STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	**2059 TORREDGE ROAD DURHAM, NC 27712**

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F 000	INITIAL COMMENTS The surveyor entered the facility on 8/8/23 to conduct a complaint investigation and exited on 8/10/23. Additional information was obtained on 8/11/23. Therefore, the exit date was changed to 8/11/23. Event ID# HYRD11. The following intakes were investigated NC 204775, NC 205542, NC 205440, NC 205667, and NC 205681. Twelve of twelve complaint allegations did not result in deficiency.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §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, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		9/1/23

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

Electronically Signed | 08/28/2023

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F 607	Continued From page 1 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to implement their abuse policy to 1) assure an abuse allegation was reported to facility administration immediately in order that administration take further actions per their policy and 2) to assure the investigation was thorough enough to identify and talk with a witness who had been present. This was for one (Resident # 6) of four residents reviewed for abuse. The findings included: The facility's abuse policy, last revised on 8/30/2022, included the following information. "The center will investigate any alleged abuse/neglect or misappropriation of resident property in accordance with state or federal law. The center will report such allegations to the state, as per state/federal regulation. The center will report immediately but no later than 2 hours after forming the suspicion if the events that cause the allegation involve abuse or result in serious bodily injury." Resident # 6 was admitted to the facility on 2/15/22. Resident # 6's quarterly MDS assessment, dated 6/14/23, coded Resident # 6 as cognitively intact. Resident # 6 was assessed to have verbal	F 607	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth by the surveyors on-site. This letter is solely prepared because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Interventions for the affected resident Resident #6 was not affected by the facility non-compliance. The allegation of abuse/neglect was unsubstantiated. Intervention for residents identified as having the potential to be affected. All staff will be re-educated on the abuse and neglect policy and reporting abuse by the Director of Nursing, Administrator or Social Service Director/or designee by 8.28.23. Interviews will be conducted on all cognitively intact residents by Director of Nursing (DON), Unit Manager (UM), Social Services Director or/ designee on	

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F 607	Continued From page 2 behaviors one to three days during the MDS assessment period. Resident # 6 was also coded to need supervision for locomotion in the facility. Resident # 6's care plan, revised on 8/8/23, noted Resident # 6 exhibited manipulative and persuasive behaviors. On 7/15/23 at 3:20 PM Nurse # 1 entered a nursing note into Resident # 6's record noting the following. "Resident had altercation with another resident in T.V room. Staff heard resident screaming, upon arrival, resident states resident hit her. Other resident removed from room. Resident assess for injuries. No injuries noted. RP/MD (responsible party/medical doctor) notified. Other resident on 15 min monitoring. Will continue to monitor." According to the facility's investigation into the incident, Resident # 5 had been the resident who had allegedly hit Resident # 6. Review of Resident # 5's record revealed Resident # 5 was admitted to the facility on 7/1/22. Resident # 5's annual Minimum Data Set Assessment (MDS), dated 7/1/23, coded Resident # 5 as cognitively intact and as independent in his locomotion within the facility. Resident # 5 was not coded to have behavior problems during the MDS assessment period. Resident # 5's care plan, updated on 8/8/23, noted Resident # 5 had behaviors related to inappropriate sexual advances and sexually inappropriate language towards others. This had been added to the care plan on 10/13/22 and	F 607	abuse and neglect by 8-28-23. A 100% skin audit will be conducted on all cognitively impaired residents by nurse management team (DON, UM, Nurse Supervisor) by 8-28-23. Administrator, DON, UM, and Social Services Director will be re-educated on the investigation process for allegations of abuse and neglect. This education will be conducted by the Corporate □ Director of Clinical Services by 8-28-23. All newly hired staff will be educated on the abuse and neglect policy and the reporting of abuse by the Director of Nursing or designee. Systemic changes Beginning 8-28-23, education retention questionnaires will be conducted with (5) staff members by the Director of Nursing, Unit Manager, Nurse Supervisor or Social Services Director weekly for (12) weeks to determine staff retention of education related to timely reporting. Beginning 8-28-23, all alleged allegations of abuse and/or neglect will be reviewed by the regional support team (Vice President of Operations or Director of Clinical Services) to ensure timely reporting and thorough investigation. This review will be conducted with each allegation of abuse/neglect for the next six (6) weeks.	

