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WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

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F 000	INITIAL COMMENTS An unannounced on-site complaint survey was conducted from 12/7/23 through 12/8/23. The team conducted offsite review from 12/11/23 through 12/14/23 for a partial extended survey. The survey team returned on 12/14/23 to validate the corrective action plan. Therefore, the exit date was changed to 12/14/23. Event ID# ELNH11. The following intake was investigated NC00210540. One (1) of 1 allegation resulted in immediate jeopardy. Past noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. A partial extended survey was conducted.	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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		

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

Electronically Signed | 01/12/2024

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, staff, Psychiatric Nurse Practitioner and Law Enforcement interviews the facility failed to protect a resident's right to be free from physical abuse when Nurse Aide (NA) #1 and NA #2 forcefully turned Resident #1 causing her forehead and left knee to hit the wall. The two NAs continued to provide incontinence care after the resident yelled and screamed for them to stop. Resident #1 reported she no longer felt safe when new staff came in to provide care to her. One of three sampled residents were affected by the deficient practice (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/30/23. The Resident was discharged to the hospital on 11/20/23 and readmitted to the facility on 11/27/23. She was admitted with diagnoses that included acute cystitis, unspecified dementia without behavioral disturbances, fibromyalgia, lack of coordination, muscle weakness, chronic pain syndrome and osteoarthritis. Resident #1's care plan dated 09/03/23 revealed no focused area, goals, or interventions for behaviors such as resistance to care or physical or verbal aggression. The care plan included the focused area of care for an activities of daily living self-care performance deficit with interventions to include the Resident required extensive to total assistance by 1-2 staff for toileting needs. No intervention for brief size or color preference was noted.	F 600	Past noncompliance: no plan of correction required.	

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A review of the physician's orders dated 11/28/23 revealed when Resident #1 returned from a stay in the hospital on 11/27/23 she was prescribed the blood thinner, Apixaban 5 milligrams 1 tablet daily, for deep vein thrombosis prevention.

Resident #1's skin assessment dated 11/28/23 revealed a body chart marked with greenish bruising to the left antecubital area (front of the elbow), purple bruising on the left knee, yellow bruising on her ankle, purple bruising on both wrists, yellow bruising on left forearm, and greenish/yellow bruising to back of upper right arm. Also noted were small, open areas on each buttock.

A quarterly Minimum Data Set (MDS) dated 12/01/23 indicated Resident #1 was cognitively intact. She required substantial/maximal assistance for bed mobility, toileting, and personal hygiene. The assessment indicated Resident #1 was frequently incontinent of bowel and bladder. The assessment further indicated Resident #1 had no behaviors such as resistive to care or physical or verbal aggression, hallucinations, or delusions.

On 12/07/23 at 7:45 AM an interview with Resident #1 revealed on 12/01/23 at approximately 11:30 PM, NA #1 and NA #2 entered her room to provide incontinence care after she pressed her call bell. She stated she needed to be changed because she had been incontinent of urine only. She stated she did not have a bowel movement. She stated the NAs brought a yellow brief (extra-large) with them and Resident #1 informed them she wore blue briefs (large). She stated she told them her blue briefs

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were in her top drawer, but they refused to get one from the drawer. She stated the NAs said they were not going to look in her drawer. Resident #1 stated NA #1 said, "You will wear what I want you to wear". She said she told the NAs to just leave her wet and go on their way. They refused, saying they could not leave her wet and insisted she be changed. Resident #1 stated NA #1 was positioned at her legs and NA #2 was positioned at her shoulders. NA #2 proceeded to forcefully turn her in the bed, causing her head and left knee to hit the wall. She stated she yelled and screamed for them to stop because she did not want to wear the yellow brief and they were hurting her. Resident #1 stated they would not stop when she asked. She stated she kept screaming and yelling for them to stop. Resident #1 stated they finally rolled her back over and forcefully pulled the brief up between her legs. They turned off the light, left and closed the door. Resident #1 stated she called her family member and told her what happened, and her family member called the Administrator and informed her of the incident. She further stated she doesn't feel safe anymore when new staff come in to provide care to her. She stated incontinence care for her was usually provided by only one NA.

An observation on 12/07/23 at 7:45 AM of the room revealed Resident #1's bed was on the right side of the room, lengthwise along the wall, with the head of the bed at the doorway entrance. A curtain separated the beds of Resident #1 and Resident #2. Resident #2's bed was 3-4 feet crosswise with the head of her bed at a 90° angle to the foot of and approximately 3- 4 feet away from the foot of Resident #1's bed.

