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| L 000 | INITIAL COMMENTS<br><br>An onsite complaint investigation was conducted on 4/14/23. The following intake was investigated: NC 200551 (Event 8RJ811)<br>Additional information was obtained on 4/20/23. Therefore, the survey exit date was changed to 4/20/23.<br><br>Two of two allegations resulted in Type B Violations. | L 000 | | |
| L 049 | .2210(A) REPORTING, INVESTIGATING ABUSE, NEGLECT<br><br>10A-13D.2210 (a) A facility shall take measures to prevent patient abuse, patient neglect, or misappropriation of patient property, including orientation and instruction of facility staff on patients' rights and the screening of and requesting of references for all prospective employees.<br><br>This Rule is not met as evidenced by:<br>Type B Violation<br><br>Based on observation, record review, and staff interview the facility failed to 1) assure a staff member did not barricade a sick, infectious resident within his room, 2) make a video of the barricaded and partially clothed resident while using an expletive in a derogatory way on the video to refer to the resident's situation, and 3) then transmit the video to someone via way of | L 049 | | |

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digital device. This was for one (Resident # 1) of one resident reviewed for abuse. The reasonable person concept was applied to this deficiency as individuals would not want disrespectful videos made and shared of them and they would not want to be barricaded in their room.
The findings included:

Resident # 1 was admitted to the facility on 9/7/22 with Alzheimer's disease and behavioral disturbance related to the Alzheimer's disease.

Resident # 1's care plan, updated on 3/13/23, noted Resident # 1 had wandering behavior. This was initially added to Resident # 1's care plan on 10/6/22. One of the interventions on the care plan was to allow the resident to vent feelings, attempt to identify concerns and redirect the resident. According to the care plan update of 3/13/23, Resident # 1 tested positive for COVID (Coronovirus Disease) .

Review of facility reports revealed on 3/22/23 the facility initiated an investigation into abuse for Resident # 1. The report noted, "(Resident # 1) was alleged to have been physically restrained in his room by (NA # 1) , by utilizing two interlocked hoyer lifts (mechanical lifts) with the purpose of confining the resident to his room sometime between March 13th and March 14th. This incident was reported to the community administrative staff by email on March 22nd that included a video depicting the resident asking for help with the visual of two Hoyer lifts blockading his egress from the room." This investigative statement had been written by the COO (chief operating officer) of the retirement village of which the skilled facility was part.

The COO was interviewed on 4/14/23 at 10:15

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| L 049 | Continued From page 2<br>AM and the video, which was referenced in the investigation, was viewed at that time with the COO. The video was brief. At the beginning of the video a male voice could be heard saying, "Look at this (expletive)." The male voice appeared to be coming from the male who was shooting the video. It was confirmed with the COO that this is what he heard the male voice saying also. In the video, Resident # 1 could be seen standing in his room asking for help. He had a shirt on but no pants. In the doorway were two mechanical lifts with the legs of the lifts interlocked; barricading the resident from exiting his room. Resident # 1 was asking for someone to please help him as he stood behind the barricade. The length of Resident # 1's shirt along with the distance from which the video was made and the lifts being placed in front, thereby shielded Resident # 1's private areas from being clear on the video. The COO reported the following. There were two former employees of the retirement village which had been involved in alerting the facility to the incident. Former Employee # 1 was the girlfriend of NA # 1. On 3/21/23 another former employee (Former Employee # 2) had reached out by email to the retirement village's human resource department and inquired if Employee # 1 had sent a video to them. The human resource employee had let Former Employee # 2 know that she had not received anything. Later that evening/ night, Former Employee # 2 sent the video by email to the human resource department letting them know that she had received it from Former Employee # 1 and felt the facility should know about it. The video was then seen by them the next business day of 3/22/23. Once the video was received, they started an investigation which entailed talking to NA # 1, suspending, and terminating him. During the facility's investigation, | L 049 | | |

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NA # 1 had acknowledged he had barricaded Resident # 1 in his room on his own accord without consulting or letting any other staff member know. He had done it because Resident # 1 had COVID and the resident was wandering outside of his room. NA # 1 had told the COO that he checked on Resident # 1 and offered him food and drink while he was barricaded. NA # 1 had not had an explanation that plausibly explained the video that had been transmitted.

