STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 9/26/23 through 9/28/2023. Event ID# KIFT11. The following intakes were investigated: NC00207340, NC00207228, NC00206710, NC00206337, NC00206880. One (1) of the 12 complaint investigations resulted in deficiency.	F 000		
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		10/18/23

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

Electronically Signed | 10/22/2023

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F 561	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview and Nurse Practitioner (NP) interviews, the facility failed to allow 1 of 4 residents the choice to take a shower (Resident #1). Resident #1 was very sad and stated she felt less than a person not being able to get a shower. The findings included: Resident #1 was admitted to the facility on 5/2/18 with a diagnosis that included major depressive disorder and spinal stenosis. Review of physician order dated 3/20/20 revealed Resident #1 was to have a shower on Monday, Wednesday, and Friday. The quarterly Minimum Data Set (MDS) dated 7/23/23 indicated Resident #1 was cognitively intact and was dependent on 2 staff for bathing. The MDS assessment also noted it was very important to her to choose between a bed bath, tub bath or shower. Review of Resident #1's care plan dated 7/23/23 revealed she required staff assistance with activities of daily living secondary to impaired mobility and muscle weakness, associated with diagnosis of Multiple Sclerosis. The interventions included she would be provided a sponge bath when a full bath or shower could not be tolerated, receive extensive assistance of one staff person for mobility, and required a mechanical Lift. The shower documentation log revealed the following documented showers for Resident #1 recorded by Nurse Aide (NA) #5.	F 561	1. Resident # 1 receives showers per her choice. Resident # 1 received shower during survey on 09.27.2023. Resident was interviewed by Unit Manager on 09/29/2023 for shower preferences, plan of care was updated to reflect resident's individual wishes. 2. All residents have the potential to be affected. Nursing leadership completed an audit of current residents' shower preferences on 09/27/2023 and shower documentation to ensure that all residents who desire to have a shower are receiving showers a minimum of twice per week, indicating specifically those who would need a shower in the bathing room. Nine residents were identified as needing this. These residents received their bathing on 09/29/2023 and the plan of care was updated to reflect residents' future needs. 3. Nursing staff educated 9/29/23, 10/2/23 and 10/3/23 (three sessions) by the Quality Assurance Nurse on bathing preferences and giving showers as requested. All residents will be interviewed upon admission by admitting nurse to bathing preferences and those who need to be bathed in central bathing area will be indicated on residents cardx by admitting nurses. C.N.A's will be assigned to provide bathing as ordered. 4. Director of Nursing or Assistant Director of Nursing to audit shower documentation weekly x 4 weeks and	

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F 561	Continued From page 2 - 8/31/23 - 9/14/23 - 9/19/23. An interview was attempted on 9/27/23 at 3:17 pm but not successful with NA #5. Resident # 1 was interviewed on 9/26/23 at 11:15 am. Resident #1 indicated that she was upset because she had not had a shower for over a year. She further indicated she had made a complaint that she had not been getting a shower on 8/17/23. Resident further stated she was unable to bend her hips, knees, and feet in order to sit in a shower chair, she also had contractures of both hands. The resident continued by indicating she was very sad and felt less of a person because she was not able to get a shower. Resident #1 further indicated she wanted to get a shower like she did when she was at home. The Assistant Director of Nursing (ADON) #2 was interviewed on 9/26/23 at 2:40 pm. She revealed she was not aware the facility had not provided Resident #1 with a shower or for others residents who would benefit from the use of a shower bed. Observation and interview with the Maintenance Director on 9/27/23 at 8:45 am revealed whirlpool room #1 and whirlpool room #2 had no shower head. The Maintenance Director indicated the whirlpool rooms were being used as storage and a shower head needed to be installed to provide residents with a shower that could not be showered in individual resident bathrooms. The interview further revealed individual showers in resident rooms would accommodate residents who used adaptive equipment such as shower	F 561	randomly thereafter to ensure showers are being given per preferences. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/18/23	

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F 561	Continued From page 3 chair. NA #4 was interviewed on 9/27/23 at 9:20 am revealed that she had not given Resident #1 a shower just a bed bath. Interview with the NP on 9/28/23 at 11:56 am revealed Resident #1 had ordered showers on Monday, Wednesday, and Friday. She further indicated she had not been notified that Resident #1 was not getting the ordered showers, but if the patient was getting clean, she would not expect them to call her for that. She lastly indicated she was not aware a shower bed was not available for any resident to get a shower. An interview with the Administrator on 9/28/23 at 4:00 pm indicated that he was not aware there was not a facility in the facility where residents could take a shower other than the residents' individual bedrooms. He further stated he did not know that not being able to take showers made Resident #1 feel sad and less of a person.	F 561		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		10/18/23

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§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all

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information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance

