STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345001	A. BUILDING ______ B. WING ______	C 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	**1417 W PETTIGREW STREET DURHAM, NC 27705**

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff and family interviews, record review, the facility failed to implement or follow the abuse policy in the area of reporting for 1 of 3 sampled resident who had an allegation of abuse (Resident #1). The findings included: Record review of the policy titled "Abuse Reporting" not dated, revealed Policy Statement All personnel must promptly report any incident or suspected incident of resident abuse, including injuries of an unknown source and misappropriation of resident property. Resident #1 was admitted to the facility on 3/19/19 with diagnoses of cerebral vascular accident and aphasia. Resident #1 was readmitted on 4/3/ 19 with diagnosis of spastic hemiplegia, encephalopathy aphasia, cerebral infarction, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) dated 4/3/19 revealed Resident #1 was	F 607	This plan of correction constitutes Hillcrest Convalescent Center's written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Resident #1 was admitted to Hillcrest on March 19, 2019 for short term rehabilitation after hospitalization for CVA. Resident's daughter has been with resident every day since he came to Hillcrest to assist with care and to advocate for resident due to his impaired cognition and impaired communication. Staff reported resident bit his daughter while she was attempting to assist staff with resident taking medications orally and daughter reacted by hitting resident in the	6/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/04/2019

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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coded as severely cognitively impaired with no documented behaviors. He had a feeding tube. The resident was coded as having had received antianxiety medications, and antidepressant medication each day of the seven-day assessment period.

Review of an unscheduled MDS assessment dated 06/05/19 revealed Resident #1 had behavior symptoms directed toward others 4-6 days but less than daily and rejection of care 1-3 days of 7.

Record review of the Quality Assurance Complaint Review 6/4/19, revealed "Concern identified family member of Resident #1 with physically holding his arms and mouth to promote medication administration and hit his face." The employee statements were contained in the Quality Assurance program.

During an interview on 6/12/19 at 10:15 AM, Family Member indicated she had been accused of "abuse" of Resident #1. She indicated that the Nurse Supervisor #1 (NS) tried to give Resident #1 medication orally. He spit his medications out. NS #1 asked her to try and she gave him the pill. She explained that she put the medication into his mouth, covered his mouth and massaged his cheeks to get him to swallow. On Tuesday 6/4/19, Nursing Supervisor #2 asked her to leave the facility because there was a report that she had abused Resident #1, and she didn't know the specifics. The family member stated to Nurse Supervisor #2 that she had not abused Resident #1 and refused to leave. She said Nursing Supervisor #1 was in the room during the "alleged abuse" and she didn't say anything to her.
During an interview on 6/12/19 at 12:36PM NS #1

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face. An Initial Report to North Carolina Department of Health and Human services was not submitted as all staff witnesses stated there was no “willful infliction of injury … with resulting physical harm, pain or mental anguish” as the CMS regulations define abuse.

1. Address how corrective action will be accomplished for affected resident.

Despite the daughter’s action not meeting the definition of abuse, Hillcrest proactively took the following action to assure the safety of the resident. On June 4, 2019, upon notification of resident’s interaction with daughter, witness/staff interviews were initiated and resident’s records were reviewed. Review of resident’s medical record indicated the resident’s diagnosis included, but were not limited to CVA, encephalopathy, pneumonia, dysphagia, atrial fibrillation, aphasia, cognitive/communication deficits, hemiplegia, CKD, HTN, malnutrition and glaucoma. Resident with noted refusal of medications and foods with combative behavior and muscle spasms. Quarterly MDS dated 5/29/19 indicates BIMS interview unable to be completed. Short term and long term memory impaired and severely impaired cognition for daily decisions. Communication is impaired with speech unclear and resident is rarely/never understood or able to understand others.

On June 4, 2019 an interview with resident was attempted by Social Worker

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indicated that Resident #1 had had a great day. Around 4PM he has a scheduled antianxiety medication which he received. Later in the shift he was still agitated. The medication aide was unsuccessful to administer the PRN (as needed) antipsychotic medication. NS #1 stated that she had also attempted to administer the medication by mouth and was unsuccessful. The family member got up from the chair and put her weight on him. She leaned on him trying to keep his a/rms restrained. He resisted the family member. She asked for the medication, and put it into his mouth and pinched his lips to gather with both hands. She used her left hand to scrape the medication back into his mouth. He bit her. She removed her hand paused while she looked at her hand and then took her right hand and slapped him across his left side of his face. When NS was asked if that wasn't considered abuse? She stated that she didn't consider it as abuse because she was a family member. Afterwards the family member joked that they had "brawls" like this before. It was not big deal. NS #1 stated she had access to the administrative staff, but she didn't report this incident. She told the oncoming night Nurse Supervisor #2, when she came on duty. The information made it to the Director of Nursing by Tuesday.

