STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite 3/13/23 through 3/15/23. One of ten complaint allegations resulted in a deficiency. Intakes NC00199542, NC00199278, NC00199103 and NC00198463 were investigated. Event ID# B9FT11.	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 record review, resident and staff interviews, the facility failed to protect a resident's right to be free from mistreatment while Resident #1 received personal care and indicated he had been jerked around in bed which had resulted in a sore arm. This occurred for one of three residents reviewed for staff to resident abuse. (Resident#1). The Findings included:	F 600	Resident #1 was reported to be affected by the deficient practice. Resident# 1 was interviewed and physically evaluated the day that the incident was reported (2/22/2023) and the physical assessment revealed no new areas of concern. Resident#1 continued to be monitored by staff during the days after the reported incident. NA#1 was immediately suspended from work on 2/22/2023 the day the facility was informed of the	4/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/05/2023

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F 600	Continued From page 1 Resident #1 was admitted to the facility on 2/10/23 with a diagnosis of lack of coordination, peripheral vascular disease, cellulitis, acquired absence of right leg above knee, aneurysm of iliac artery and cerebral infarction without residual deficits. The Admission Minimum Data Set (MDS) dated 2/16/23 revealed Resident #1 had moderately impaired cognition and he required extensive assistance with activities of daily living. A review of a Health Care Personnel Registry 24-Hour Initial Report, allegation report by facility/provider dated 2/22/23 revealed the allegation/incident type was resident abuse. The allegation description indicated that Resident #1's Nursing Assistance (NA#1) was "jerking" him (Resident #1) around in bed when providing care. The description of physical or mental injury / harm revealed Resident (#1) stated his arm was hurting. A report from the Social Service Director (SSD) dated 2/24/23 revealed, Resident #1 called his family member on 2/21/23 and reported that NA #1 was jerking and shoving Resident #1. The SSD interviewed Resident #1 on 2/22/23 and Resident #1's roommate Resident #7 after she learned of the incident from Resident #1's family member on 2/22/23. The SSD interview read; "Resident (#1) stated that on 2/21/23 NA (#1) jerked and shoved him (Resident #1) around when transferring him (Resident #1) from his wheelchair to his bed. Resident (#1) reported that during the transfer the NA (#1) told him he (Resident #1) needed to use his body and arms because she (NA #1) was not going to hurt her back trying to help him (Resident #1). Resident	F 600	incident and staff education regarding customer service was initiated by the facility. Subsequently Resident #1 discharged 3.26.2023. As of 3.30.2023 NA#1 has not worked at Five Oaks Rehabilitation Center. All residents rendered care by NA#1 would be at risk of being affected by the alleged deficient practice. As of the date of the reported incident, there has been no other reports and or other indication such as skin evaluations and or complaints of pain, that would indicate that the alleged behaviors exhibited by NA#1 occurred with any other resident under NA#1 care. The Abuse policy was reviewed and revised on 3.30.2023 by the corporate nurse to specifically indicate staff to resident abuse and to ensure that notification of regulatory agencies such as Adult Protective Services (APS) was indicated when appropriate. An Investigation Checklist form was also created 3.30.2023 to ensure that APS and other investigative steps are addressed if necessary. Staff were educated on the Abuse policy and Regulation F600 (483.12) Freedom from Abuse, Neglect, and Exploitation, by the Director of Nursing and or other designee on or before 4.5.2023. The Unit Manager or designee(s) will randomly monitor 3 staff members per week while providing ADL care weekly for 4 weeks, then monthly for 3 months. Any deficient practice observed will be corrected right away by the unit manager or designee(s).	