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F 585	Continued From page 6 decision. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews and record review, the facility failed to ensure the resolution of grievances for 1 of 4 residents who preferred to have showers instead of a bed bath (Resident #1). The findings included: Resident #1 was admitted to the facility on 5/2/18 with a diagnosis that included major depressive disorder and spinal stenosis. Review of physician order dated 3/20/20 revealed Resident #1 was to have a shower on Monday, Wednesday, and Friday. The quarterly Minimum Data Set (MDS) dated 7/23/23 indicated Resident #1 was cognitively intact and was dependent on 2 staff for bathing. It was very important to her to choose between a bed bath, tub bath or shower. Review of Grievance dated 8/17/23 included a complaint about Resident #1 not getting a shower. The previous Assistant Director of Nursing (ADON) met with Resident #1 to review the complaint and develop a plan to address it. The resolution was that the staff were given an in-service. Based on the in-service sign in sheet 8/18/23, the staff verbalized their understanding. Resident # 1 was interviewed on 9/26/23 at 11:15 am. Resident #1 indicated that she had not gotten a shower in over a year. She further indicated she had made a complaint that she had not been getting a shower on 8/17/23. She further	F 585	1. Resident # 1: 09/29/2023: Administrator met with resident to ensure she had all current grievances resolved to her satisfaction. Resident #1 expressed satisfaction with the resolution. 2. All residents have the potential to be affected. Administrator reviewed all grievances for the past 30 days (08.26.2023 thru 09.26.2023) to ensure that resolution had been achieved and documented. No other residents were identified as being affected. 3. Education provided to the leadership team by the Administrator on 09/29/23 regarding the regulation for following up on grievances timely and ensuring that residents/families are satisfied with resolution and that the resolution is documented accordingly. All grievances will be reviewed in the morning meeting with Social Services responsible for monitoring for timely follow up and resolution. 4. Education provided to newly hired staff at New Hire Orientation on 10/5/23 and 10/12/23 by Human Resource Director; and will be ongoing in all New Hire Orientations regarding the grievance reporting processes. 5. The Administrator or Assistant Administrator to audit grievance resolution weekly X 4 weeks to ensure	

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F 585	Continued From page 7	F 585		

revealed the Social Worker (SW) told her she would get the shower bed ordered. Resident #1 further indicated she wanted to get a shower like she did when she was at home.

Interview with SW #2 on 9/26/23 at 12:10 pm revealed on 8/17/23 the Resident's grievance regarding her showers had been resolved. SW #2 further stated staff were in-serviced regarding Resident# 1 receiving showers and not a bed bath 8/18/23. The in-service indicated the staff verbalized understanding. The interview did not reveal there had been a follow-up.

The SW #2 revealed during an interview 9/28/23 at 3:30 pm after the grievance was written, it was given to the department that the complaint was associated with. The ADON in this case reviewed the grievance and decided on a plan of resolution. The plan would then be carried out, such as an in-service, and the signed copies would come back to her. SW #2 would then write the decision letter and deliver or mail to the complainant. She further revealed that this was the last step, without any further follow-up.

NA #4 interviewed 9/27/23 at 9:20 am revealed that she had not given Resident #1 a shower just a bed bath and there was no method of providing Resident #1 with a shower.

Observation and interview with the Maintenance Director on 9/27/23 at 8:45am revealed whirlpool room #1 and whirlpool room #2 revealed there was no shower head in the shower stall. The Maintenance Director indicated the whirlpool rooms were being used as storage and a shower head needed to be installed to provide residents with a shower. The whirlpool rooms were the

resident/family satisfaction and documentation of the resolution. Results of this monitoring to be reviewed with Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.

6. Date of Compliance 10/18/23

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F 585	Continued From page 8 only space in the facility that would accommodate a resident's need to have a shower with the use of a shower bed. The individual showers in resident rooms would not accommodate a shower bed. Interview 9/28/23 at 11:50 pm with Director of Nursing, Administrator, and SW indicated the grievance process once recorded, was given to each appropriate department to investigate, come up with a plan and discuss with the Administrator. They further indicated once the plan was carried out it was signed and any paperwork such as in-services, reports was returned to SW. The SW would then send out the letter to the complainant stating the complaint had been resolved. The Director of Nursing indicated Resident #1 had not had a shower although the grievance was documented as resolved.	F 585		
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	F 600		10/18/23

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by:
Based on record review and resident, staff, and Nurse Practitioner interviews, the facility failed to protect 1 of 3 residents (Resident #3) right to be free from physical abuse when Resident #4 assaulted Resident #3 which resulted in chest pain, left thumb pain, swelling and an x-ray being ordered to the chest and thumb. Resident #3 was administered Acetaminophen as needed (PRN) for pain. This assault made Resident #3 feel scared.