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remained part of Resident # 5's care plan.

On 7/15/23 at 3:26 PM Nurse # 1 entered a nursing note into Resident # 5's record noting Resident # 5 had been in an altercation and Resident # 5 was placed on every 15 minute checks by staff.

Review of the facility's investigation into the incident revealed the 7/15/23 incident was reported to the state agency on 7/17/23, which was two days after the incident occurred. The investigation summary noted, "Resident (Resident # 6) claims to have been hit by another resident. It was not witnessed and residents in question kept changing their account of incident. No injuries noted on either resident."

Resident # 6 was interviewed on 8/9/23 at 4:45 PM and reported the following. On the date of the 7/15/23 incident, Resident # 5 kept saying sexual remarks to her while they were in the television room, and she told him to go away. While Resident # 5 was seated in his wheelchair behind her, Resident # 5 then pulled her (Resident # 6's) wheelchair back towards him and hit her in the arm, chest, and head. At the time Resident # 8 was present in the room also and saw what happened. The nurse came in after she was hit. The nurse asked them what happened, and Resident # 5 "lied" and said that she (Resident # 6) had pushed her wheelchair into him. Resident # 6 stated that was not true, and she had not pushed her wheelchair into Resident # 5. Resident # 6 reported she was not hurt, but it did make her sore where she had been hit.

Resident # 5 was interviewed on 8/10/23 at 1:35 PM and reported the following. He did not recall

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the details of any specific altercation with another resident and stated he had never hit anyone. He did at times make sexual jokes but meant no harm by them, and only said them to people who he thought might not be upset by his remarks.

Nurse # 1 was interviewed on 8/10/23 at 10:00 AM and reported the following. When the 7/15/23 incident occurred no staff member had witnessed the incident. She heard Resident # 6 yell out. When she entered Resident # 5 was not at the back of Resident # 6's wheelchair. Resident # 5 was facing towards Resident # 6 from a diagonal position. Resident # 6 reported to her that Resident # 5 had hit her. Resident # 5 reported to her that Resident # 6 had pushed her wheelchair into his knees, and he wanted to hit her but had not done so. At the time Resident # 8 was present. She (Nurse # 1) asked Resident # 8 what happened, and Resident # 8 stated Resident # 5 had hit Resident # 6. Nurse # 1 reported the incident occurred on a weekend, and she tried to call the Director of Nursing (DON) but could not get in touch with her. At the time of the incident, Resident # 6 did not report any problems with Resident # 5 making sexual remarks to her. She placed Resident # 5 on every 15 minute checks and called the responsible parties and physician.

A review of Resident # 8's record revealed an annual MDS assessment of 6/1/23 noting Resident # 8 was cognitively intact. Resident # 8's care plan, updated on 8/9/23, revealed Resident # 8 exhibited manipulative behaviors and would fabricate information.

The facility social worker assistant was interviewed on 8/10/23 at 12:00 PM and reported

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Resident # 5, Resident # 6, and Resident # 8 all have behavioral issues. To her knowledge, Resident # 5 used to exhibit sexual behavior to staff only and not towards residents, but his behaviors had improved. Resident # 6 and Resident # 8 were close friends, and she thought Resident # 8 would say anything that Resident # 6 wanted her to say although it might not be true. The Social Worker Assistant provided examples of both Resident # 6's and Resident # 8's behaviors.

The Director of Nursing and interim Administrator were interviewed on 8/10/23 at 11:15 AM and reported the following. The DON was reviewing clinical records on 7/17/23 and found the notation about the 7/15/23 incident. This was the first time she or the interim Administrator knew about the incident. Her staff had not reported it before then. She always carried and answered her phone at all times when she was at or away from the facility. The staff could have reached her on the weekend. Both Resident # 5 and Resident # 6 were interviewed during the facility's investigation and were inconsistent in what they reported. Resident # 6 had not reported any problems with Resident # 5 making sexual remarks to her. During their investigation, they had not been made aware Resident # 8 had witnessed the incident and therefore had not talked to her and given any consideration to her details of what happened.