A review of NA # 1 's personnel file revealed he had been screened before hiring and upon hire had attended training on resident rights and abuse/ neglect by the facility.

NA # 1 was interviewed on 4/14/23 at 11:42 AM via phone and reported the following. On the evening of the incident, Resident # 1 would not stay in his room. He typically wandered and if a staff member left the room, "he (the resident) would be ahead of you going somewhere." On the incident night, Resident # 1 had COVID and NA # 1 did not want anyone else to get COVID. Around 5:00 to 5:30 PM, NA # 1 had to assist residents to eat. The other NA, who was working on the unit, also had residents to feed. Therefore, he used the mechanical lifts to keep Resident # 1 in his room. He stated he did not know exactly how long he kept Resident # 1 barricaded. When interviewed about the video of Resident # 1 being barricaded, NA # 1 replied that he thought that his former girlfriend was trying to get him in trouble and she must have done a "screen shot" somehow. When interviewed about an explanation of the male voice at the beginning of the video saying, "Look at this (expletive)," NA # 1 had no plausible explanation how that could have been made by a screenshot to his girlfriend. NA # 1 reported he had not consulted or told anyone

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about what he had done in barricading the resident. He also stated he knew that it was a HIPPA (Health Insurance Portability and Accountability Act) violation to make and transmit a video of a resident and he would not have done that.

According to the facility staffing sheets, the following employees had been on duty on 3/13/23.
Nurse # 1 had worked on 3/13/23 from 3:00 PM to 7:00 PM on Resident # 1's unit.

Nurse # 2 had worked on 3/13/23 from 7:00 PM to 11:00 PM on Resident # 1's unit.

Nurse # 3 had worked on 3/13/23 from 11:00 PM to 7:00 AM on 3/14/23 on Resident # 1's unit.

NA # 2 had worked from 3:00 PM on 3/13/23 to 7:00 AM on 3/14/23 on Resident # 1's unit with NA # 1.

Nurse # 1 was interviewed on 3/14/23 at 12:45 PM and reported the following. She had not witnessed NA # 1 barricading Resident # 1 in his room, and NA # 1 had not come to her to report that he was having trouble feeding residents and attending to Resident # 1. If he had done so, she would have reported to the supervisor to determine what needed to be done. She was not knowledgeable of any abuse or a video being made of a resident, and if she were ever made aware of such, she would immediately report it.

Nurse # 2 could not be reached for interview during the survey.

Nurse # 3 was interviewed on 3/14/23 at 12:10 PM and reported the following. She did not see

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Resident # 1 barricaded in his room. When she went by his room, the mechanical lift was in the hall but was not barricading his room. NA # 1 had not come to her to report any problems. If he had, she would have gone to the supervisor or called the DON (Director of Nursing).

NA # 2 was interviewed on 3/14/23 at 1:19 PM and reported she had not seen Resident # 1 barricaded in his room. If she ever saw something that was not right then she would go to a supervisor.

The facility Administrator was interviewed on 3/14/23 at 1:50 PM and reported the following. She had been made aware of the incident on 3/22/23 from the COO, and had worked with the COO to investigate the incident. NA # 1 had tested positive for COVID on 3/14/23 and was not scheduled to work again until 3/23/23. On that day, they did not allow him to work and interviewed him about the incident. They sent him home and terminated him. Their investigation had not identified anyone else who had been knowledgeable about the incident, and she felt they had done everything they could to have prevented it from occurring. On the evening of 3/13/23, there had been a supervisor in the facility, and her help could have been obtained to manage Resident # 1's behavior in monitoring his wandering behavior, but NA # 1 had never reported any problems. She had inserviced all of her staff on 3/22/23 which were available to inservice on that date. They had been in a COVID outbreak and therefore some of the staff had not been available to inservice. She was continuing to inservice her staff, but all had not been completed as of 4/14/23.

On 4/20/23 the facility presented the following

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| L 049 | Continued From page 6 | L 049 | | |

written plan regarding how the facility would immediately remove the Type B Violation in order to protect residents from further risk or additional harm.