In a follow-up interview with Resident #1 on

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12/07/23 at 1:10 PM she stated she did not recall a third NA being in the room. She stated she never heard anyone mention NA #3's name while they were in her room. Resident #1 became tearful and stated while in therapy the Social Worker (SW) and another administrative person came to the therapy room and said they wanted to measure her to see if her brief fit her correctly. She stated they informed her none of this would have happened if she had been wearing the right brief. Resident #1 said she knew they meant to put her in yellow briefs even though she said she explained to them she doesn't like the yellow briefs because they bunched up between her legs, they were bulky, and they allowed urine to leak through.

On 12/07/23 at 5:50 PM during a phone interview with NA #1 she revealed she was in the hallway charting at the kiosk when NA #2 went to answer a call light for Resident #1. She stated NA #2 came and got her to assist her to turn the Resident with the draw pad. She stated the Resident requested a certain brief they were out of at the time. NA #1 stated she told her they were out of that color. NA #1 added she told Resident #1 they needed to change her because she had had a bowel movement. NA #1 stated they provided incontinence care and put a yellow brief on the Resident. NA #1 explained they slid the yellow brief under Resident #1 and left the room to get the nurse because the Resident was screaming loudly. NA #1 stated she was in Resident #1's room with NA #2 and NA #3. The nurse aide stated the resident was just screaming, she did not say any words just made sounds. NA #1 stated they continued to put the yellow brief on Resident #1 after Resident # 1 told her to stop because she could not leave her in a

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soiled brief.

On 12/07/23 at 5:38 PM a phone interview was conducted with NA #2. NA #2 stated Resident #1 rang her call bell and she went into the room to change her. She stated Resident #2 was out of blue briefs. She stated she told the Resident and that the blue briefs were too small. She stated she told the resident she would have to use a yellow brief. NA #2 stated when she turned Resident #1 over with the draw pad the Resident started screaming. NA #2 stated they cleaned Resident #1 up quickly and left the room. NA #2 stated Resident #1 kept screaming about the yellow brief. NA #2 added Resident #1 screamed "Stop, I don't want the yellow brief". NA #2 stated at that point she stopped and went in the hallway to get NA #1 because they usually worked together. She stated NA #3 was in the room with her when she went to get NA #1. She stated NA #3 was there to observe. NA #2 explained she was at Resident #1's shoulder and NA #1 came and helped turn the Resident over to change her. NA #2 said the resident didn't refuse to be changed, it was just all about the brief. NA #2 stated they continued to put the yellow brief on Resident #1 after Resident #1 told her to stop because she could not leave her in a soiled brief.

On 12/07/23 at 6:01 PM a phone interview was conducted with NA #3, and she stated NA #1 asked her for assistance to provide incontinence care to Resident #1. She stated she was in the room with NA #1 and NA #2. NA #3 stated when she got in the room, NA #1 and NA #2 were cleaning the Resident. She stated the Resident was "fussing" about the brief. NA #3 stated the Resident said she always wore a blue brief not the yellow ones. NA #3 stated Resident #1 was

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screaming "Leave me alone" and kept screaming she only wore blue briefs. She stated she tried to calm and comfort Resident #1. After the incident, NA #3 stated she went back in Resident #1's room and offered to change her into a blue brief. She stated the Resident declined because she was still upset. She offered to change her from the yellow brief to the blue brief because she saw how much it had upset the resident. NA #3 said when she went back later, and the Resident did allow her to change her to a blue brief. When asked why she didn't intervene, NA #3 stated she planned to go back to Resident #1 after NA #1 and NA #2 left to put a blue brief on her and help her calm down.

On 12/07/23 at 9:18 AM an interview was conducted with Resident #1's roommate (Resident # 2). Resident #2 was cognitively intact. Resident #2 stated two NAs had a yellow brief with them when they came into the room and pulled the curtain. Resident #1 told them she didn't wear a yellow brief; she wore blue ones. Resident #2 stated one of the NAs said something to the effect of you are going to wear these ones now. She stated she heard Resident #1 screaming, "No". Resident #2 said she could see between the curtain and the wall and saw the NAs "slam" Resident #1 into the wall roughly. She stated that was all she could see but she heard Resident #1 screaming a lot. Resident #2 said she went to the door and called out for help for Resident #1. Resident #2 added the two NAs came and stood at the door laughing and listening to the conversation between Nurse #1 and Resident #1. Resident #2 stated she had never witnessed any NAs behave in such a manner in the two years she had been a resident in the facility. She said she had not seen anyone

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as rude or hateful as the two NAs. Resident #2 stated to her knowledge there were only two NAs, NA #1, and NA #2, in the room providing care to Resident #1.