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F 600	Continued From page 2 (#1) reported he hurt his left arm during the incident. Resident (#1) reported he did not report the incident to staff. He (Resident #1) called his family member. The report indicated the SSD interviewed Resident's (#1) roommate, Resident #7 who was present at the time of the incident. The interview with Resident #7 read; "Resident #7 reported that when NA (#1) came into their room to put Resident (#1) to bed to change him, while transferring him she stated to (Resident #1) you are going to have to help me because I am not hurting my back. Resident #7 reported he heard NA (#1) yelling at Resident (#1) telling him to use his body and his arms. Resident #7 reported Resident #1 responded, "I don't have a body to use, and I only have one arm". Resident #7 also stated that Resident #1 stated he felt like he was going to fall, and NA (#1) yelled "you ain't going to fall, you ain't going to fall." Resident #1's roommate; Resident #7 was admitted to the facility on 11/14/22 with a diagnosis of lymphedema. A quarterly MDS assessment dated 2/13/23 coded Resident #7 as having intact cognition and adequate hearing and vision. An interview was conducted on 3/13/23 at 3:51 with Resident #1's roommate Resident #7 who stated that NA #1 treated Resident #1 "pretty bad" when she was changing him. Resident #7 stated that NA #1 was talking to him (Resident #1) badly and yelled at him stating "you have to do some of the work and use your muscles because she (NA #1) was not going to hurt her back". Resident #7 stated that Resident #1 said he did not want to fall, and NA #1 said to Resident #1 "don't worry I got you" but Resident #1 started screaming. Resident #7 stated that NA #1 is "nasty and	F 600	All allegations of abuse are to be tracked and trended by the Administrator and or his or her designee and presented to the QAPI team. Results of the staff monitoring will be reviewed at Quality Assurance Meeting x 3 months for further resolution if needed. Date of substantial compliance: April 5, 2023	

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demeaning" and that he had told a nurse (but could not remember which nurse) he did not want NA #1 working with him either.

An interview was conducted with Resident #1 who stated that NA #1 had been jerking him around, pulled him and grabbed his arm. Resident #1 stated she (NA#1) said he had to help himself. Resident #1 stated he was not afraid of falling and he was not injured but that his arm hurt and she made him feel bad. Resident #1 was asked how NA #1 made him feel bad and Resident #1 stated "like he was worthless". Resident #1 was unable to recall the exact date this had happened and stated that he did not tell anyone at the facility but called and told a family member.

An interview was completed with NA #1 on 3/14/23 at 12:14 PM who explained on 2/21/23 and Resident #1 had a bowel movement. NA #1 stated that she pulled the bed out from the wall (which would have been Resident #1's right side) and had pulled the bed pad towards her and rolled the pad so Resident #1 would roll onto his left side. NA #1 stated she had told Resident #1 to grab the bed rail. NA#1 stated that she cleaned him up on his left side and then had repeated to clean Resident #1 on is right side by using the pad to turn him to roll onto his right side. NA #1 stated she cleaned him up on his right side and put a brief on him and had put a cover on him. NA #1 stated that Resident #1 was fine, he did not scream or say anything to NA #1. NA #1 stated she did not say anything related to her not wanting to hurt her back and did not tell Resident #1 to use his muscles. NA #1 stated that she had not touched his arm but had Resident #1 grab the side rails when turning him.

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An interview was completed with the Social Service Director (SSD) on 3/14/23 at 1:37 PM who stated that Resident #1's family member came to the SSD office on 2/22/23 in the afternoon to inform her of an incident with NA #1 and Resident #1 which happened on 2/21/23. The family member reported to the SSD that Resident #1 called her on his cell phone on 2/21/23. The SSD interviewed both Resident #1 and his roommate Resident #7 and this was reported as an abuse allegation. The SSD stated that when she met with Resident #1 on 2/22/23 he stated to the SSD that his left arm was sore but not as sore as it was during the initial incident 2/21/23. The SSD stated she did look at his arm and did not see any bruising but had reported to the Director of Nursing (DON) regarding his arm. The SSD spoke with Resident #7 if he had any concerns about NA #1 and the SSD stated Resident #7 stated "she is just mean and nasty". The SSD stated she could not recall if she reported Resident #7's comment about NA #1 to anyone else.

An interview was conducted with the DON on 3/14/23 at 2:20 PM who stated that the SSD brought the incident to her attention on 2/22/23. The DON stated that she had spoken to Resident #1 but did not have her conversation documented as the SSD took the initial report from Resident #1. The DON recalled that Resident #1 said the same thing as what was written in the report from the SSD that NA #1 was jerking Resident #1 around while he was in the bed and the DON stated that the roommate (Resident #7) interjected and said the roommate was concerned of falling and the NA #1 told the Resident #1 he was not going to fall. The DON

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stated that she did ask NA #1 if she had yelled at Resident #1 and NA #1 reported to the DON that she had not yelled and was just telling Resident #1 he was not going to fall. The DON stated that a nurse came in and assessed his arm and he did not have any pain. The DON was asked if she had any of the information she had reported during the interview and she replied, the only information I would have gotten would had been a statement from NA #1 but that was not in the facility investigation file but would look for it. The DON stated that after the investigation it had been concluded that NA#1 had bad customer service with Resident #1.

