STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	**1987 HILTON ROAD BURLINGTON, NC 27217**

(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 A complaint investigation survey was conducted on 11/20/24. Event ID# XN3V11. The following intake was investigated: NC00223818. One (1) of 1 complaint allegation resulted in a 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, and resident and staff interviews, the facility failed to protect a resident's right to be free from abuse when Resident #1 struck Resident #2 with a 15 ounce can of peaches. This affected 1 of 3 residents reviewed for abuse. The findings included: Resident #4 most recent admission to the facility was on 08/29/24 with diagnoses that included hemiplegia following cerebral infarction, contracture, essential hypertension, and major	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/04/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

(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 1 depressive disorder. Review of the quarterly Minimum Data Set (MDS) dated 09/19/24 revealed Resident #4 was cognitively intact with no behaviors. Resident #3 was admitted to the facility on 12/27/22 with diagnoses that included chronic obstructive pulmonary disease, essential hypertension, anxiety disorder, and depression. Review of the quarterly MDS dated 10/01/24 revealed Resident #3 was cognitively intact and had verbal behavioral symptoms directed towards others that included threatening others, screaming at others, cursing at others, and rejection of care. Resident #3's Care Plan updated on 11/04/24 included Resident had behaviors related to history of cocaine use and alcohol abuse; angers easily, yelling, verbally aggressive towards staff, throwing personal items, physical aggression. fabricates stories and has manipulative behaviors, residents play music loud at times, resident antagonizes other residents. Review of a Facility Reported Incident (FRI) dated 11/03/24 revealed that Resident #3 threw a can of peaches at Resident #4 because he thought he ate his food off his tray. Residents were immediately separated and Resident #3 was placed one on one. Resident #4 was placed in a different room. Resident #4 was sent to the emergency room for further evaluation; however, he refused to go. This allegation type was classified as resident abuse. A review was completed of the 5-working day	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

(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 2	F 600		

investigation report dated 11/07/24. The review revealed Resident #3 was provoked due to Resident #4 allegedly ate Resident #3's tray and Resident #3 threw a can of peaches at Resident #4 out of frustration. Resident #3 is blind and was unable to see where he was throwing the object. Resident #3 threw the can of peaches, and it struck Resident #4 on the right side of the head above his right eye, and he sustained a laceration. Residents were separated and educated on how to voice concerns and issues. Residents remained in vastly different geographic areas of the center. Both remained in good health and had no animosity. Resident #4 sustained a laceration to the right outer eye that was cleansed with normal saline and taped closed. Emergency Medical Technicians (EMTs) were called and Resident #4 refused to go to the hospital. EMTs glued resident's laceration closed and covered it with tape. The provider was made aware. Police were notified. The Psychiatry provider was notified. Resident #4 was moved to another room.

An observation and an interview were conducted with Resident #4 on 11/20/24 at 1:15 pm and he indicated he was asleep and Resident #3 threw a can and hit him in the face. Resident #4 stated, "he thought I ate his dinner, his food, woke up to him throwing a can to my head." He indicated he had a cut above his right eye and declined to go to the hospital. A healed scar was observed above Resident #4's right eye.

An interview was conducted with Resident #3 on 11/20/24 at 1:21 pm and he indicated he was asleep in bed when a staff member (resident could not remember who it was) came in to get his tray, but he had not eaten his food. He stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

(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 3	F 600		

"I asked the man did he eat my food, he was coming towards me, I'm blind, only see shadows, heard his bed moving and he was cussing at me, I grabbed a can of peaches and threw them his way, didn't know I hit him, was mad he ate my food, I left out the room and told the nurse, they took him out of the room".

On 11/20/24 at 1:30 pm an interview was conducted with NA#1, and she indicated she was assigned to Resident #3 and #4 on 11/03/24. She indicated she did not pick Resident #3's tray up and did not recall who did. She stated she did not witness the altercation however she saw Resident #3 rolling himself up the hall and heard Resident #4 say he was going to bust him upside the head. NA #1 indicated Resident 3 said Resident #4 ate his food off his tray.

An interview was conducted on 11/20/24 at 1:46 pm with Nurse #1 and she indicated she was assigned to Resident #3 and Resident #4 on 11/3/24. She indicated she heard Resident #3 fussing about his food, and he was in the hallway. She indicated Resident #4 was going up the hall and was bleeding from the right side of his head above the eye. She indicated Resident 4 had an open area about 1/2 centimeters above his right eye and she cleaned it up and put steri-strips on it. Nurse #1 indicated Resident #4 told her he got hit in the head because Resident #3 said he ate his food.