On 12/08/23 at 9:40 AM a telephone interview was conducted with Resident #1's Family Member who was her Responsible Person (RP). The Family Member stated her mother called her on Friday night, 12/01/23 at 11:22 PM. She stated her mother's exact words were, "[NA #1 and NA#2] manhandled me". She stated they made her hit her head on the wall. She stated her mother told her she yelled for help, and no one came to help her. She stated her mother said NA #1 and NA #2 told her she was going to do as they said. The Family Member stated her mother said she told them no and she asked them to stop. The Family Member said her mother said NA #1 and NA #2 insisted she put on a yellow brief. The Family Member stated her mother always wore a blue brief until this occurred. She said NA #1 and NA #2 put the yellow brief on her and didn't tape the brief on, turned off the light, left the room, and closed the door. The Family Member stated she called the Administrator on her cell phone. The Family Member stated she told the Administrator what had happened and didn't want NA #1 and NA #2 back in her mother's room. The Family Member stated she told the Administrator exactly what her mother said that NA #1 and NA #2 had manhandled her and put a yellow diaper on her and pushed her head against the wall. The Family Member stated she had not talked to the Administrator again until 12/07/23, when the Administrator called her with the Director of Nursing [DON] on the line with her. She stated the Administrator apologized for not communicating sooner with her. The Family

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Member stated the Administrator told her that she knew exactly how things happened because there were three NAs in the room not two. The Family Member stated that the Administrator told her there was another NA in the Resident's room who saw and heard everything. The Family Member stated, "so now my Mama is the one who is combative, and all her bruises are from the hospital." The Family Member stated that she told the Administrator and DON it was hard to believe there were three NAs in her mother's room because she could hardly ever even get one in there when she pressed her call bell. The Family Member stated this was the first time she had ever received a report that her mother was combative with staff. She stated she had never reviewed a care plan which included a plan for combative behavior. The Family Member stated her mother told her she was measured in therapy yesterday, 12/07/23, to determine her brief size. The Family Member stated her mother told her the Social Worker (SW) and another staff told her none of this would have happened if she had been wearing the right brief. She stated the SW called her on 12/07/23 and told her she needed to talk to her mother (Resident #1) about wearing a yellow brief. The Family Member stated the SW worker said her mother had it in her head that she needed the blue brief. The Family Member stated her mother preferred the blue brief because it didn't bunch up between her legs and it did not leak. The Family Member stated she felt it should be her mother's choice. She stated her mother had never been combative. The Family Member stated when she visited her mother on 12/02/23 at about 7:00 AM the day shift nurse, Nurse #3, told her she called the police and reported the incident. The Family Member stated Nurse #3 said the events from the previous night on

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12/01/23 had not been reported to her. The Family Member said she asked Nurse #3 to help roll Resident #1 over so she could look at her and she herself took pictures of her mother's bruises.

A phone interview with Nurse #1 on 12/08/23 at 10:16 AM. Nurse #1 stated, on Friday 12/01/23, NA #1 and NA #2 came to her and told her Resident #1 was upset. She stated she went to assess the resident and Resident #1 told her she was upset and angry because the NAs had put a yellow brief on her instead of a blue brief. Nurse #1 stated the Resident was irritated and didn't want NA #1 and NA #2 back in her room. She stated she told the resident she was sorry they upset her and didn't do as she requested. Nurse #1 stated she told the Resident she would talk to them about it and switch their assignments, and they should never come in her room again. She stated she did not observe any bruises or red marks when she assessed the Resident. She stated the Resident said she told the NAs not to put a yellow brief on her, but they did it anyway. Nurse #1 said she asked Resident #1 if she was okay and the Resident said she was mad about the brief. Nurse #1 stated she reassigned NA #1 and NA #2 to another hall. Nurse #1 stated she told NA #3 to change the resident to a blue brief the next time the resident needed changed. She stated NA #3 went back in later and offered to change the resident, but she declined because she was still upset. Nurse #1 stated the Resident never said anything about the NAs being rough or abusive. Nurse #1 stated she checked on the Resident hourly throughout the night and the Resident slept without any issues. She stated the Resident eventually did allow NA #3 to change her during the next rounds.