10 A NCAC 13D .2210 A

Immediate interventions:

Upon receipt of the video, the administration at Carolina Meadows acted quickly to ensure that the employee, Nurse Aide #1, was interviewed and immediately suspended pending investigation. Through conversation and further investigation with Nurse Aide #1, it was determined that he was knowledgeable about Carolina Meadows' abuse prevention policies, including expectations for identifying and reporting as indicated by his extensive in-service records and testing. Despite his knowledge of these policies, he admitted to acting alone without the knowledge of his peer CNA, licensed nurse, or nursing supervisor who were all immediately present. For this reason, it was reasonable to conclude that this was an isolated incident involving one team member who knowingly deviated from the community's policy. Upon completion of the investigation, Nurse Aide's #1 employment was terminated.

Resident #1's well-being was assessed and did not appear to have any residual impact from the incident that occurred.

The incident was reported to DHSR within 24 hours.

Through post-incident rounds, it was determined that staff who were interviewed were aware of the abuse prevention and restraint-free policies and their obligation to report.

Facility rounds were completed immediately, and observations affirmed that there were no additional observations of inappropriate restraints of any other residents.

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| L 049 | Continued From page 7<br><br>Assessment of Nurse Aide #1's deficient practice and its potential impact on others: there were no additional observations of inappropriate restraints of any other residents within the Health Center at Carolina Meadows.<br><br>Education and corrective action:<br>It is the policy of the Health Center at Carolina Meadows that each resident has the right to be treated with dignity, respect and free from abuse (including verbal, sexual, physical, mental abuse, involuntary seclusion, neglect, misappropriation of property, and exploitation.) It is further required of all staff be mandated reporters of abuse.<br>Carolina Meadows has taken appropriate measures to ensure that other team members are clear regarding expectations for resident rights, including preventing, recognizing, and reporting abuse. Education and re-training on the topics of abuse prevention, reporting and restraints was provided to staff to ensure knowledge of the facility's policy. To date, 82 team members have attended re-education training. Training will continue until all staff are trained as they report for duty according to their schedule.<br><br>Monitoring: ongoing quality assurance is monitored through appropriate daily observations of residents and employees. Regular rounds will be conducted by clinical and administrative staff for 30 days to ensure observations are consistent with our policies and expectations. Any identified deviations will be reported immediately to the administrator for immediate corrective action and appropriate follow up. These findings will be reported to the QAPI committee monthly for 90 consecutive days for action planning and | L 049 | | |

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| L 049 | Continued From page 8 additional follow-up as needed. | L 049 | | |
| L 078 | .2305(C) QUALITY OF CARE<br><br>10A-13D.2305 (c) The facility shall not utilize any chemical or physical restraints for the purpose of discipline or convenience, and that are not required to treat the patient's medical condition. An evaluation shall be done to ensure that the least restrictive means of restraint have been initiated on patients requiring restraints.<br><br>This Rule is not met as evidenced by:<br>Type B Violation<br><br>Based on observation, record review, and staff interview the facility failed to assure a staff member did not barricade a sick, infectious resident within his room. This was for one (Resident # 1) of one resident reviewed for restraints. The findings included:<br><br>Resident # 1 was admitted to the facility on 9/7/22 with Alzheimer's disease and behavioral disturbance related to the Alzheimer's disease.<br><br>Resident # 1's care plan, updated on 3/13/23, noted Resident # 1 had wandering behavior. This was initially added to Resident # 1's care plan on 10/6/22. One of the interventions on the care plan was to allow the resident to vent feelings, attempt to identify concerns and redirect the resident. On 3/13/23 the care plan was updated to reflect | L 078 | | |