During a telephone interview on 11/20/24 at 1:59 pm with the Unit Manager she indicated she took over when Nurse #2 left after providing treatment to Resident #4's eye. She stated, " I was not present at the time of the altercation but followed up with everything, called the police, EMS,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

(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 4 Resident #4 did not want to go to the hospital so they had him sign a form stating he refused, moved Resident to the front of the building, Resident #3 stayed in his room and had a sitter the remainder of the shift that sat with him all night". An interview was conducted with the Administrator on 11/20/24 at 2:28 pm and he indicated Resident #3 had a history of being incarcerated and after he interviewed him concluded due to Resident being blind, he did not have any intention of abusing his roommate and the allegation was unsubstantiated. The Administrator indicated Resident #3 had been triggered when his roommate ate his food and was why Resident #3 became frustrated and threw the can. The Administrator stated, "he isn't capable of seeing that the can was going to hit his roommate." The facility implemented the following Corrective Action Plan with a completion date of 11/08/24. -Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 3 became frustrated when his roommate, Resident #4, ate his food. Resident #3 is blind and grabbed a can of peaches and threw it out of frustration. The can of peaches hit roommate Resident # 4. After the incident, the residents were immediately separated by the unit nurse and the alleged aggressor was immediately placed on 1 on 1 care by the nursing supervisor, until evaluated by psychiatric services. Psychiatric services reviewed the aggressor on 11/04/2024 and determined that there was no need to continue the one-on-one supervision.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	**1987 HILTON ROAD** **BURLINGTON, NC 27217**

(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 5	F 600		

Resident #3 was placed on 1:1 immediately after separating from Resident #4. Resident #4 was evaluated for injury by the floor nurse. The Medical Provider was notified by the nurse. Both Resident representatives were notified of the altercation by the floor nurse. Adult Protective Services and Local Police department were contacted by the Administrator. Resident #4 had an injury, and it was recommended that he go to the emergency room. However, residents refused and Emergency Medical Services (EMS) glued the laceration together. Psychiatry provider evaluated and made recommendations to remove Resident #3 from one-to-one care. Depakote 125mg by mouth daily was initiated for Resident #3. Trauma screens were completed by the social worker/discharge planner to evaluate the effect of the incident on the residents. Trauma screens were completed on Resident #3 and #4. This was done on 11/04/2024. Education on "free from abuse" was initiated by the Staff Development Coordinator and Assistant Director of Nursing on 11/03/2024 for all current staff. The Administrator and Director of Nursing were notified of the occurrence at the time of the occurrence by the nursing supervisor.

-Address how the facilty will identify other residents having the potential to be affected by the same deficient practice;
Current residents at risk for resident-to-resident altercations were identified by the interdisciplinary team during the ADHOC meeting on 11/04/2024. No residents were identified during the interview process. . On 11/04/2024 alert and oriented residents were interviewed by the Administrator and designees of the Director of Nursing regarding abuse and were educated to alert staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	**1987 HILTON ROAD** **BURLINGTON, NC 27217**

(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 6 immediately of any concerns. Residents were also educated and notified by the Administrator and designee during the interview, that there will be no tolerance for abuse. -Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Progress notes are reviewed by the Unit Managers or designee for the previous 24 hours daily, potential residents that have behavior notes documented are discussed with the interdisciplinary team during morning clinical meeting daily Monday through Friday. Current residents with a BIMS score of 13-15 will be interviewed weekly regarding safety concerns at the center during angel rounds. Current residents with a BIMS of 13-15 will be assigned by the Administrator to department managers. The results of the interviews are provided to the Administrator during the morning meeting. The interview questions are to evaluate safety concerns the current residents have in the center. These interviews will help determine if there is a particular resident that is starting to make other residents feel uncomfortable. These identified residents from the resident interview process will be referred to psychiatric provider to determine if behaviors are escalating or if it is temporary as a result of an underlying medical condition. Appropriate interventions such as one on one during the acute episode, or medication adjustment, and/or notification of the primary provider to initiate medical evaluation. Staff will be made aware by huddle given by the Unit Managers, when the resident is identified. Identifying potential escalations in resident behaviors will assist in preventing resident	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

(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 7 altercations, thus preventing abuse. -Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; All occurrences of resident-to-resident behavior will be reviewed by the Administrator weekly x 12 weeks. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. ADHOC with interdisciplinary team met on 11/04/202. The facility's alleged compliance date was 11/08/24. The Corrective Action Plan was validated onsite on 11/20/24 and concluded the facility had implemented an acceptable corrective action plan on 11/08/24. A review was conducted of the education dated 11/03/24 provided to staff. Interviews with current nursing staff revealed they received education on and training on "free from abuse" and resident to resident physical altercations. A review of the audits dated 11/04/2024 was conducted of alert and oriented residents interviewed by the Administrator and designees of the Director of Nursing regarding abuse reporting. There were no altercations revealed from the audits conducted for the week of 11/11/24-11/15/24. Interviews were conducted with alert and oriented residents and no concerns were identified. The compliance date of 11/08/24 was validated.	F 600		