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A phone witness statement was given by Nurse #1 to the DON on 12/07/23, untimed. The statement related to the accusation of abuse that was reported on December 2, 2023. The statement read, NA #1 and NA #2 told her Resident #1 was mad because they had put a yellow brief on her instead of a blue brief. The statement revealed Nurse #1 asked if Resident #1 was okay and the NAs told her "Yes". Nurse #1 told the NAs she had changed their assignment and Resident #1 was ok with the change. She said she then asked Resident #2 if she had heard or seen anything, and Resident #2 stated "I haven't heard or seen anything because my curtain was pulled". Nurse #1 stated in the phone statement NA #3 went into the room and offered to place a blue brief on Resident #1 and she stated, "I'm ok, get out, I will be fine". Nurse #1 stated in her phone witness statement she checked on Resident #1 four more times, and she was asleep.

The phone witness statement given by Nurse #1 to the Administrator on 12/07/23 at 8:00 PM revealed Nurse #1 stated she told Resident #1 the assignments had been changed and asked her if she was okay and she said, "Yes, I am just mad." When Nurse #1 asked her why she was mad, she said, "Because I told them that I wanted a blue brief and they put a yellow one on me." The phone statement revealed Nurse #1 asked Resident #1 if she would feel better if they changed her into a blue brief and she said, "No, I am fine for now, but I am glad that they will not be back in my room. [NA #3] already offered to change me, I'm okay." Nurse #1 said Resident #1 told her she had talked to her family member and felt better. In her phone statement, Nurse #1 stated on her rounds during the night she went in

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Resident #1's room four times and she was sleeping.

In a phone witness statement given by Nurse #1 to the Administrator and DON on 12/07/23 at 8:00 PM Nurse #1 stated on 12/01/23 between 11:50 PM and midnight, she was informed that Resident #1 did not want NA #1 and NA #2 to work with her, so the assignments were changed. She stated she went to Resident #1 to let her know the assignments were changed. She said, Resident #1 said, "Good."

A review of Nurse #3's witness statement written on 12/02/23 revealed Nurse #3 assessed Resident #1 during the morning medication pass. Resident #1 stated her left shoulder hurt because NA #1 and NA #2 had been extremely rough with her the previous night. Resident #1 told Nurse #3 the NAs forced the wrong brief on her and pushed her into the wall. Bruising was noted to the left kneecap and small round marks noted to left arm and wrist. Resident #1 stated she hit her head and shoulder against the wall. Nurse #3's statement revealed she notified the Resident's RP who directly called the Administrator. Nurse #3 stated she immediately contacted the Administrator who notified both the DON and the ADON. The witness statement revealed the County Sheriff's Department was also notified and they went to the facility and took statements.

An interview was conducted on 12/08/23 at 10:55 AM with Nurse #3. Nurse #3 stated when she came in the morning of 12/02/23 she did not receive report of any concern from night shift regarding Resident #1. She stated when she went to give Resident #1 her medications and take vital signs, she noticed the Resident was upset and

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asked her what was wrong. Nurse #3 said the Resident told her two girl NAs were rough with her. She said the Resident told her the NAs put the wrong color brief on her. Nurse #3 stated the Resident said when they rolled her, they were very aggressive, and her head and knee hit the wall. Nurse #3 stated the Resident started pointing out bruises. She stated the Resident had several small bruises and discolorations on her forearms that were not phlebotomy or Intravenous (IV) sticks from the hospital. She stated these bruises were small, circular, dime-sized and she had a noticeable bruise on her inner left knee. Nurse #3 stated after she assessed Resident #1, she reported Resident #1's allegation to the Administrator. She stated the DON instructed her to call the police and report suspected abuse. She stated she called the police as instructed. She stated when the Assistant Director of Nursing [ADON] arrived she collaborated with her on the report. She stated the ADON notified the medical provider and completed the investigation. Nurse #3 stated the police arrived about the same time as the Resident's son and took everyone's info and took Resident #1's statement. Nurse #3 stated when the Resident's Family Member (RP) arrived she assessed her mother head-to-toe and took pictures. Nurse #3 stated she assisted the Family Member with assessing her mother and pointed out the small bruises on her arm and leg. Nurse #3 stated the bruises were there, but she did not imply to the Resident's Family Member how they got there.

