STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING ______ B. WING ______	C 03/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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F 000	INITIAL COMMENTS The survey team entered the facility on 02/26/19 to conduct a complaint investigation survey and exited on 02/26/19. Additional information were obtained on 03/11/19. Therefore, the exit date was changed to 03/11/19.	F 000		
F 600 SS=G	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 resident and staff interviews and record reviews, the facility failed to protect a resident's right to be free from verbal abuse including yelling, pointing the finger and threat not to provide care for 1 of 1 resident reviewed for abuse (Resident #1) resulting in the resident upset, feeling hurt, berated, and crying for a period of time. The findings included: Resident #1 was admitted to the facility on 2/5/15. The diagnoses included, visual impairment, and	F 600	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged	3/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/15/2019

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 chronic obstruction pulmonary disease. The most recent Minimum Data Set (MDS) dated 1/16/19, indicated Resident #1 cognition was intact and she was totally dependent upon staff for all activities of daily living. The care plan dated 1/16/19 identified the problem as resident had an activities of daily living self-care performance deficit related to amputation, limited mobility, limited range of motion and musculoskeletal impairment. The goal included resident would maintain current level of function. The interventions included assist resident to have a neat and clean appearance as needed, encourage resident to discuss feelings about self-care deficit, encourage resident to participate to the fullest extent possible with each interactions, resident requires oral inspection with oral care and report changes to the nurse, resident requires daily skin inspection with activities of daily care and weekly skin checks and provide the resident with short, simple instructions. During an interview on 2/26/19 at 6:30 AM, Resident #1 reported that she was "verbally abused" by NA #4. The resident explained that on Saturday 2/9/19, nursing assistant (NA) #4 did not complete the resident's normal routine care, like brush her teeth, comb her hair, put on her earrings and get her ready for the day. The NA was called out of the room before she could complete the normal routine care and she did not come back later. The resident's remote control was also missing, and she had to watch the same channel on Saturday. Resident #1 revealed that, on 2/10/19, when NA#4 came back to work, the resident asked the NA why she did not complete	F 600	deficiencies cited have been or will be completed by dates indicated. Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #1 was evaluated by NP on 2/12/19, evaluated by Medical Director on 2/13/19 and NP on 3/1/19. Resident #1 had medication changes related to management of depression and anxiety per NP on 3/1/19. Resident #1 was evaluated by psychiatry on 3/6/19. Identification of residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. On 3/14/19 Social worker and Director of Nursing completed interview for abuse monitoring with interviewable residents. On 3/14/19 Social Worker and Director of Nursing completed resident observations for indications of abuse for resident considered non-interviewable. 2/26/19 in-service education began for all staff by Social Worker and continued by Social Worker, Administrator, Director of Nursing and Nursing Supervisor on abuse policy including procedure for reporting	

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F 600 Continued From page 2

the routine personal care for the resident on 2/9/19 and asked her if she had seen the remote to the resident's television. The resident stated "I was just asking when (NA#4) became very upset yelling and telling me that she knew she took good care of me." The resident reported the NA saying to the resident "why would you say I didn't do my job and I didn't take your remote." The resident stated "I was so stunned and upset that she would be yelling at me and pointing her finger in my face, like I didn't matter. My feelings were hurt, and I felt berated by her. There was no reason for her behavior toward me or anyone else. She was a very good worker and has done good care for me, just don't know why she would react the way she did. I cried and cried for two hours so much I didn't know what to do. I went to the administrator and director of nursing about what happened. I was still so upset, and the administrator really helped me calm down and told me that the staff would be suspended until the investigation was completed. I was later told the staff was terminated. I am very satisfied with the action the administrator and director of nursing took to address NA#4's verbal abuse. I feel like the administrator and director of nursing handled things appropriately"

During a follow-up interview on 2/26/19 at 11:20 AM, Resident #1 stated "I know I was verbally abused by the staff and it should never happen to anyone in the facility, I still get upset talking about it because I know I did not deserve that kind of behavior." "I hated she got fired, I just pray she doesn't do that to anyone else when she gets upset. (NA#4) did give me good care overall."

During a telephone interview on 2/26/19 at 1:42 PM, NA#4 stated she had worked with Resident

F 600

abuse, neglect and resident rights. All staff will receive in-service education prior to next scheduled shift.

Measures / systemic changes made to ensure that the deficient practice will not recur

2/26/19 in-service education began for all staff by Social Worker and continued by Social Worker, Administrator, Director of Nursing and Nursing Supervisor on abuse policy including procedure for reporting abuse, neglect and resident rights. All staff will receive in-service education prior to next scheduled shift.

Quarterly training will be conducted by Social Worker for all staff on abuse, neglect and resident rights.

Training for all staff on abuse, neglect and resident rights for newly hired employees.

Social Worker will complete resident interviews for abuse monitoring with interviewable residents weekly x 4 weeks, then monthly x 3 months then quarterly thereafter.

Social Worker will complete resident observations for indications of abuse for residents considered non-interviewable weekly x 4 weeks, then monthly x 3 months then quarterly thereafter.