On 8/11/23 at 5:45 PM the facility's corporate Vice President (VP) was interviewed. According to the VP, the facility's investigation should have identified there was a witness on 7/15/23 and the witness should have been interviewed during the facility's investigation.

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F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, Psychiatric Nurse Practitioner, and Psychologist interview the facility failed to assure the providers of psychiatric services were aware of altercations and behaviors for residents for whom the psychiatric providers were treating. This was for three (Residents # 5, # 6, an #8) of three residents reviewed for behavioral problems. The findings included. 1. Review of Resident # 5's record revealed Resident # 5 was admitted to the facility on 7/1/22. The resident had a diagnosis of depression and a diagnosis of cognitive social or emotional deficit following a stroke. Resident # 5's annual Minimum Data Set Assessment (MDS), dated 7/1/23, coded Resident # 5 as cognitively intact and as independent in his locomotion within the facility. Resident # 5 was not coded to have behavior problems during the MDS assessment period. Resident # 5's care plan noted Resident # 5 had	F 740	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion s set forth by the surveyors on-site. This letter is solely prepared because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Interventions for the affected residents. Interventions for those affected: Residents # 5, # 6, and #8 newly reported behaviors were communicated to psychiatric services on 8-10-23(#5) and 8-14-23(#6, #8)by the Social Services Director. Interventions for residents identified as having the potential to be affected.	9/1/23

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F 740	Continued From page 7 behaviors related to inappropriate sexual advances and sexually inappropriate language towards others. This had been added to the care plan on 10/13/22 and remained part of Resident # 5's care plan. An intervention for Resident # 5's sexual behavior was to provide a psychological evaluation as needed. Review of Resident # 5's psychotherapy notes revealed Resident # 5 was seen on 6/2/23. The clinical psychologist noted no mention of sexual behaviors in her notes. She noted Resident # 5 had the following symptoms: Anhedonia (the inability to feel pleasure), anxiety, fatigue, grief/loss, life dissatisfaction, poor decision making, ruminating thoughts, sadness, and worry. She further noted his next treatment plan was due 8/5/23. Review of Resident # 5's social work notes for the month of July 2023 and August 2023 revealed no notation of behavioral issues. On 7/15/23 at 3:26 PM Nurse # 1 entered a nursing note into Resident # 5's record noting Resident # 5 had been in an altercation with another resident, and Resident # 5 was placed on every 15 minute checks by staff. Nurse # 1 was interviewed on 8/10/23 at 10:00 AM and reported the following. When the 7/15/23 incident occurred no staff member had witnessed the incident. Resident # 6 had been the other resident involved in the altercation. She had heard Resident # 6 yell. When she entered the room, Resident # 6 had reported to her that Resident # 5 had hit her. She assessed Resident # 6 and found no injuries. Resident # 5 denied he had hit Resident # 6. Instead, Resident # 5 stated	F 740	A review of current resident's progress notes for the past 14 days will be conducted for any documented behaviors and need for psychiatric referrals. This review will be conducted by the Director of Nursing (DON), Unit Managers (UM) and Social Services Director by 8-30-23. The facility Administrator will provide education to the Director of Nursing, Unit Manager, Nurse Supervisor and Social Services Director on ensuring psychiatric referrals are initiated for any resident who exhibits behaviors including resident to resident altercations. This education will be provided by 8-30-23. All Licensed Nurses will be re-educated by the Director of Nursing on documenting resident's behaviors in the resident electronic record by 8-30-23. Systematic changes All newly hired Licensed Nurses will be educated by the Director of Nursing on documenting resident's behaviors in the resident's electronic health Beginning 8-31-23, current resident's progress notes will be reviewed daily for (12) weeks by the Interdisciplinary Team (DON, UM, and Social Services Director) in the clinical meeting for any identified resident behaviors. Psychiatric referrals will be initiated as appropriate. Beginning 8-31-23, psychiatric referrals will be initiated by the Social Services	