Findings included:

Resident #3 was admitted to the facility on 1/12/2015 with diagnosis that included vascular dementia, bipolar disorder, major depressive disorder, and anxiety disorder.

Resident #3's annual Minimum Data Set (MDS) dated 6/28/2023 revealed he was cognitively intact, had no behaviors coded, required extensive assistance with bed mobility and transfers.

Resident #4 was admitted to the facility on 5/5/2023 with diagnosis that included cognitive communication deficit, muscle weakness, restlessness and agitation, dementia, major depressive disorder and received 7 days of antidepressant medication.

A review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated 8/11/2023 revealed he was severely cognitively impaired, had no coded behaviors and was independent with bed mobility and supervision with transfers.

Review of the Initial Allegation Facility Reported

1. Resident # 3 is free from injury related to the resident-to-resident altercation. Resident # 4 was seen by psych on 08/28/2023 and has had no further resident- to- resident altercations.

2. Resident # 4 was immediately removed from the event location, had an initial room change on 8/28/23 and later moved to a different unit on 08/30/2023.

3. All residents have the potential to be affected. Nursing Leadership to include Social Workers and Unit Managers on 09/26/2023 reviewed all current residents with behaviors for any indication of potential resident to resident altercations and ensured interventions are in place to prevent altercations/escalations (lookback period: 08.26.2023 thru 09.26.2023). No further resident-to-resident altercations have occurred. Residents were interviewed for concerns of roommate choices: out of that audit 1 resident was identified and adjustments were made.

4. 9/29; 10/1; 10/2 (three sessions to reach all staff): Education provided to all staff on Abuse Prevention to include identification of behaviors and prevention of resident-to-resident altercations. Education included review of Abuse Prevention Policy to include placing residents who have exhibited behaviors that threaten or endanger others on 15-minute checks for acute monitoring to promote prevention of Resident-to-Resident altercations. All

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F 600	Continued From page 10 Incident (FRI), submitted to the N.C Department of Health and Human Services (DHHS) on 8/27/2023 at 3:22am by the facility administrator revealed facility was aware of resident-to-resident abuse at 2:07am on 8/27/2023. The initial FRI report indicated that Resident #4 was upset that Resident #3 had his TV and bedside light on at 1:45am. The report also indicated that Resident #4 threw his bedside table, glass of water at Resident #3 and then got up and punched Resident #3 in the chest twice. Resident #4 was moved to a private room and placed on every (Q)15-minute checks. The facility then submitted to the NC DHHS an investigation report on 8/31/2023, that revealed Resident #3 upon interview with facility social worker (SW) stated he did not feel safe with Resident #4 remaining on the unit after the resident-to-resident abuse. The investigation report further revealed statements by nursing staff. Written statement from Nursing Assistant (NA) #1 dated 08/28/2023, used by the facility during their initial investigation, revealed NA #1 stated Resident #4 was complaining, wanting Resident #3 to turn off TV so he could rest. NA #1 continued to state that Resident #4 couldn't get his way, and assaulted Resident #3. NA #1 also stated when she got to the room, the table appeared thrown against Resident #3, both him and his property were wet, he was shaking, appeared red and crying. On 9/27/2023 at 10:44am a telephone interview was conducted with NA #1 in reference to the resident-to-resident abuse between Resident #3 and Resident #4. NA #1 stated while doing night shift room rounds, Resident #4 had told her, Resident #3 did not want to turn off his TV. NA #1	F 600	staff members received education prior to working again. New staff members including agency will receive orientation prior to working their initial shift. 5. Effective 9/26/23 provided education to administrative staff that all room assignments and/or changes will be lead and approved by clinical and social services teams (Director of Nursing and Director of Social Services) to ensure clinical and behavioral aspects are reviewed to ensure the most appropriate room mates are chosen. Staff educated on behavior interventions (i.e. resident not getting along, poor roommate choices) on 09/29/2023. 6. Staff members will immediately intervene when an escalation in behavior occurs, identify causative factors, and initiate immediate interventions to prevent behaviors resulting in resident-to-resident altercations. Nursing Leadership and Social Services review documentation of behaviors in Clinical Morning Meeting to identify residents at risk for escalation and provide interventions to promote prevention of Resident-to-Resident altercations, to include 15-minute checks as indicated. They will also evaluate root causes of the altercations and the changes to the residents' plan of care and the effectiveness of these immediate changes, modifying the plan of care from an interdisciplinary approach as necessary. Results of this monitoring will	

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told Resident #4 that she would notify the Nurse on duty (unknown). NA #1 notified Nurse on duty (unknown). NA#1 went on to state, 15 minutes later while doing room rounds, she went back to his room and upon entering the room Resident #3 was shaking, upset and afraid, had a red mark line across his clavicle, his left hand was balled up, his thumb looked like it was jumped and had water all over his overbed table, face, gown, and bed. NA #1 called out for assistance and other nursing staff (including Nurse #1, NA #2) came into his room. Resident #3 stated to NA #1 that Resident #4 had stood up from his wheelchair, pushed his table against his chest, threw water all over him and hit his face twice.