On 12/07/23 at 1:22 PM an interview was conducted with NA #5. She stated she was familiar with Resident #1. She further stated she was able to change her brief and provide care for

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Resident #1 by herself. She said she had never needed two or more people to care for Resident #1. She stated Resident #1 preferred the blue briefs. She added she could not recall a time when the resident was combative or refused care.

In an interview with NA #4 on 12/07/23 at 1:25 PM she revealed she had worked at the facility for about one year. She stated she did not use two people to provide incontinence care for the Resident #1. She further stated she had never had to use three people with Resident #1. She said she had not observed Resident #1 refuse care or be combative. She stated Resident #1 used blue briefs.

On 12/11/23 at 9:05 an interview was conducted with the County Detective in charge of Resident #1's case. He stated he was still in the process of investigating the allegation. He revealed the initial police report was filed on 12/02/23 and the investigation was ongoing.

A late entry progress note entered by the ADON on 12/07/23 at 8:01 AM revealed she performed a skin assessment on Resident # 1 on 12/02/23 at 12:49 PM. The note revealed upon full body assessment, there was a small area of discoloration to the left knee. Three small areas of discoloration noted to the left forearm, very light yellow in color, and old in appearance. The progress note read the Resident pointed to an area on her right forehead and stated, "that is where my head hit the wall". The progress note revealed upon inspection of the area, there was no raised area, redness, bruising, abrasions, or other evidence of recent trauma present. Scattered bruising to bilateral hands. The note added the Resident stated those bruises were

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from IV sites.

Review of the witness statement written by the ADON on 12/02/23 revealed she was contacted by the Director of Nursing at approximately 11:30 AM regarding an incident reported by Resident #1. She obtained a statement from Resident #1 who had notified the day shift nurse of an issue with the night shift CNAs. After obtaining her statement, the ADON wrote that she completed a full body assessment to identify any skin issues. Her written assessment revealed there were scattered bruises noted to both hands. When questioned about the bruises, Resident #1 stated those bruises were from the IVs and needle sticks during her recent hospitalization. There was a half-dollar sized bruise noted to her right wrist. Resident #1 stated that bruise was also from an IV previously placed there. Resident #1 pointed out an area on right forehead and stated, "this is where they slammed my head against the wall". The ADON wrote she was unable to identify any abnormalities to the area. There was no redness, bruising, swelling, raised areas, or other discoloration indicating any trauma. The written statement read Resident #1 then held up her left arm and stated, "you can see the fingerprints here". The ADON statement read, upon inspection of area, there were three small areas of discoloration, very dull yellow in color and the areas appeared older in age. She wrote Resident #1 denied pain to area. The only other area noted was a small area of discoloration on the left knee. No other skin issues were identified. The ADON's written statement further revealed she observed no signs of recent trauma.

In an interview on 12/07/23 at 4:00 PM with the ADON she revealed on 12/02/23 she took

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statements from NA #1, NA #2, NA #3, and Resident #1. When asked if she interviewed the Roommate, she stated no. The ADON stated Resident #1 told her that the roommate turned on the light and opened the door, but the ADON said the Roommate did not tell her she did so. The ADON said the roommate told her that the Resident was upset but that she did not see anything. The ADON stated that during her interview with Resident #1, the Roommate got back in bed and faced the wall like she did not want to get involved. The ADON revealed Resident #1 said she didn't want to get anyone in trouble, but NA #1 had been rough with her. The ADON stated the resident kept going on and on about the brief. She stated the NAs told her they had to use the yellow brief. The ADON said NA #2 said they explained to the resident that the blue briefs wouldn't fit her. The ADON said Resident #1 told her that NA #1 and NA #2 said she was going to have to do what they said do. The ADON stated Resident #1 told her the two nurse aides rolled her over and hit her knee against the wall and slammed her head against the wall. The ADON said she assessed Resident #1 and there was no trauma to her right forehead. The ADON said she did a full body audit and asked Resident #1 about the needlestick bruises. She said she saw discoloration on the left knee. The ADON stated the resident wanted her to check the bruises on her arm. The ADON said she observed very light yellowed old bruises. The ADON added the resident informed her that some of the bruises were caused by intravenous fluid administration and blood draws that were performed in the hospital. The ADON stated that NA #2 told her that she had worked with Resident #1 before, and she had been pleasant. The ADON stated that on 12/01/23 NA #2 said the