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F 740	Continued From page 8 that Resident # 6 had run her wheelchair into him. Resident # 5 stated he had wanted to hit Resident # 6 but had not done so. Resident # 8 had been present at the time and reported Resident # 5 had hit Resident # 6. The facility social worker assistant was interviewed on 8/10/23 at 12:00 PM and again on 8/11/23 at 12: 29 PM and reported the following. She was familiar with both Resident # 5 and Resident # 6. Both had behavioral issues. Resident # 5's behavioral issue involved making sexual comments to staff. She had never known Resident # 5 to make the comments to residents. His behavior had improved since he had resided at the facility. Review of the facility's Psychiatric Nurse Practitioner's (NP) notes revealed Resident # 5 was seen on 7/19/23. The Psychiatric NP noted the following. She was seeing Resident # 5 for a visit related to chronic problems with insomnia and sexual behavior. Staff had reported no problems with his mood, sleep and appetite. His sexual behavior was noted to be managed with an antidepressant. There was no mention in the Psychiatric NP's notes about the altercation that had occurred on 7/15/23. Resident # 5 was interviewed on 8/10/23 at 1:35 PM and reported the following. He did not recall the details of any specific altercation with another resident, and he stated he had never hit anyone. He did at times make sexual jokes but meant no harm by them, and only said them to people who he thought might not be upset by his remarks. Resident # 6 was interviewed on 8/9/23 at 4:45 PM and reported the following. On the date of the	F 740	Director /or designee for all resident behaviors reported including resident to resident altercations. The Director of Nursing or Administrator will audit to ensure any psychiatric referrals related to behaviors has been initiated/completed. This audit will occur weekly for (12) weeks. Beginning 8-31-23, weekly meetings will be held with the Social Service Director, Director of Nursing, and the psychiatric provider to address any newly reported resident's behaviors x 12 weeks. Beginning 8-31-23, behavioral interviews will be conducted with (3) Licensed Nurses weekly for 12 weeks by the Director of Nursing, Unit Manager or Social Services Director. These interviews will include inquiring on any recent resident behaviors and reviewing the record to see if stated behaviors were documented. After interviews, any ongoing educational opportunities related to documentation will be conducted with the Licensed Nurse (as applicable). Monitoring of the change for sustain system compliance In the facility monthly Quality Assurance Performance Improvement (QAPI) meeting, DON will audit and report finding to QAPI committee for 12 weeks for recommendations. QAPI Committee will review audits and make recommendations to assure compliance is maintained ongoing. QAPI Committee will	

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7/15/23 incident, Resident # 5 kept saying sexual remarks to her while they were in the television room, and she told him to go away. Resident # 5 then hit her.

During the interview with Nurse # 1 on 8/10/23 at 10:00 AM, Nurse # 1 reported neither Resident # 6 nor the witnessing resident (Resident # 8) had said anything about sexual advances by Resident # 5.

The Psychiatric NP was interviewed on 8/11/23 at 2:20 PM and reported the following. She saw Resident # 5 routinely every month. When she visited the staff always told her Resident # 5 had verbal sexual behaviors towards staff but not to residents. She had started Resident # 5 on an antidepressant to help decrease his Libido. She did not think Resident # 5 meant to hurt anyone from his remarks. She had seen Resident # 5 on 7/19/23 and none of the facility staff had mentioned the 7/15/23 altercation that had occurred between Resident # 5 and Resident # 6. Their practice had a triage line that was available to the facility 24 hours per day and at any point if an altercation occurred or details about behaviors needed to be discussed, the facility could call and talk to someone through their practice.

The clinical psychologist, who provided psychotherapy to Resident # 5 and Resident # 6, was interviewed on 8/11/23 at 3:15 PM and reported the following. She routinely saw both Resident # 5 and Resident # 6. She was in the facility every other Friday and talks to the staff. She would like to know about any altercations and behaviors that her residents have, but she was never informed about any altercation between Resident # 5 and Resident # 6 that

determine the need for further auditing beyond 3 months.

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occurred in July 2023. The clinical psychologist stated details about behaviors and altercations are important for her know.

