for 01/18/24. The facility provided the following plan of correction: DATE: 11-10-23 Occurrence: On 11-10-23, Resident #2 was beating his tissue box against his bedside table as part of his normal behavior. Resident #1 got up, grabbed the tissue box and hit resident #2 forcefully across the face. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " On 11-10-23 the Staff Development Nurse immediately assessed Resident # 2 for the cut to his left lateral eye and initiated cleaning and dressing to the area per facilities standing orders, at this time nuero checks were also initiated. " Resident # 2 was immediately moved to 300 hall and Resident # 1 resides in same room on 100 hall alone. Both residents now reside in a single occupancy room on 11-10-23. " Resident #1 was placed on Q15 minute checks on 11-10-23; 15 minute checks were continued until further evaluation from Medical Director. Law enforcement was immediately notified and a report was completed and filed by the responding officer. Surry County Department of Social Services were immediately notified and a report being filed. The facility Medical Director was immediately notified. Resident #1 and Resident #2 families were immediately notified. Resident #1 was immediately placed on facility psych and MD rounds and labs were also drawn per MD telephone order. Resident # 1 was	F 600		

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F 600	Continued From page 11 assessed on 11-13-23 by the Medical Director for any potential underlying issues as well as any potential need for continued monitoring. " Resident # 2 was assessed by the Medical Director for further evaluation of left eye laceration as well as resident's overall well-being with no areas of concerned noted. Both residents were placed on psychiatric rounds to assess for any underlying psychiatric issues on 11-10-23. These two Interdisciplinary Team Members (Medical Director and Psychiatric Physician) along with Social Work and both resident representatives will discuss findings before the consideration of potential roommates. " Education was immediately provided by the Director of Nursing with all 100 hall staff members. Education included, monitoring any type of aggression, 15 minute checks, and immediate reporting on 11-10-23. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " On 11-14-23, the Staff Development Nurse, Infection Preventionist, Nurse Scheduler, Wound Nurse, Registered Nurse Supervisor, and 300 Hall Nurse immediately completed skin assessments on all residents to determine if there were any injuries or suspicion of injury that could have been caused by resident to resident altercation . There were no new areas of concern noted. " On 11-14-23, interviews were completed by Social Worker, Activity Director, Medical Records Supervisor, and Minimum Data Set (MDS) Coordinator with all alert and oriented residents to determine if there any other resident to resident altercations have occurred that facility staff were not aware of. The interview questions included:	F 600		

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Is everyone treating you well?
Has anyone hurt you?
Has anyone ever said anything that hurt you or made you feel uncomfortable?
Do you feel safe?
Has your roommate or any other resident hurt you?
Has your roommate or any other resident said anything that upset you?
Are there any residents who live here that make you feel uncomfortable?
Do you know who to talk to if anyone makes you feel uncomfortable?

There were no new areas of concern noted.
" On 11-14-23, the Director of Nursing interviewed direct care staff to determine if there were any other potential resident to resident altercations. The question was: Do you have any concerns about any residents that may not always get along? There were no new areas of concern noted by any interviewed staff members.
-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
" On 11-10-23, members of the Interdisciplinary Team met to discuss mechanisms, policies, training of staff relative to resident to resident abuse and determined the following would continue and/or be implemented. The Administrator notified each of the staff listed below of their responsibilities (as listed).
" On 11-14-23, the Staff Development Nurse and/or her designee immediately began educating all staff including full-time, part time, and agency staff on the Abuse Policies and Procedures with an emphasis on (Resident to Resident Abuse). Highlights of this education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING ______ B. WING ______	C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

included: what were potential signs of resident to resident abuse, how to intervene if you witness resident to resident abuse, who to report any instances of resident to resident abuse to, to never leave a resident to resident altercation/abuse situation (to remain with the victimized resident/residents until the situation is completely resolved or the threat of harm is over), and the importance of reporting resident to resident abuse immediately. During this education, the Staff Development Nurse and/or her designee performed Question and Answer (Q&A) with staff to ensure understanding of all education provided.

" On 11-14-23, the Staff Development Nurse and/or her designee educated facility staff to observe residents for aggressive/inappropriate behavior towards other residents, family members, visitors, and/or staff members and to immediately report all occurrences to the Nurse Supervisor, Director of Nursing, or Administrator.

" On 11-14-23, all staff were given the Abuse Policy and Procedure and the facilities Abuse Reminders Sheet. Which includes: definitions associated with abuse, ways to prevent abuse, monitoring of residents for aggressive/inappropriate behavior, occurrences of such incidents being reported immediately, and remaining with the victimized resident/residents until the situation is completely resolved or the threat of harm is over. This is not an all-inclusive list of the Abuse Reminder Sheet.

" On 11-14-23, the Activity Director, Activity Assistants, and/or their designee immediately completed education with facility residents on the following:

Who to report any type of abuse instances/situations to.

How to report any type of abuse

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F 600	Continued From page 14 instances/situations. Education on how there will be no type of retaliation for reporting abuse. Education on how the facility will keep you protected during the entirety of the investigation. " All staff were required to sign educational rosters to validate they received the education. As outlined above (Abuse Policy and Procedure and the Abuse Reminders Sheet). " The Staff Development Nurse and/or her designee monitored and tracked which staff received education by running an employee roster and checking each staff member off when they received the education. All staff received the education on or before the beginning of their next shift. " Newly hired employees and agency staff will be educated on the Abuse Policy and Procedure during orientation. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. " The Director of Nursing and/or her designee will conduct weekly skin assessments x 4 weeks to determine if there are any injuries/areas suspicious of resident to resident altercations. An audit tool titled "Weekly Skin Assessments" was created to record the weekly results. Audits will be completed by 12-8-23. " The Social Worker and/or her designee will conduct resident interviews with all alert and oriented residents weekly x 4 weeks to determine if there has been any resident to resident altercations or other forms of abuse that have not been reported to facility staff. An audit tool titled "Resident Interviews" was created to record all weekly results. Weekly interviews will be completed by 12-8-23.	F 600		

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F 600	Continued From page 15 " The Staff Development Nurse and/or her designee will continue to do abuse education with all staff upon hire, annually, and at all mandatory general staff meetings on Abuse Policy and Procedures. Resident to Resident Abuse will be highlighted during continuous education. " The Director of Nursing and Social Worker will share results of the above audits in the Quality Assurance Performance Committee meetings where the information will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Compliance Date: 11-14-23 The plan of correction was validated onsite on 12/05/23. The validation included review of the initial assessment of Resident #2. The immediate separation of both residents, the 15-minute checks that were initiated for Resident #1 and the neurologic checks initiated for Resident #2. All skin checks were reviewed for completeness and all resident interviews were reviewed with no additional findings noted. The 24 hour and 5 working day report were sent to the State Survey agency and all regulatory agencies along with family and MD were notified of the incident. Staff interviews revealed that they had received recent education on abuse and were able to verbalize the procedure. Monitoring tools were reviewed and continued. Signature sheets were reviewed to confirm all staff were educated. The compliance date of 11/14/23 was validated.	F 600		