Resident #1's Medication Administration Record was reviewed, and a pain scale had been completed each shift indicated Resident #1 did not have pain from 2/21/23 through 2/23/2023.

A review of Resident #1 skin assessment dated 2/22/23 with an effective date of 11:01 PM completed by Nurse #1 revealed no changes from previous skin assessments that had been completed on 2/10/23 and 2/15/23.

A telephone interview was completed with Nurse #1 on 3/14/23 at 8:10 PM who stated that she worked on February 21-23rd from 3:00 PM to 11:00 PM and stated she did not recall anyone asking to look at Resident #1's arm.

A written statement dated 2/22/23 from NA #1 was received from the DON on 3/15/23 at 9:00 AM. The statement from NA #1 which read in part; "I got him up after breakfast, after dinner, I put him in his bed. I had to move his bed from side to side to change him."

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An interview was completed on 3/15/23 at 9:18 AM with the Administrator who serves as the facilities abuse coordinator.
The Administrator stated that he learned of the allegation on 2/22/23 at 3:33 PM. The Administrator met with Resident #1 on 2/22/23 after he had submitted the Health Care Personnel Registry 24-Hour Initial Report but had not documented his conversation. The Administrator stated Resident #1 did not seem distraught (agitated with doubt or mental conflict or pain) and Resident #1 stated he was not afraid of NA #1 and that Resident #1 liked the girl who was providing care for him on that day 2/22/23. The Administrator stated that at the same time when meeting with Resident #1 he asked his roommate (Resident #7) about his care provision and Resident #7 replied to the Administrator that he was fine. The Administrator stated that when he spoke with NA #1 (he did not recall the date) she (NA #1) did not feel she had done anything wrong. The Administrator stated that after the investigation concluded on 2/28/23 to his knowledge it was "regarding provision of ADL (activities of daily living) care." The Administrator further explained that based on his follow up with Resident #1 and him not being fearful and talking to NA #1 it was concluded that Resident #1 and NA #1 did not work well together and did not substantiate with the intent of abuse and felt that NA #1 displayed poor customer service with Resident #1.

A phone interview was conducted on 3/15/23 at 10:32 AM with NA #2 who worked on 2/21/23 and 2/22/23 from 3-11 PM who stated that she takes Resident #1 out to smoke, and she did not remember Resident #1 complaining of any pain or had not mentioned anything to her (Resident

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#2) about any mistreatment.

A follow up interview was completed on 3/15/23 at 11:00 AM with Resident #1 who was asked if NA #1 was transferring him and Resident #1 stated that he thought he was already in bed when NA #1 needed to change him. Resident #1 stated "she had grabbed my forearm and it hurt, and she was jerking me around when she was changing me and said that she (NA #1) would mess her back up if he (Resident #1) didn't help her." Resident #1 stated that he was "not afraid of NA #1, she had a very stern voice and made me feel worthless, I guess that is just her way." Resident #1 stated that he just wanted to be treated fairly and not yelled at, Resident #1 went on to explain that he felt like a school kid getting disciplined the way she had talked to him.

A follow up interview was completed with Resident #7 on 3/15/23 at 11:32 AM who was asked if the privacy curtain was pulled during the interaction with the Resident #1 and NA #1 and Resident #7 replied the privacy curtain was pulled (this would visually block Resident #7's view of Resident #1's bed). Resident #7 was asked if he knew if Resident #1 was being transferred from his wheelchair to the bed and Resident #7 stated that he thought Resident #1 was already in his bed. Resident #7 stated NA #1 stated you roll over and use your muscles and Resident #1 stated he had no muscles. Resident #7 stated he heard Resident #1 state "you are hurting me."

An interview was completed with the Unit Manager on 3/15/23 at 11:45 AM and did not recall anything happening between NA #1 and Resident #1. The Unit Manager found out about the incident on 2/22/23 in the afternoon.

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On 3/15/23 the DON presented an undated written statement of her interview with Resident #1. The report read in part; On 2/24/23 DON interviewed Resident #1 regarding the incident that was reported on 2/22/23. DON asked Resident #1what happened. Resident #1 sated NA #1 was rude, rolling me from side to side, and my (Resident #1) arm was sore. DON asked Resident #1 if someone came to look at his arm and if he felt fearful of NA #1. Resident #1 stated "I wouldn't want to work with her again and they checked" DON asked Resident #1 if he feels safe and he replied "yes".