Written Statement on 08/27/2023 by Nurse #1 used during facility initial investigation revealed Nurse #1, upon arriving to room, noted tray from Resident #4 was on top of Resident #3, water was also covering Resident #3, his gown, phone, and he was visibly trembling.

Written statement from NA #2 dated 08/28/2023, used by the facility during their initial investigation, revealed NA #2 went to room after NA #1 called for assistance. NA #2 indicated that the bedside table was turned over onto Resident #3 and his hand was hurt.

A review of Resident #3's nurse note dated 8/27/2023 at 5:02am written by Nurse #1 revealed Resident #3 and his roommate Resident #4 got into an altercation regarding the TV being on. Resident #4 liked the TV off at night and Resident #3 liked the TV on. The note further stated the altercation between Resident #3 and Resident #4 was unwitnessed. Nursing Assistant (NA) #1 heard the commotion and called out for

be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for adjusting and maintaining this plan for ongoing compliance.

7. Date of Compliance 10/18/23

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CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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help. Nurse #1 went to residents' room and found Resident #3 visible shaking. Resident #4 was getting back into his bed and told staff that he wanted Resident #3 to turn the TV off. Resident #3 stated Resident #4 threw the bedside table to his chest as well as punched him. The nurses note continued with, Resident #3 at the time, complained of minimal pain and Acetaminophen was administered. Resident #4 was moved to a different room and the on-call provider has been notified. The nurse practitioner (NP)#1 ordered x-ray for Resident #3's left thumb and chest.

On 09/28/2023 at 10:34 am, a telephone interview was conducted with Nurse #1 in reference to the resident-to-resident incident between Resident #3 and Resident #4. Nurse #1 indicated that she responded to a call for assistance from NA #1 in room (Resident #3 and Resident #4 room). Nurse #1 indicated that the tray table was leaning over Resident #3, who could not move. Nurse #1 indicated Resident #4 was moved to a different room in the same unit and was checked on frequently. Nurse #1 indicated prior to the resident-to-resident incident between Resident #3 and Resident #4, she was not notified of any disagreements or concerns from either resident by NA#1.

A review of Resident #3 nurse practitioner note dated 8/27/2023 by NP #1 revealed nursing staff had reported Resident #3 was involved in altercation with his roommate (Resident #4). Resident #3 sustained an injury to his left thumb and had a bruise across chest from the bedside table. Resident #3 denied chest pain but reported pain to his thumb and Acetaminophen as needed (PRN) was given. The note further indicated that NP #1 ordered an x-ray of Resident #3's left

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thumb for swelling and chest due to bruising. Ice was applied to Resident #3's chest and thumb for pain and swelling.

Nurses note dated 8/28/2023 at 10:14am written by Assistant Director of Nursing (ADON), indicated effective date 8/27/2023 at 1:45am, revealed Nurse #1 responded to a call for assistance from NA#1 that Resident #4 was upset that Resident #3 had his TV and light on. The note further indicated that, there was a bedside table toppled over and observed wet with water. The note also indicated that new orders were obtained for x-ray of the chest and hand for Resident #3 and Resident #4 had labs and Urine Analysis (UA) Culture and Sensitivity ordered.

X-ray results for Resident #3 chest and hand revealed no evidence of fracture or acute abnormalities to left thumb or any abnormal findings to chest.

A review of Resident #3's SW #1 note, dated 8/28/2023 at 10:34am, revealed Resident #3 recalled altercation with Resident #4. The note further indicated SW #1 identified Resident #4 as the aggressor.

An in-person interview was conducted on 9/27/2023 at 3:27pm with SW #1 in reference to the resident-to-resident abuse that happened between Resident #3 and Resident #4. SW #1 indicated that Resident #3 recalled an altercation with Resident #4. SW #1 indicated Resident #3 stated he didn't feel safe and did not want to close his eyes, because he felt that Resident #4 would return to the room. SW #1 indicated that Resident #4 did not recall the resident-to-resident abuse. SW#1 also indicated that resident #1 had

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a psychiatry evaluation on 9/11/2023, and no new changes were made for his plan of care. SW #1 stated Resident #4 did not have any prior concerns or behaviors towards Resident #3 prior to the resident-to-resident abuse that occurred on 8/27/2023.