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resident was very agitated when she first went in the room. The ADON said NA #2 told the resident she was going to change her because the resident said she was wet. The ADON said NA #2 told her she went and got a yellow brief and when she returned Resident #1 became more agitated because NA #2 had a yellow brief in her hand. The ADON said NA #2 told her Resident #1 started yelling about wearing a blue brief not a yellow brief. NA #2 told the ADON that she explained to the Resident that the blue brief would not fit around her hips. The ADON stated NA #2 said the resident told her she was only a little wet and she didn't have to change her. At that time NA #2 explained to Resident #2 once they knew a resident was wet, they had to go ahead and change them to prevent skin breakdown. The ADON said NA #2 told her the Resident calmed down and became agreeable to being changed. The ADON said NA #2 told her she stepped out and went to get her NA #1 to help change Resident #1. The ADON said NA #2 told her when they got back to the room and started to change the Resident, she saw the yellow brief and started refusing again. The ADON said NA #2 said she saw the resident had had a large bowel movement. The ADON stated NA #2 said when the Resident looked back over her shoulder, she saw the yellow brief and began pushing against the wall to keep them from putting the yellow brief under her. The ADON stated that NA #2 told her that NA #3 was in the room and explained to the Resident that they were trying to get her clean and she needed to stop pushing against the wall. The ADON said the NAs told her they were not able to get Resident #1 completely clean, so they pulled the brief up but didn't attach the sides and left to give her time to calm down.

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An interview with the Director of Nursing (DON) was conducted on 12/07/23 at 12:44 PM. The DON stated she did not make assignment sheets for night shift. She stated when night shift staff arrived the nurse on the hall assigned them to a set of rooms on each hall. She stated on 12/01/23 NA #1 and NA #2 were assigned to the hall on which Resident #1 resided. She explained NA #3 was assigned to a different hall but had been asked by NA #1 and NA #2 to assist with incontinence care for Resident #1.

On 12/07/23 at 1:30 PM an interview was conducted with the Psychiatric Mental Health Nurse Practitioner (PMHNP). The PMHNP stated he was familiar with the resident. He further stated he had not seen her since July when she went to the hospital. He stated when she came back from the hospital, she had not been picked up by him. He stated when he saw her today, he had come into the room to see her roommate. He said after speaking with Resident #1 he was going to reactivate her or pick her back up for services because she was upset and anxious during his conversation with her earlier in the day.

In a second interview with the DON on 12/07/23 at 2:02 PM she stated when Resident #1 got upset, she became fixated on whatever upset her and would not let it go. She further stated the resident would continuously talk about whatever upset her and stayed worked up about small issues. She explained there were three NAs in the room the night of 12/01/23 because NA #1 was still orienting. The DON stated NA #1 was not a new NA, but she was slower about picking up on things and needed more guidance. She stated NA #1 worked with NA #2. The DON stated

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that NA #3 was assigned to another hall but was helping on that hall that night. The DON stated NA #1 and NA #3 had informed her when they turned Resident #1 over, she had feces on her. The DON stated NA #1 and NA #3 told her when the resident saw the yellow brief, she got mad and started swinging and became combative. She stated that the NAs told her they wanted to leave Resident #1 safe but had to get the feces off her. The DON explained NAs are trained to leave a resident when they are combative, but they had to leave her safe.

In an interview on 12/07/23 at 3:43 PM with the Administrator and the DON, the Administrator revealed the incident occurred on 12/01/23 at approximately 11:20 PM to 11:30 PM. She stated Resident #1's Family Member called her and said she didn't want NA #1 and NA #2 in her mother's room because her mother was upset about the brief. The Administrator stated she called the DON at 11:40 PM and told her to move [NA #1 and NA #2] because they had put a yellow brief on the resident and that's not what the Resident preferred. The DON stated they moved NA #1 and NA #2 because they thought it would lessen Resident #1's anxiety so she could rest. The DON stated she tried to call Nurse #1's cell phone. Nurse #1 did not answer so Nurse #2 was called. Nurse #1 was the nurse assigned to Resident #1's hall. The DON stated when Nurse #2 went to Resident #1's room she heard the resident yell, "Get out". When asked again why there were three NAs in the room, the DON stated NA #3 assisted NA #1 and NA #2 to turn the resident. When asked if it was necessary for three NAs to provide incontinence care for Resident #1, the DON stated sometimes.

