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 03/16/2023

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

(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 from 03/15/23 through 03/17/23. Event ID# KOXL11 . NC00196352, NC00198381, NC00194895, NC00199334, NC00199409, NC00197436, NC0001971352 10 of 11 did not result in defiency, NC00196398 1 of 1 resulted in deficiency and NC001966569 1of 1 resulted in deficiency.	F 000		
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	F 609		3/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/30/2023

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 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on residents, staff, administration interviews, and record review, the facility failed to report an allegation of abuse to the State Agency within two hours of becoming aware of the allegation for 1 of 2 allegations of abuse reviewed (Resident #5 and 6). Findings included: Resident #5 was re-admitted to the facility on 2/8/20. A review of his annual Minimum Data Set (MDS) assessment, dated 1/26/23, revealed severe cognitive impairment and behavioral symptoms directed toward others. Resident 5's diagnoses including aphasia (inability to communicate), a history of stroke, and a cognitive communication deficit. Resident #6 was re-admitted to the facility on 4/21/20. A review of his quarterly MDS assessment, dated 2/17/23, revealed severe cognitive impairment. Resident 6's diagnoses including diabetes mellitus. Record review revealed the nurses' notes, dated 9/20/22, indicated the altercation between two residents on 9/18/22: Resident #5 struck out at Resident #6. Record review revealed the Initial Allegation Report, dated 9/19/22, indicated that the facility became aware of the incident on 9/19/22 at 12:30 PM. Resident #5 was "observed by staff smacking another resident (Resident #6) in the face after elevated voices between the residents	F 609	F-609 (1) How corrective action will be accomplished for resident(s) found to have been affected: The 2 hour reporting timeline had passed for residents #5 and #6. However, no other residents were noted to be affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 3/16/2023 the Administrator, Director of Nursing, and the Staff Development Coordinator initiated re-education to all staff regarding the guidelines and requirements for state reporting obligations along with the required timeline for reporting. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:	

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F 609	Continued From page 2 we exchanged". Law Enforcement was notified at 1:00 PM. The Initial Allegation Report for resident abuse was faxed to the State Agency on 9/19/22 at 1:00 PM. Record review revealed the nurses' notes, dated 9/19/22 at 7:10 AM, indicated that Resident #5 exchanged elevated words with another resident (Resident #6), reached out, and smacked another resident (Resident #6) in the face. Staff separated residents. Record review revealed the statement, written by the Administrator, indicated that on Sunday (9/18/22) Medical Director was notified by staff regarding the altercation between Resident #5 and Resident #6. On 3/16/23 at 10:20 AM, during the phone interview, Nurse #2, who worked as Director of Nursing in the facility at the time of the incident, indicated that on Sunday (9/18/22), Nurse #1 notified her over the phone about the altercation incident between Resident #5 and Resident #6. Nurse #2 directed her to assess both residents for safety and keep them separate. Nurse #2 continued that the following day (9/19/22), within 24 hours, the facility reported the incident to the State and Law Enforcement. On 3/16/23 at 2:10 PM, during an interview, Resident #5 had difficulties answering questions, used body language, and could explain he did not remember the incidents between him and other residents. On 3/16/23 at 2:20 PM, during an interview, Resident #6 recalled the incident when Resident #5 initiated the arguments and tried to hit him in	F 609	A monitor sheet will be done by the Administrator or the Director of Nursing to monitor and ensure that all state reporting obligations were done within the appropriate timeline. This monitoring process will take place weekly for 4 weeks and then monthly for 3 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 3/21/2023	

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F 609	Continued From page 3 the face, but Resident #6 stopped him. There was no "actual fighting," and the staff moved Resident #5 to his room. On 3/16/23 at 2:45 PM, during an interview, the Director of Nursing (DON) indicated that the incident occurred before his employment in this facility. Medical records showed no injury as a result of the incident. It was DON's understanding that the abuse allegation without injury must be reported to the State within 24 hours. On 3/16/23 at 3:15 PM, during an interview, the Administrator indicated that the incident occurred before his employment in this facility. Nurse #1, who reported the incident to the administration on 9/18/22, and Nurse #2, who worked as Director of Nursing at the time of the incident, no longer work at the facility. The Administrator thought the facility was obligated to report abuse without injury within 24 hours.	F 609		