Nurse Practitioner progress note dated 8/28/2023, written by NP #2 revealed Resident #3 was being seen for a follow up of resident-to-resident abuse and x-ray. NP#2 indicated Resident #3 was observed sitting up in his bed, awake and alert. Resident #3 informed NP#2 that on the day of the resident-to-resident abuse, he was sitting up in bed watching TV and his roommate (Resident #4) came out of the bathroom and came over to him, knocked his bedside table over onto his chest, threw water on him, and hit him twice in the face. Resident #3 further stated to NP#2, that he pressed his call bell for assistance and nursing staff came and removed his roommate (Resident #4) from the room. The NP #2 note also indicated Resident #3 stated that he did not want to close his eyes to go to sleep, because he felt nervous and did not feel safe.

A telephone interview was done on 9/28/2023 at 12:02pm with NP #2 in reference to Resident #3 and Resident #4. NP#2 indicated that after the resident-to-resident abuse, Resident #3 informed her that he was nervous and did not feel safe after the incident. NP #2 indicated that Resident #4 did not remember anything about the resident-to-resident abuse.

Interview with Resident #3 was completed on 09/26/2023 at 3:16pm. Resident #3 indicated that he recalled the incident that happened to him and

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F 600	Continued From page 15 his prior roommate Resident #4. Resident #3 indicated that Resident #4 wanted him to turn off his TV, and when he did not do that, Resident #4 got up from his wheelchair, beat him twice on the face, pushed the table at him and threw water all over him. Resident #3 continued to state that Resident #4 was moved to a different room. Resident # 3 further stated that he was afraid and could not even sleep at night after the incident. An attempt to interview Resident #4 on 09/26/2023 at 3:09pm revealed he could not recall anything about resident-to-resident abuse, between him and Resident #3. On 9/27/2023 at 10:23am, an interview was conducted with the Administrator. The Administrator indicated that he was notified of the incident between Resident #3 and Resident #4 by ADON on 08/27/2023 at 2:15am. The administrator stated he was in the facility at 3:45am. Administrator further stated that Resident #4 was moved to a different room in the same unit as Resident #3, before his arrival to facility and was asleep when he checked on him. Administrator stated that Resident #3 was still awake when he went to see him. The administrator also stated that Resident #3 was scared, complained of chest discomfort and his finger not doing well.	F 600		
F 607 SS=G	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	F 607		10/18/23

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F 607	Continued From page 16 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. §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 follow the abuse policies in the area of protection after an allegation of abuse for 1 of 3 resident (Resident #3), by not implementing Q 15-minute checks on Resident #4 following a resident-to-resident abuse. The findings included: Resident #3 was admitted to the facility on 1/12/2015 with diagnosis that included vascular dementia, bipolar disorder, major depressive	F 607	1. Resident # 3 is free from injury related to the resident-to-resident altercation. Resident # 4 was seen by psych on 08/28/2023 and has had no further resident- to- resident altercations. 2. Resident # 4 was immediately removed from the event location, had an initial room change on 8/28/23 and later moved to a different unit on 08/30/2023. 3. All residents have the potential to be affected. Nursing Leadership to include	

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F 607	Continued From page 17 disorder, and anxiety disorder. Resident #3's Annual Minimum Data Set (MDS) dated 6/28/2023 revealed he was cognitively intact, had no behaviors coded, required extensive assistance with bed mobility and transfers. Resident #4 was admitted to the facility on 5/5/2023 with diagnosis that included cognitive communication deficit, muscle weakness, restlessness and agitation, dementia, major depressive disorder and received 7 days of antidepressant medication. A review of Resident #4's Quarterly Minimum Data Set (MDS) assessment dated 8/11/2023 revealed he was severely cognitively impaired, had no coded behaviors and was independent with bed mobility and supervision with transfers. Review of the Initial Allegation Facility Reported Incident (FRI), submitted to the N.C Department of Health and Human Services (DHHS) on 8/27/2023 at 3:22am by the facility administrator revealed facility was aware of resident-to-resident abuse at 2:07am on 8/27/2023. The initial FRI report indicated that Resident #4 was upset that Resident #3 had his TV and bedside light on at 1:45am. The report also indicated that Resident #4 threw his bedside table, glass of water at Resident #3 and then got up and punched Resident #3 in the chest twice. Resident #4 was moved to a private room and placed on every (Q)15-minute checks. The facility then submitted to the NC DHHS an investigation report on 8/31/2023, that revealed Resident #3 upon interview with facility social worker (SW) stated he did not feel safe with Resident #4 remaining	F 607	Social Workers and Unit Managers on 09/26/2023 reviewed all current residents with behaviors for any indication of potential resident to resident altercations and ensured interventions are in place to prevent altercations/escalations (lookback period: 08.26.2023 thru 09.26.2023). No further resident-to-resident altercations have occurred. Residents were interviewed for concerns of roommate choices: out of that audit 1 resident was identified and adjustments were made. 4. 9/29; 10/1; 10/2 (three sessions to reach all staff): Education provided to all staff on Abuse Prevention to include identification of behaviors and prevention of resident-to-resident altercations. Education included review of Abuse Prevention Policy to include placing residents who have exhibited behaviors that threaten or endanger others on 15-minute checks for acute monitoring to promote prevention of Resident-to-Resident altercations. All staff members received education prior to working again. New staff members including agency will receive orientation prior to working their initial shift. 5. Effective 9/26/23 provided education to administrative staff that all room assignments and/or changes will be lead and approved by clinical and social services teams (Director of Nursing and Director of Social Services) to ensure clinical and behavioral aspects are reviewed to ensure the most appropriate room mates are chosen. Staff educated	