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On 12/07/23 at 5:00 PM an interview was conducted with the Administrator. Present during the interview were the ADON, the DON, and the Admissions Coordinator. The Administrator stated she didn't think the NAs intentionally abused Resident #1, but they did violate her rights. The Administrator stated the NAs should have left the room when the Resident told them to leave her alone. The Administrator stated she would have explained to Resident #1 what was in her best interest and then she would have put the brief of her preference on her. The Administrator stated, as a nurse we know we always want what is in the best interest of the resident, but we must take into consideration their rights, wishes, and preferences. All staff mentioned above stated they agreed with the Administrator's statement that Resident #1's choice of brief color/size should have been honored and NA #1 and NA #2 should have left the room when Resident #1 told them to leave her alone.

The Administrator was notified of immediate jeopardy on 12/08/23 at 4:45 PM.

The facility provided the following corrective action plan with a completion date of 12/07/23.

Immediate Action:
NA #1 and NA #2 were suspended on 12/2/23. Resident #1 was immediately informed that NA #1 and NA #2 would no longer be working with her. Night shift RN on duty 12-2-23, emotionally assessed Resident #1 when informed that she was mad. Night shift RN checked on Res. #1 throughout the night. The RN Charge nurse completed a skin check on 12-2-23 @ 11:10 am. The Director of Nursing performed a skin check on 12-2-23 @ 11:45 am of Resident #1. These

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skin checks were compared to the readmission skin assessment performed by Unit Manager on 11/28/23 at 9:30 am
Identification of other Residents:
Skin sweeps were completed on all residents with a BIMS 8 or less by the Assistant Director of Nursing on 12-2-23 between 1 and 3 pm. The Social Worker interviewed all residents with a BIMS of 9 or more to identify if there were any other abuse noted. The Social Worker interviewed staff regarding any other knowledge of identified abuse on 12-2-23, 12-3-23 and 12-4-23. An audit was completed by the Social Workers on 12/3/23 at 5 pm to identify any other residents at risk for physical abuse or violations of their residents' rights.
Systemic Changes:
The Executive Director, the Director of Nursing and/or the RN Educator educated the staff across all departments on identifying abuse and neglect, reporting abuse & neglect, understanding the residents' rights & adhering to resident's preferences & choices, and behavior management beginning 12/2/23 with completion on 12/6/23. All staff will be educated prior to the next scheduled shift. All newly hired staff members will receive this education in orientation.
Quality Assurance:
An ADHOC Quality Assurance Performance Improvement Committee was held on 12/6/23, at 12 noon, to formulate and approve a plan of correction for the deficient practice. The Executive Director will be responsible for the completion of the corrective action plan. The Executive Director, The Director of Nursing, The Assistant Director of Nursing, The Unit Managers, the Social Worker, the Discharge Planner, The MDS Director will complete audits by observations and interviews of 10 random

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residents, across both shifts 5 times a week for 8 weeks, then 3 times a week for 4 weeks, then weekly for 8 weeks. The Executive Director, The Director of Nursing, The Assistant Director of Nursing, The Unit Managers, the Social Worker, the Discharge Planner, The MDS Director will complete audits by observations of care and interviews of 4 random staff members 5 times a week for 8 weeks, then 3 times a week for 4 weeks, then weekly for 8 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.

Completion dated 12/07/2023.

The past noncompliance was validated on 12/11/23 when staff interviews revealed that they had received recent education on the Abuse policy and procedures and resident rights to be free from mistreatment. The education included the staff need to stop providing care if a resident request they stop.

Facility documentation revealed staff were trained on the following topics: Abuse policy and procedures, resident's rights education, and interviewing for abuse or mistreatment. Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Newly hired staff received an in-service packet prior to working and this was verified by the facility trainers and added to the orientation checklist.