The interim Administrator and the Director of Nursing were interviewed together on 8/10/23 at 11:15 AM and reported the following. Both Resident # 5 and Resident # 6 were interviewed about the altercation which had occurred on 7/15/23, and both were not consistent in their details of the altercation. No staff member or resident had mentioned to them that Resident # 5 made sexual comments to other residents.

2. Review of Resident # 6's record revealed Resident # 6 was admitted to the facility on 2/15/22 and had a diagnosis of depression.

Resident # 6's quarterly MDS assessment, dated 6/14/23, coded Resident # 6 as cognitively intact. Resident # 6 was assessed to have verbal behaviors one to three days during the MDS assessment period. Resident # 6 was also coded to need supervision/cueing for independent locomotion in the facility within the assessment period.

Resident # 6's care plan noted Resident # 6 received medication to treat depression. This was added to the care plan on 2/20/23 and remained part of Resident # 6's current care plan. Staff were directed on the care plan to monitor Resident # 6 for behaviors such as sadness, irritability, anger, and attention seeking behaviors.

On 7/15/23 at 3:20 PM Nurse # 1 entered a nursing note into Resident # 6's record that the resident had been involved in an altercation. Nurse # 1 noted she had heard Resident # 6

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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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scream and when she responded, Resident # 6 alleged she had been hit by another resident.

Review of a facility's 7/17/23 investigation into the altercation, which occurred on 7/15/23, revealed Resident # 6 alleged that Resident # 5 had hit her.

On 7/19/23 the Psychiatric NP noted she saw Resident # 6 for a chronic mood disorder and insomnia. The Psychiatric NP noted there were no concerns from staff, and there was no notation about the altercation that had occurred on 7/15/23.

On 8/8/23 Resident # 6's care plan was updated to reflect she had been in an altercation with another resident. On 8/9/23 another problem was "created" on Resident # 6's care plan noting the resident exhibited manipulative and persuasive behaviors. This problem was noted on the care plan to have been "initiated" on 7/18/23 as applicable to Resident # 6.

Resident # 6 was interviewed on 8/9/23 at 4:45 PM and reported the following. On the date of the 7/15/23 incident, Resident # 5 kept saying sexual remarks to her while they were in the television room, and she told him to go away. While Resident # 5 was seated in his wheelchair behind her, Resident # 5 then pulled her (Resident # 6's) wheelchair back towards him and hit her in the arm, chest, and head. The nurse came in after she was hit. The nurse asked them what happened, and Resident # 5 "lied" and said that she (Resident # 6) had pushed her wheelchair into him. Resident # 6 stated that was not true, and she had not pushed her wheelchair into Resident # 5.

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	345458	A. BUILDING _____ B. WING _____	C 08/11/2023

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During the interview with Nurse # 1 on 8/10/23 at 10:00 AM, Nurse # 1 reported neither Resident # 6 nor the witnessing resident (Resident # 8) had said anything about sexual advances by Resident # 5 and no staff member had witnessed the incident.

The facility social worker assistant was interviewed on 8/10/23 at 12:00 PM and again on 8/11/23 at 12: 29 PM and reported the following specific behaviors Resident # 6 demonstrated. Resident # 6 had verbal and manipulative behaviors. She would try to ask staff and residents for cigarettes and when she did not get her way, she would go off cursing down the hall. She was "not fond of anyone" and her words were not always kind to other residents. The previous week, she (the SW assistant) had heard Resident # 6 mimic a cognitively impaired resident who was asking repetitively about where her room was. Resident # 6 had also befriended Resident # 8, who was alert and oriented, and the SW Assistant felt as if Resident # 6 could get Resident # 8 to agree with Resident # 6 even if something was not true.

The Psychiatric NP was interviewed on 8/11/23 at 2:20 PM and reported the following. She saw Resident # 6 routinely every month. She had seen Resident # 6 on 7/19/23 and none of the facility staff had mentioned the 7/15/23 altercation that had occurred between Resident # 6 and Resident # 5. She was not aware it had occurred. Also, none of the staff had mentioned to her any details about unkind words Resident # 6 was saying to other residents or that another resident was copying Resident # 6's opinions about things. She visited every month and would want to know

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about altercations and behavior details. Their practice had a triage line that was available to the facility 24 hours per day and at any point if an altercation occurred or details about behaviors needed to be discussed, the facility could call and talk to someone through their practice.