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F 607	Continued From page 18 on the unit after the resident-to-resident abuse. On 09/28/2023 at 10:34 am, a telephone interview was conducted with Nurse #1 in reference to the resident-to-resident incident between Resident #3 and Resident #4. Nurse #1 indicated that she responded to a call for assistance from NA #1 in room (Resident #3 and Resident #4 room). Nurse #1 indicated that the tray table was leaning over Resident #3, who could not move. Nurse #1 indicated Resident #4 was moved to a different room in the same unit and was checked on frequently. A review of Resident #3's SW #1 note, dated 8/28/2023 at 10:34am, revealed Resident #3 recalled altercation with Resident #4. The note further indicated SW #1 identified Resident #4 as the aggressor. Resident #3 stated he didn't feel safe and did not want to close his eyes, because he felt that Resident #4 would return to the room. An in-person interview was conducted on 9/27/2023 at 3:27pm with SW #1 in reference to the resident-to-resident abuse that happened between Resident #3 and Resident #4. SW #1 indicated that Resident #3 did share with her that Resident #4 did in fact come back to his room, after he was moved to a different room after the resident-to-resident abuse. SW #1 indicated that Resident #4 was moved from the room in the same unit as Resident #3, to a different room in another unit to ensure that Resident #4 would not come back to the room where Resident #3 resided. SW #1 indicated she interviewed Resident #4 on 8/28/2023 and he did not recall the resident-to-resident abuse that occurred on 8/27/2023 between him and Resident #3. SW#1 also indicated that Resident #4 had a psychiatry	F 607	on behavior interventions (i.e. resident not getting along, poor roommate choices) on 09/29/2023. 6. Staff members will immediately intervene when an escalation in behavior occurs, identify causative factors, and initiate immediate interventions to prevent behaviors resulting in resident-to-resident altercations. Nursing Leadership and Social Services review documentation of behaviors in Clinical Morning Meeting to identify residents at risk for escalation and provide interventions to promote prevention of Resident-to-Resident altercations, to include 15-minute checks as indicated. They will also evaluate root causes of the altercations and the changes to the residents' plan of care and the effectiveness of these immediate changes, modifying the plan of care from an interdisciplinary approach as necessary. Results of this monitoring will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for adjusting and maintaining this plan for ongoing compliance. 7. Date of Compliance 10/18/23	

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evaluation on 9/11/2023, and no new changes were made for his plan of care. SW #1 stated Resident #4 did not have any prior concerns or behaviors towards Resident #3 prior to the resident-to-resident abuse that occurred on 9/27/2023.

Nurse Practitioner progress note dated 8/28/2023, written by NP #2 revealed Resident #3 was being seen for a follow up of resident-to-resident abuse and x-ray. NP#2 indicated Resident #3 was observed sitting up in his bed, awake and alert. Resident #3 informed NP#2 that on the day of the resident-to-resident abuse, he was sitting up in bed watching TV and his roommate (Resident #4) came out of the bathroom and came over to him, knocked his bedside table over onto his chest, threw water on him, and hit him twice in the face. Resident #3 further stated to NP#2, that he pressed his call bell for assistance and nursing staff came and removed his roommate (Resident #4) from the room. Resident #3 went on to state to NP#2 that Resident #4 came back twice after he was removed but did not approach him and staff quickly removed him from the room. The NP #2 note also indicated Resident #3 stated that he did not want to close his eyes to go to sleep, because he felt nervous and did not feel safe.

A telephone interview was done on 9/28/2023 at 12:02pm with NP #2 in reference to Resident #3 and Resident #4. NP #2 indicated that Resident #4 was moved to a different room on the same unit and did not remember anything about the resident-to-resident abuse. NP#2 indicated that after the resident-to-resident abuse, Resident #3 informed her, that he was nervous and did not feel safe. NP #2 indicated Resident #3 informed

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her that Resident #4 had come back at least once to his room and staff had to assist Resident #4 back to his new room. NP#2 indicated she reassured Resident #3 of his safety.