During a telephone interview on 6/12/19 at 1:59 PM Medication Aid (MA) indicated that the nurse supervisor tried to orally administer medication and Resident #1 resisted. The family member volunteered to give the medication. She used a spoon with food, she put it in his mouth and pinched his lips together. He was fighting and shook his head. He had food on his face. He had bit her and she popped him in the face. MA said, "It didn't look like abuse to me." She continued

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with Speech Therapist present for interventions for communication. Resident was unable to participate in interview; therefore staff later attempted a second resident interview. In the second interview resident provided inconsistent and unreliable responses to questions asked. On June 4, 2019, MD was notified of interaction between resident and his daughter. Resident #1 was examined for any signs and symptoms of injury with skin assessment. There were no marks on the resident's face; a small scratch was noted to his left forearm. Our social worker's notes do not indicate the resident had any signs or symptoms of distress.

On June 4, 2019, the resident's daughter, who is also the responsible party, was asked to allow the resident to have time without visitors. Daughter was offered a separate area to rest/sleep however his daughter declined to leave the resident's room. One-to-one staff was placed at resident's bedside as review continued. Resident's son, K, was contacted and notified of concern related to caregiver burnout with daughter and suggested family support. Son did not report that there was a history of similar behavior between resident and K's sister.

Resident #1's care plan was updated for medication administration in chocolate pudding for taste and increased compliance, or via G-tube. Music and Memory Program in place for calming. Antibiotics were ordered June 6-11, 2019, due to diagnosis of UTI. Consistent

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"If she had witnessed abuse or neglect she would go straight to the supervisor and she was in the room with me."

During a telephone interview on 6/12/19 at 3:10 PM Nurse Supervisor #2 indicated during report Nurse Supervisor #1 reported that Resident #1 was agitated when he returned to the bed and she saw a family member slap him because he did something to her. At the time she assumed Nurse Supervisor #1 had reported the abuse. She didn't clarified it with Nurse Supervisor #1 and she didn't think about it at the time. She stated that she didn't think to report the abuse to management. She assumed Nurse Supervisor #1 reported it since she witnessed it.

During interview on 6/12/19 at 4:00PM the Director of Nursing (DON) indicated she was notified on Tuesday the 4th by the Staffing Coordinator (SC) that Resident #1 was slapped. She told the SC to interview Nurse Supervisor #1 to determine if it was abuse or not. Resident #1 was severely impaired. Based on the staff statements we asked the family member to leave on Tuesday. She refused to leave and stated that she had nowhere to go. We offered her a room in assisted living. She declined. We initiated 1:1 supervision. The investigation was completed with staff statements. We used the regulatory guidelines for visitor resident abuse the staff should have called me when this situation occurred. The nurse supervisor had struggled with whether it was abuse or not.

During an interview on 06/13/19 at 10:59 AM the Administrator indicated that the DON got the information and staff made clear that there was no willful injury. Our decision was that there was

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staffing assignments continued. Resident #1's care plan was updated for these approaches for staff to take during care routine. A psychiatry consultation was recommended for resident but declined by daughter as neurology is following for medication regimen.

Durham Police were called on June 13, 2019. Officer Ellis, Durham Police Department, responded and came to the independent conclusion that a report would not be filed. Initial Allegation Report was submitted to NC DHHS on June 13, 2019. Investigation Report was submitted on June 14, 2019

2. Address how corrective action will be accomplished for those residents having a potential to be affected.

All staff, including NS #1 and MA, were in-serviced regarding recognizing and reporting allegations of resident abuse. All staff were given the opportunity to ask questions and to report any suspected abuse that had not been previously reported; no allegations were reported. Also, all direct care staff who care for residents with severely impaired cognition for daily decisions coded on MDS were individually interviewed and asked:

Have you ever witnessed visitors, residents, or staff abusing a resident? and if yes,

Have you reported this to your Administrator or Director of Nursing

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F 607	Continued From page 4 no abuse. take all reports seriously and we take we go above and beyond to make sure the residents are safe. We put into place 1:1 observation to confirm that there was no abuse. We never considered abuse had occurred based on the witnesses. We were over protective doing the one on one at our expense.	F 607	immediately? All staff answered no to the first question. The North Carolina Department of Health and Human Services Initial Allegation Report form was printed and provided to RN Supervisors to allow for quick access to document for reporting 24 hours a day/7 days a week. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. In-Service provided to all staff regarding investigation protocol and reporting of abuse. In-service to include training to ensure staff is aware: (a) of what constitutes abuse; (b) that all allegations of abuse shall be reported immediately to NC DHHS, regardless of whether it is perpetrated by facility staff, residents or visitors; (c) that allegations shall be reported prior to completing the investigation or evaluation of whether the occurrence meets the definition of an alleged violation or abuse. In-services on abuse reporting and protocol were completed June 13-18, 2019. In-services will be conducted upon hire and quarterly. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON or designee will administer an abuse test at random to 6 arbitrary facility staff to	

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F 607	Continued From page 5	F 607	verify understanding of the abuse identification and reporting policy x 4 weeks and monthly x 4 months. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance and Assessment meeting. The dates for random tests are subject to the review of the Quality Assurance committee.	