The clinical psychologist, who provided psychotherapy to Resident # 5 and Resident # 6, was interviewed on 8/11/23 at 3:15 PM and reported the following. She routinely saw both Resident # 5 and Resident # 6. She was in the facility every other Friday and talks to the staff. She would like to know about any altercations and behaviors that her residents have, but she was never informed about any altercation between Resident # 5 and Resident # 6 that occurred in July 2023. The clinical psychologist stated details about behaviors and altercations are important for her know.

The interim Administrator and the Director of Nursing were interviewed together on 8/10/23 at 11:15 AM and reported the following. Both Resident # 5 and Resident # 6 were interviewed about the altercation which had occurred on 7/15/23, and both were not consistent in their details of the altercation. The DON further reported that she was aware Resident # 6 did not always portray the truth in what she said, and the DON had witnessed this herself.

3. Resident # 8 was admitted to the facility on 7/19/22. The resident's diagnoses included depression and a history of substance abuse.

Resident # 8's Minimum Data Set assessment, dated 6/1/23, coded Resident # 8 as cognitively intact and without behaviors during the

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assessment period.

Resident # 8's care plan revealed Resident # 8 received medication for depression. This was initially added to Resident # 8's care plan on 8/4/22 and remained part of Resident # 8's current care plan. Staff were directed on the care plan to monitor Resident # 8 for behaviors, which included attention seeking behaviors. Staff were also directed on the care plan to refer Resident # 8 for mental health services as needed.

On 8/2/23 Resident # 8 was seen by the Psychiatric Nurse Practitioner. The psychiatric NP noted she was seeing Resident # 8 for depression and insomnia, which were chronic conditions for which she had been seeing Resident # 8. The Psychiatric NP noted that staff reported no new behavioral issues or concerns. The Psychiatric NP did not note any behavioral issues regarding manipulation or fabrication.

On 8/9/23 another problem was "created" on Resident # 8's care plan to reflect Resident # 8 had manipulative and persuasive behaviors and would fabricate information. The care plan reflected this problem had been "initiated" on 7/18/23.

Nurse # 2 was interviewed on 8/11/23 at 12:05 PM regarding Resident # 8's behaviors and reported if Resident # 8 wanting something, then she would work to get it. Nurse # 2 reported the following example regarding Resident # 8's behavior. Within the last month another resident (Resident # 10) had a soda drink which Resident # 8 wanted. Resident # 8 lied to a NA (Nurse Aide) and told the NA that Resident # 10's soda drink was hers while thinking she would then get

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the drink for herself. A second NA then approached during the interaction, spoke up and let the first NA know that she (the second NA) had gotten the drink for Resident # 10 and that Resident # 8 was not being honest in order to take the soda drink from Resident # 10.

The facility social worker assistant was interviewed on 8/10/23 at 12:00 PM and again on 8/11/23 at 12: 29 PM and reported the following. Resident # 8 had been befriended by another resident (Resident # 6), who also had manipulative behavior. Since they had formed a friendship, Resident # 8 copied Resident # 6's opinions. The social worker gave the following example. Resident # 8 used to be friends with another resident in the facility (Resident # 9). Resident # 6 did not get along or like Resident # 9. Therefore, Resident # 8 no longer counted or treated Resident # 9 as a friend either.

The Psychiatric NP was interviewed on 8/11/23 at 2:20 PM and reported she was not aware Resident # 8 was "copying" another resident's opinions for her own or had manipulative behavior. She stated details were significant in the treatment of behavioral issues and she had been unaware of Resident # 8's recent behaviors towards other residents.

The Director of Nursing was interviewed on 8/10/23 at 11:15 AM and reported the following. The DON reported that she was aware Resident # 8 did not always portray the truth in what she said, and the DON had witnessed this herself.

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