Review of the facility's Q 15-minute form, that was used to document checks on Resident #4, revealed Q 15-minute checks for Resident #4 were initiated on 08/27/2023 at 7:00am to 08/29/2023 at 10:45am, and then from 08/29/2023 at 7:30pm to 8/30/2023 7:30am. Q 15-minute checks from 8/27/2023 2:30am to 8/27/2023 6:45am and 8/29/2023 11am to 08/29/2023 at 7:15pm were not documented. The facility did not provide any other Q 15-minute check forms.

Interview with Resident #3 was completed on 09/26/2023 at 3:16pm. Resident #3 indicated that he recalled the incident that happened to him and his prior roommate Resident #4. Resident #3 indicated that Resident #4 wanted him to turn off his TV, and when he did not do that, Resident #4 got up from his wheelchair, beat him twice on the face, pushed the table at him and threw water all over him. Resident #3 continued to state that Resident #4 was moved to a different room but Resident #4, after the incident, would come back to the room where he resided. Resident # 3 further stated that he was afraid and could not even sleep at night because Resident #4 kept coming back to his room for more than a week before Resident #4 stopped.
An attempt to interview Resident #4 on 09/26/2023 at 3:09pm revealed he could not recall anything about resident-to-resident abuse, between him and Resident #3.

Interview with NA #3 was conducted on 9/27/2023

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at 2:10pm in reference to the resident-to-resident abuse that happened between Resident #3 and Resident #4. NA #3 indicated that Resident #4 was moved to a different room on the same unit as Resident #3, after the incident, and she had to complete Q 15-minute checks on Resident #4 but did not recall documenting this on any form. NA #3 indicated that Resident #4 did leave his room and NA #3 would redirect Resident #4 because he would come out and go towards the hallway of the room where Resident #3 resided.

Interview with Nurse #2 was conducted on 9/27/2023 at 11:07am revealed that she was aware of the resident-to-resident abuse that happened between Resident #3 and Resident #4. Nurse #2 indicated that Resident #4 was moved to a different room on the same unit as Resident #3, after the incident. Nurse #2 indicated that she performed Q15-minute checks on Resident #4 while in his new room and documented using the Q15-minute check form. Nurse #2 also indicated that Resident #4 left his new room and went down the hallway of the room where Resident #3 resided but never got into the room.

On 9/27/2023 at 10:23am, an interview was conducted with the Administrator. The Administrator indicated that he was notified of the incident between Resident #3 and Resident #4 by ADON on 08/27/2023 at 2:15am in which he informed ADON to initiate Q15-Minute checks on Resident #4 immediately. The administrator stated he was in the facility at 3:45am. Administrator further stated that Resident #4 was moved to a different room on the same unit as Resident #3, before his arrival to facility and was asleep when he checked on him. Administrator stated that Resident #3 was still awake when he

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F 607	Continued From page 22 went to see him. The Administrator also stated that Resident #3 was scared, complained of chest discomfort and his finger not doing well. The administrator indicated that after Resident #4 was moved to a different room on the same unit as Resident #3, Resident #4 did, at least once, go back to the room where resident #3 resided. The Administrator continued to state, that was the reason why Resident #4 was moved from the room on the same unit as Resident #3 on 8/30/2023, to another new room, in a different unit. The Q 15-minute checks from 8/27/2023 2:30am to 8/27/2023 6:45am and 8/29/2023 11am to 08/29/2023 at 7:15pm were not documented. Administrator indicated that he did not have the documentation for the Q 15minute checks from 8/27/2023 2:30am to 8/27/2023 6:45am and 8/29/2023 11am to 08/29/2023 at 7:15pm. The Administrator indicated that the Q 15-minutes checks were stopped on Monday 8/28/2023 because Resident #4 was moved to a different room after the resident-to-resident abuse.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 3 sampled residents reviewed for accurate assessments (Resident #3).	F 641	1. Resident # 3 had a Modification MDS to 09/28/23 assessment with an ARD of 06/28/23 completed to correctly code resident's PASRR status on 9/28/23 by the MDS Nurse. 2. MDS Nurses completed an audit on	10/18/23