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| L 078 | Continued From page 9<br>Resident # 1 tested positive for COVID (coronavirus disease).<br><br>Review of facility reports revealed on 3/22/23 the facility initiated an investigation into alleged abuse for Resident # 1. The report noted, "(Resident # 1) was alleged to have been physically restrained in his room by (NA # 1) , by utilizing two interlocked hoyer lifts (mechanical lifts) with the purpose of confining the resident to his room sometime between March 13th and March 14th. This incident was reported to the community administrative staff by email on March 22nd that included a video depicting the resident asking for help with the visual of two Hoyer lifts blockading his egress from the room." This investigative statement had been written by the COO (chief operating officer) of the retirement village of which the skilled facility was part.<br><br>The COO was interviewed on 4/14/23 at 10:15 AM and the video, which was referenced in the investigation, was viewed at that time with the COO. In the video, Resident # 1 could be seen standing in his room asking for help. He had a shirt on but no pants. In the doorway were two mechanical lifts with the legs of the lifts interlocked; barricading the resident from exiting his room. Resident # 1 was asking for someone to please help him as he stood behind the barricade. The COO reported the following. There were two former employees of the retirement village which had been involved in alerting the facility to the incident. Former Employee # 1 was the girlfriend of NA # 1. On 3/21/23 another former employee (Former Employee # 2) had reached out by email to the retirement village's human resource department and inquired if Former Employee # 1 had sent a video to them. The human resource employee had let Former | L 078 | | |

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Employee # 2 know that she had not received anything. Later that evening/ night, Former Employee # 2 sent the video by email to the human resource department letting them know that she had received it from Former Employee # 1 and felt the facility should know about it. The video was then seen by them the next business day of 3/22/23. Once the video was received, they started an investigation which entailed talking to NA # 1, suspending, and terminating him. During the facility's investigation, NA # 1 had acknowledged he had barricaded Resident # 1 in his room on his own accord without consulting or letting any other staff member know. He had done it because Resident # 1 had COVID and the resident was wandering outside of his room. NA # 1 had told the COO that he checked on Resident # 1 and offered him food and drink while he was barricaded. NA # 1 had not had an explanation that plausibly explained the video that had been transmitted.

A review of NA # 1 's personnel file revealed he had been screened before hiring and upon hire had attended training on resident rights and abuse/ neglect by the facility.

NA # 1 was interviewed on 4/14/23 at 11:42 AM via phone and reported the following. On the evening of the incident, Resident # 1 would not stay in his room. He typically wandered and if a staff member left the room, "he (the resident) would be ahead of the staff member going somewhere." On the incident night, Resident # 1 had COVID and NA # 1 did not want anyone else to get COVID. Around 5:00 to 5:30 PM, NA # 1 had to assist residents to eat. The other NA, who was working on the unit, also had residents to feed. Therefore, he used the mechanical lifts to keep Resident # 1 in his room. He stated he did

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| L 078 | Continued From page 11 | L 078 | | |

not know exactly how long he kept Resident # 1 barricaded. NA # 1 reported he had not consulted or told anyone about what he had done in barricading the resident.

According to the facility staffing sheets, the following staff members were on duty on 3/13/23.

Nurse # 1 had worked on 3/13/23 from 3:00 PM to 7:00 PM on Resident # 1's unit.

Nurse # 2 had worked on 3/13/23 from 7:00 PM to 11:00 PM on Resident # 1's unit.

Nurse # 3 had worked on 3/13/23 from 11:00 PM to 7:00 AM on 3/14/23 on Resident # 1's unit.

NA # 2 had worked from 3:00 PM on 3/13/23 to 7:00 AM on 3/14/23 on Resident # 1's unit with NA # 1.

Nurse # 1 was interviewed on 3/14/23 at 12:45 PM and reported the following. She had not witnessed NA # 1 barricading Resident # 1 in his room, and NA # 1 had not come to her to report that he was having trouble feeding residents and attending to Resident # 1. If he had done so, she would have reported to the supervisor to determine what needed to be done.

Nurse # 2 could not be reached for interview during the survey.

Nurse # 3 was interviewed on 3/14/23 at 12:10 PM and reported the following. She did not see Resident # 1 barricaded in his room. When she went by his room, the mechanical lift was in the hall but was not barricading his room. NA # 1 had not come to her to report any problems. If he had, she would have gone to the supervisor or called

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| (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) COMPLETE DATE |
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the DON (Director of Nursing).

NA # 2 was interviewed on 3/14/23 at 1:19 PM and reported she had not seen Resident # 1 barricaded in his room. If she ever saw something that was not right then she would go to a supervisor.