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F 600	Continued From page 22 The deficiency was corrected on 12/07/2023.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and submit an Initial Report within 2 hours to the state regulatory agency for staff to resident abuse (Resident #1)	F 609	1. The initial report was sent on 12/2/23. 2. All facility-initiated reports from 6/2/23 forward were audited by the Regional	1/5/24

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F 609	Continued From page 23 for 1 of 3 residents reviewed in facility reported incidents. Findings included: Resident #1was admitted to the facility on 01/30/23 from an acute healthcare facility with diagnoses which included acute cystitis, unspecified dementia without behavioral disturbances, fibromyalgia, lack of coordination, muscle weakness, chronic pain syndrome and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated 12/01/23 revealed Resident #1 was cognitively intact for daily decision making. Resident #1 required extensive to total assistance by 1-2 staff for toileting needs. On 12/08/23 at 9:40 AM a telephone interview was conducted with Resident #1's Family Member who is her Responsible Person (RP). The Family Member stated her mother called her on Friday night, 12/01/23, at 11:22 PM. She stated Resident #1's exact words were "[NA #1 and NA#2] manhandled me". She stated they made her hit her head on the wall. She stated Resident #1 told her she yelled for help, and no one came to help her. She stated Resident #1 said NA #1 and NA #2 told her she was going to do as they said. The Family Member stated Resident #1 said she told them no and she asked them to stop. The Family Member said Resident #1 said NA #1 and NA #2 insisted she put on a yellow diaper. The Family Member stated Resident #1 always wore a blue brief until this occurred. The Family Member stated she called the Administrator at approximately 11:30PM on her cell phone. The Family Member stated she	F 609	Director of Clinical Services, the Executive Director, the Director of Nursing and the Social Worker on 1/3/24. 3. On 1/4/24, the Regional Director of Clinical Services educated the Executive Director, the Director of Nursing, the Assistant Director of Nursing, the Social Worker and the Assistant Social Worker regarding investigative measures for timely identification and reporting of abuse. The same education will be provided to any newly hired Executive Director, Director of Nursing, Assistant Director of Nursing, Social Worker or Social Worker Assistant during the orientation process. 4. On 1/4/24 a monitor was put into place that will be completed by the Executive Director or by the Director of Nursing in the absence of the Executive Director. This monitor will be completed weekly for 3 months and then monthly for 3 months. The results of this monitoring will be presented to the Quality Assurance Performance Improvement Committee at each meeting for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

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F 609	Continued From page 24	F 609		

told the Administrator what had happened and didn't want NA #1 and NA #2 back in her mother's room. The Family Member stated she told the Administrator exactly what her mother said that NA #1 and NA #2 had manhandled her and put a yellow diaper on her and pushed her head against the wall.

A review of the initial report revealed on 12/02/23 at 11:30 AM the facility was made aware Resident #1 alleged she had been treated roughly by two NAs on 12/01/23 at approximately 11:00 PM. The Initial Report alleged abuse and injury of unknown origin. The details of physical harm included bruising to the left inner knee, and left forearm with fingerprint pattern.

In an interview on 12/07/23 at 4:00 PM with the Assistant Director of Nursing (ADON) she revealed on 12/02/23 at 11:30 AM Resident #1 made an abuse allegation. The ADON stated she initiated the investigation and filed the initial report.

An interview with the Director of Nursing (DON) on 12/07/23 at 12:44 PM. The DON stated the incident on 12/01/23 was not reported to her as an allegation of abuse. She stated she was only made aware Resident #1 was upset about the color of the brief NA #1 and NA #2 put on her.

In an interview on 12/07/23 at 3:43 PM with the Administrator and the DON, the Administrator revealed the incident occurred on 12/01/23 at approximately 11:20 PM to 11:30 PM. She stated Resident #1's daughter (RP) called her 12/01/23 at approximately 11:30 PM and said she didn't want NA #1 and NA #2 in Resident #1's room because Resident #1 was upset about the brief.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

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F 609	Continued From page 25	F 609		

The Administrator stated she called the DON at 11:40 PM and told her to move NA #1 and NA #2 because they had put a yellow brief on Resident #1 and that's not what the Resident preferred. The DON stated they moved NA #1 and NA #2 because they thought it would lessen Resident #1's anxiety so she could rest.

On 12/07/23 at 5:00 PM an interview was conducted with the Administrator. Present during the interview were the ADON, the DON, and the Admissions Coordinator. The Administrator stated she would have explained to Resident #1 what was in her best interest and then she would have put the brief of her preference on her. The Administrator stated, as a nurse we know we always want what is in the best interest of the resident, but we must take into consideration their rights, wishes, and preferences. The Administrator stated she didn't think the NAs intentionally abused the resident, but they did violate her rights. The Administrator stated the NAs should have left the room when the Resident told them to leave her alone.