Resident interviews and observations for abuse monitoring will be reviewed by Administrator weekly x 4 weeks, then

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F 600	Continued From page 3 #1 for the past 4 years and she was very familiar with her care needs and her preference regarding ADLs. She reported she had worked with the resident on Saturday and was pulled away to assist with another resident. NA #4 reported she had told the resident this information and another staff would be in to do her weights. NA#4 reported she had provided all the resident's care and did not think to go back to do the resident's hair. The NA reported that when "I arrived to work on Sunday 2/10/19, I was orienting an agency aide when the resident started accusing me of not doing my job on Saturday. I did tell her that she knew I took very good care of her. The conversation did get a little loud because I know I have taken very good care of the resident and she got upset because I didn't comb her hair and I didn't know where her remote was. I normally put the remote in a specific place to make sure it didn't get wet when I would provide care for the resident." "When the resident started to accuse me of not doing my job and taking a remote, things got loud, I never put my hand or finger in her face. I was told she was very upset and crying for a long period by other staff and the administrator who called me on the phone and told me I was being put on suspension. I have not received a follow-up call from the facility on my status. I was told by my co-workers that I was terminated. I did not hear it from the administrator or the director of nursing as of this date." During a telephone interview on 2/26/19 at 1:34 PM, NA#5 stated that she had worked with the resident on Sunday 2/10/19 in which she observed Resident #1 and NA#4 in a heated verbal discussion about care that NA#4 did not provide on Saturday. NA#5 further stated Resident #1 asked NA#4 about not getting her	F 600	monthly x 3 months then quarterly thereafter. Facility plan to monitor performance to make sure solutions are sustained. The Administrator will report findings of resident interviews and resident observations for abuse monitoring to the Quality Assurance and Performance Improvement Committee will review interview findings to make recommendations to ensure compliance is sustained ongoing and determine the need for further monitoring.	

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F 600	Continued From page 4 care and the loss of the remote control. NA#4 started to raise her voice with the resident, stating how well she had provided care for the resident and she was offended by what Resident #1 had stated. NA#5 stated NA#4 had pointed her finger in the resident face as she was talking very loudly. NA#4 eventually left the room and went to the nurses' station and started talking about the situation, therefore, NA#5 thought she did not need to report it to director of nursing (DON) or administrator because the nursing staff already knew what was going on. The DON later came and asked NA#5 what she saw and heard, and she told the DON then. NA reported that she did not receive any in-service training at the time of the incident. An interview was conducted on 2/26/19 at 5:00 PM, with Nurse #2 who was responsible for Resident #1's care on the 7-3 shift on 2/11/19. Nurse #2 stated she heard other staff talking about the situation between Resident #1 and NA#4 at the nursing station. Nurse #2 stated, "I went to speak with the resident and she stated she wanted to speak with the DON. The resident did not give me any details. When the DON arrived on Monday morning, I asked her to speak with the resident based on what she heard over the weekend. Nurse #2 stated at times Resident #1 would be upset or overly emotional about different things, however, when I heard that the staff was in the resident's face, was very loud and there was some finger pointing and the resident had been upset for several hours, I felt like the DON should be involved." Nurse #2 stated she did not receive an in-service on abuse at the time of the incident but did receive an in-service on 2/26/19.	F 600		

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F 600	Continued From page 5 An interview was conducted with Nurse #3 on 3/11/19 at 3:11 pm. Nurse #3 worked from 7 am till 3 pm shift on 2/10/19. Nurse #3 said she was responsible for providing care to Resident #1 and the resident did not tell her about the incident that happened between her Resident #1 and NA #4 on 2/10/19. Nurse #3 said the staff did not tell her about any incident that happened between the resident and the NA on 2/10/19. Nurse #3 said she heard from the staff in passing that there was a "disagreement" between Resident #1 and NA #4. Nurse #3 said she thought it was minor. Nurse #3 never went back to the resident nor to the staff that were talking in passing nor NA# 4 to ask them what happened. Nurse #3 said she did not see NA#4 that day and did not look for her to talk to her. Nurse #3 said if there was abuse, then she would separate the staff from the resident and then tell her supervisor or the DON. Nurse #3 said if she could not contact the supervisor or the DON or the administrator, then she would send the accused staff home and tell the supervisor as soon as possible. During an interview on 2/26/19 at 7:00 AM, the Director of Nursing stated the charge nurse reported to her on 2/11/19, Resident #1 had a complaint regarding verbal abuse with a nurse aide over the weekend on 2/10/19. The nurse reported that NA#4 had been very mean to Resident #1 and hurt her feelings and made her cry for several hours. The discussion held with Resident #1 revealed NA#1 was assigned to her on 2/9/19 and NA#4 left without completing her care. Resident #1 stated she could not find her television remote, but the 3rd shift aide found the remote in laundry and gave it back to her. Resident #1 had asked the aide if she was ok	F 600		

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F 600	Continued From page 6 when she came to work on 2/10/19. Resident #1 reported the aide became very defensive and very upset loud and yelling at her. The aide was berating her and had her hand in her face stating she would not take care of her again. There was another aide in the room. Resident #1 was very emotional during her report and upset the aide had acted this way. After completing the investigation, management substantiated the allegation and a decision was made to terminate the staff. The Director of Nursing was unable to present any information and/or in-service record that was done with staff on abuse policy at the time of incident. During a telephone interview on 2/26/19 at 4:26PM, the Administrator stated that when staff informed her that Resident #1 wanted to speak with her, the resident was very upset because NA#4 had verbally abused her. The Administrator stated the resident reported the staff was yelling and screaming and pointing in her face and she was very upset for several hours and felt like she should not be treated like that. Administrator stated she had called NA #4 and informed her that she was on suspension pending the investigation. "I tried to call the staff (NA #4) for several weeks and the staff did not respond to the calls. Since the staff did not respond, I just left it alone." The Administrator stated that she had done a huddle and verbal in-service training on the different types of abuse and the reporting process with all the staff on that day. The Administrator added that she was uncertain why the in-service documentation could not be found. Facility faxed the 24-hour report to the State Agency on 2/11/19 and 5-day report on 2/14/19	F 600		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 7 regarding the incident of 2/10/19. Review of the report indicated the staff had been terminated on 2/14/19.	F 600		