The facility Administrator was interviewed on 3/14/23 at 1:50 PM and reported the following. She had been made aware of the incident on 3/22/23 from the COO, and she had worked with the COO to investigate the incident. NA # 1 had tested positive for COVID on 3/14/23 and was not scheduled to work again until 3/23/23. On that day, they did not allow him to work and interviewed him about the incident. They sent him home following his interview and later terminated him due to the restraining, taping, and transmitting of the incident. Their investigation had not identified anyone else who had been knowledgeable about the incident. On the evening of 3/13/23, there had been a supervisor in the facility, and her help could have been obtained to manage Resident # 1's behavior and in monitoring his wandering behavior, but NA # 1 had never reported any problems. She had inserviced all of her staff on 3/22/23 which were available to inservice on that date about restraints/abuse. They had been in a COVID outbreak at that time, and therefore some of the staff had not been available to inservice. She was continuing to inservice her staff, but all training had not been completed as of 4/14/23. According to the Administrator, all employees were screened before hiring and they were also trained upon hire regarding resident rights and abuse/neglect, and she felt they had done everything they could to have prevented the incident from occurring.

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On 4/20/23 the facility presented the following written plan regarding how the facility would immediately remove the Type B Violation in order to protect residents from further risk or additional harm.

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Immediate interventions:

Upon receipt of the video, the administration at Carolina Meadows acted quickly to ensure that the employee, Nurse Aide #1, was interviewed and immediately suspended pending investigation. Through conversation and further investigation with Nurse Aide #1 it was it was determined that he was knowledgeable about Carolina Meadows' abuse prevention policies, including expectations for identifying and reporting as indicated by his extensive in-service records and testing. Despite his knowledge of these policies, he admitted to acting alone without the knowledge of his peer CNA, licensed nurse, or nursing supervisor who were all immediately present. For this reason, it was reasonable to conclude that this was an isolated incident involving one team member who knowingly deviated from the community's policy. Upon completion of investigation, Nurse Aide's #1 employment was terminated.

Resident #1's wellbeing was assessed and did not appear to have any residual impact from the incident that occurred.

The incident was reported to DHSR within 24 hours.

Through post-incident rounds, it was determined that staff who were interviewed were aware of the abuse prevention and restraint-free policies and their obligation to report.

Facility rounds were completed immediately, and observations affirmed that there were no

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additional observations of inappropriate restraints of any other residents.

Assessment of Nurse Aide #1's deficient practice and its potential impact on others: there were no additional observations of inappropriate restraints of any other residents within the Health Center at Carolina Meadows.

Education and corrective action:

It is the policy of the Health Center at Carolina Meadows to be a restraint-free environment. Physical or chemical restraints will not be used for staff convenience or to prevent residents from wandering. The Health Center at Carolina Meadows strives to ensure resident-centered care that offers holistic, non-pharmacological, individualized life enrichment activities, and physician-ordered interventions to be used as alternative approaches to restraints. Pharmacological interventions are only approved when they are physician ordered to enhance the quality of life with the agreement of the resident and/or resident representative.

Carolina Meadows has taken appropriate measures to ensure that other team members are clear regarding expectations for resident rights, including preventing, recognizing, and reporting abuse. Education and re-training on the topics of abuse prevention, reporting, and restraints were provided to staff to ensure knowledge of the facility's policy. To date, 82 team members have attended re-education training. Training will continue until all staff are trained as they report for duty according to their schedule.

Monitoring: ongoing quality assurance is

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| L 078 | Continued From page 15<br><br>monitored through appropriate daily observations of residents and employees. Regular rounds will be conducted by clinical and administrative staff for 30 days to ensure observations are consistent with our policies and expectations. Any identified deviations will be reported immediately to the administrator for immediate corrective action and appropriate follow-up. These findings will be reported to the QAPI committee monthly for 90 consecutive days for action planning and additional follow-up as needed.<br><br>In summary, Carolina Meadows is committed to ensuring the safety and well-being of its residents by prioritizing compliance with regulations and industry standards. Our 38-year history demonstrates our strong emphasis on staff training and preventative measures to mitigate any potential risks. Carolina Meadows adheres to all applicable regulations to ensure that residents receive the highest quality care possible. The community regularly reviews and updates its policies and procedures to remain in compliance and to continuously improve our services. | L 078 | | |