On 3/15/23 at 5:45 PM the DON presented an undated written statement of her interview with Resident #7 which read; "DON writer interviewed Resident #7 on 2/24/23. DON asked if he heard or witnessed an incident involving his roommate (Resident #1). Resident #7 stated he heard Resident #1 say I'm going to fall, I'm going to fall and heard NA#1 state I'm not going to let you fall. DON asked if anything else was heard or witnessed, Resident #7 denied."

An interview was completed with the DON on 3/15/23 at 2:25 PM who stated that it would be her expectation with any resident is to provide respect and the utmost care to residents. The DON stated she tells the staff when they enter a residents room to think of it as your mother, brother, sister or grandparents and how you would want them to be treated. The DON stated that she would not expect this to occur, and any resident should be in a safe environment.

An interview was completed with the Administrator on 3/15/23 at 4:59 PM who stated

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F 600	Continued From page 9 that his expectation is we are to protect our residents from abuse and should feel safe and secure and that residents feel they are in a safe homelike environment. The Administrator stated that he believed he should vet our employees as well to ensure they have the values that are congruent with the philosophy as care.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy in the areas of completing a thorough investigation, failed to immediately assess other residents who were under the care of Nurse assistant (NA#1), failed to report to Adult Protective Services (APS), and failed to report to Law Enforcement. This occurred when Resident #1 was mistreated by	F 610	Resident#1 was affected by the alleged deficient practice. Resident #1 was subsequently discharged from the facility on 3.26.2023. All residents would be at risk to be affected by the deficient practice as all residents are dependent on the facility's Administrator/abuse coordinator and	4/5/23

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F 610	Continued From page 10 being jerked around while receiving care in bed and complained of a sore arm. This occurred for one of three residents reviewed for staff to resident abuse (Resident #1). The Findings included: Review of an undated facility policy titled "Abuse-Neglect and Exploitation," read in part: "Section V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; 6. Providing complete and thorough documentation of the investigation. Section VI. Protection of Resident; The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Section VII. Reporting/Response: A. 1. Reporting of alleged violations to adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. 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. A review of a Health Care Personnel Registry 24-Hour Initial Report, allegation report by facility/provider dated 2/22/23 revealed the	F 610	facility staff to assess and provide policies and processes that would prevent further potential of abuse while an investigation is in progress. The Abuse policy was reviewed by the corporate nurse to specifically indicate staff to resident abuse and to ensure that notification of regulatory agencies such as Adult Protective Services (APS) was indicated when appropriate. An Investigation Checklist form has been created 3.30.2023 to ensure that APS and other investigative steps are addressed (if necessary), such as completing resident interviews and or skin evaluations. The Director of Nursing and the Administrator were educated on both the Abuse Policy and the Investigation Checklist tool (form) 3.30.2023. Going forward, all allegations of abuse are to have the investigation checklist utilized as part of the Quality Assurance to assist in ensuring all reported allegations of abuse have been thoroughly investigated. The result of the investigation checklist will be reviewed at Quality Assurance Meeting x 3 months for further resolution if needed. Date of substantial compliance: April 5, 2023	

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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) COMPLETION DATE
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allegation/incident type was resident abuse. The allegation description indicated that Resident #1's Nursing Assistance (NA#1) was "jerking" him (Resident #1) around in bed when providing care. The description of physical or mental injury / harm revealed Resident (#1) stated his arm was hurting.

A review of a Health Care Personnel Registry 5-day Working Day Report Investigation Report from facility/provider dated 2/28/23 revealed the investigation end date was 2/28/23 and the allegation/incident type was resident abuse. The allegation description indicated that Resident #1's Nursing Assistance (NA#1) was "jerking" him (Resident #1) around in bed when providing care. The report documented under description of resident's injury/harm below indicated; Resident (#1) stated at the time of the incident that his arm was hurting but nurse examination indicated no injuries. The report documented the incident report was not reported to the County Department of Social Services and under Law enforcement "no" was selected under a reasonable suspicion of a crime. The supporting documents to the 5-day working report read in part; "An investigation conducted on 2/22/23. Abuse is not substantiated in this investigation, but an educational opportunity has been identified for NA #1 on customer service."

An interview was completed with NA #1 on 3/14/23 at 12:14 PM who stated that she (NA #1) had to write a statement for the Director of Nursing (DON) and was suspended on 2/22/23 pending an investigation. NA #1 stated when she returned to work, she had received a verbal reprimand that she (NA #1) should inform residents what she is doing throughout the

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	345186	A. BUILDING _____ B. WING _____	C 03/15/2023

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process (ADL-activities of daily living) so the resident would have an understanding throughout the process.

A report from the Social Service Director (SSD) dated 2/24/23 revealed, Resident #1 called his family member on 2/21/23 and reported that NA #1 was jerking and shoving Resident #1. The SSD interviewed Resident #1 on 2/22/23 and Resident #1's roommate Resident #7 after she learned of the incident from Resident #1's family member on 2/22/23. The SSD interview read in part; "Resident (#1) stated that on 2/21/23 NA (#1) jerked and shoved him (Resident #1) around, Resident (#1) reported he hurt his left arm during the incident.

An interview was completed with the Social Service Director (SSD) on 3/14/23 at 1:37 PM who stated that she interviewed Resident #1 and his roommate, Resident #7 immediately after she became aware of the incident from Resident #1's family member on 2/22/23. The SSD stated that when she met with Resident #1 on 2/22/23 he stated to the SSD that his left arm was sore but not as sore as it was during the initial incident 2/21/23. The SSD spoke with Resident #7 if he had any concerns about NA #1 and the SSD stated Resident #7 stated "she is just mean and nasty". The SSD stated she could not recall if she reported Resident #7's comment about NA #1 to anyone else. The SSD stated that she reported the incident to the Director of Nursing (DON) and to the Administrator who is also the abuse coordinator. The SSD stated she did not interview any other residents regarding concerns with NA #1 but would interview anyone that is present or identified as a witness which is why she interviewed Resident #1 and his roommate

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Resident #7. The SSD was asked if the police were called, and she stated the Abuse Coordinator (the Administrator) would be the person to call the police not the SSD.

An interview was conducted with the DON on 3/14/23 at 2:20 PM who stated that the SSD brought the incident to her attention on 2/22/23. The DON stated that she had spoken to Resident #1 but did not have her conversation documented as the SSD took the initial report from Resident #1. The DON stated that she did not interview any other residents to see if they had concerns regarding NA #1 and did not do any skin assessments on any other resident who are not alert and oriented. The DON stated that typically she would not interview other residents, but sometimes the SSD would check with other people. The DON stated that a report was not made to the police because she (DON) had asked Resident #1 if he wanted the incident reported to the police and he had declined. The DON stated, "when a resident is alert and oriented, we ask them if they want it reported to the police and if the resident is not alert and oriented the Administrator would make that decision." The DON stated, "the allegation was not substantiated as the investigation concluded NA#1 had bad customer service."

An interview was completed on 3/15/23 at 9:18 AM with the Administrator who serves as the facilities abuse coordinator. The Administrator stated that he wanted to clarify the dates of the incident and when the facility became aware of the incident. The Administrator confirmed the facility became aware of the incident on 2/22/23 at 3:33 PM and confirmed the day of the incident was 2/21/23. The Administrator stated he met

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with Resident #1 on 2/22/23 after he had submitted the Health Care Personnel Registry 24-Hour Initial Report but had not documented his conversation. The Administrator stated Resident #1 did not seem distraught (agitated with doubt or mental conflict or pain) and Resident #1 stated he was not afraid of NA #1. The Administrator stated that at the same time when meeting with Resident #1 he asked his roommate (Resident #7) about his care provision and Resident #7 replied to the Administrator that he was fine. The Administrator stated that when he spoke with NA #1 (he did not recall the date) she (NA #1) did not feel she had done anything wrong. The Administrator stated that after the investigation concluded on 2/28/23 to his knowledge it was "regarding provision of ADL (activities of daily living) care." The Administrator stated if there was reason to believe a suspicion of a crime we would call the police, however, in this case he did not feel there was a suspicion of a crime nor was the resident a victim of a crime. The Administrator was asked why the Division of Social Services (DSS) was not called and the Administrator explained that DSS was not called as the circumstances did not warrant a suspicion of a crime. The Administrator was asked if other residents were interviewed regarding the care provided by NA #1, and he stated "that it would be best practice to interview other residents but in this case, we interviewed just the roommate as a witness." The Administrator explained that depending on the circumstances would warrant additional interviews with alert and oriented residents and for non-alert and oriented residents, assessments such as physical assessments depending on the situation.