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	345434	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 641	Continued From page 23 The Findings included: Resident #3 was admitted to the facility on 1/12/2015 with diagnosis that included Vascular Dementia, Bipolar Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Mood Disorder due to known physiological condition with depressive features, Agoraphobia with panic disorder, anxiety disorder. A review of the PASRR Level II Determination Notification from the NC Department of Health and Human Services, Division of Medical Assistance, dated 10/14/2009, revealed that Resident #3 was a Level II PASRR. Resident #3's Annual MDS dated 6/28/2023 revealed his Level II PASRR was not coded. The Annual MDS identified Resident #3 as PASRR Level I. A Level II screening is for resident who have serious mental illness and/or intellectual disability or a related condition. On 9/27/2023 at 3:14pm, an interview was conducted with the MDS Nurse #1 who indicated that Resident #3 had a Level II PASRR and the Annual MDS dated 6/28/2023 was not coded accurately to reflect Level II PASRR. An interview was conducted on 9/28/2023 at 11:11am with Social Worker #2 who indicated that Resident #3 had a Level II PASRR and had a care plan in place to address the Level II PASRR. On 9/28/2023 at 11:26am, an interview was conducted with MDS Nurse #2 , who was responsible for coding PASRR on the MDS , stated Resident #3 had a Level II PASRR and the Annual MDS assessment dated 6/28/2023 was	F 641	9/29/23 of all current residents to ensure that PASRR coding was correct on latest assessment. Seventeen were identified as needing updates ---- all completed by 10/04/2023. 3. Education provided to the MDS Nurses on 9/29/23 by the Interim Director of Nursing on appropriately coding resident's PASRR status. 4. Education provided to the MDS Nurses on 10.05.2023 by Regional MDS Coordinator on appropriately coding resident PASRRs. 5. MDS coordinator will appropriately code PASRR on all MDS going forward. Quality Assurance Nurse to audit for accuracy of PASRR coding on MDS for 5 random residents per week for 8 weeks, then randomly thereafter. Any deviations noted will result in an MDS modification to correct. Results of these audits to be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for modifying this plan as needed to maintain ongoing compliance. 6. Date of Compliance 10/18/23	

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F 641	Continued From page 24 not coded correctly in reference to his PASRR Level II. An interview was conducted with the Administrator on 9/28/2023 at 1:13pm. He stated the MDS should be coded accurately to reflect Level II PASRR for Resident #3.	F 641		
F 867 SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		10/18/23

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F 867	Continued From page 25	F 867		

development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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F 867	Continued From page 26	F 867		

of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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F 867	Continued From page 27 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, Nurse practitioner (NP)and staff interview, the facility's quality assurance (QA) program failed to implement, monitor, and revise as needed the action plan developed for the recertification surveys dated 8/12/2021 and 9/29/2022 and complaint surveys dated 3/2/2023 and 5/4/2023 in order to achieve and sustain compliance. These were repeat deficiencies cited during a complaint survey on 9/28/2023. The repeat deficiencies were in the areas of Minimum Data Set (MDS) Accuracy of (F641) and Resident-to-resident abuse (F600). The continued inadequate root cause analysis and lack of sustained compliance during five federal surveys of record shows pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross-referenced to: F 600: Based on record review, resident interview, staff interview and Nurse Practitioner interview, the facility failed to protect 1 of 3 resident's (Resident #3) right to be free from physical abuse when Resident #4 assaulted Resident #3 which resulted in chest pain, left thumb pain, swelling and an x-ray being ordered to the chest and thumb. Resident #3 was administered Acetaminophen as needed (PRN) for pain. This made Resident #3 feel scared. These residents were reviewed for resident-to-resident abuse (Residents #3 and #4).	F 867	1) Facility received repeat citation of F 600 and F641 during a complaint survey which had been cited on two prior surveys in the last three years. A revised plan has been developed to address Abuse Prevention and MDS coding accuracy with ongoing monitoring by the Quality Assurance and Performance Improvement Committee. 2) All residents have potential to be affected. Root Cause Analysis was completed on 10.18.2023 by the Interdisciplinary Quality Assurance Team for F 600 and F 641 to determine the systemic break that led to the deficient practice with revised plan to address. 3) Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Senior Administrator. (QAPI Team consists of: Administrator, Director of Nursing, Dining Director, Business Office Director, Human Resource Manager, Maintenance Director, Social Services Director, Housekeeping/Laundry Manager, Nursing Supervisors, Activities Director, Infection Preventionist, Medical Director and Therapy Director). Education included review of Quality Assurance and recognizing areas for Performance Improvement, Root Cause Analysis and monitoring of Plans for improvement.	

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F 867	Continued From page 28 During the previous complaint survey 5/4/2023. The facility failed to protect a resident's right to be free from physical abuse when a resident assaulted another for 1 of 3 residents reviewed for resident-to resident abuse. During complaint survey 3/2/2023. The facility failed to protect residents' right to be free from mistreatment for 2 of 4 residents investigated for staff to resident abuse. F 641: Based on record review and staff interview, the facility failed to accurately code Minimum Data Set (MDS) assessment in the area of Preadmission Screening and Resident Review (PASRR) for 1 of 3 sampled residents (Resident #3). During the previous annual recertification survey on 9/29/2022, the facility failed to accurately code the MDS for 1 of 1 resident reviewed for smoking. During the annual recertification survey on 8/12/2021, the facility failed to accurately code the MDS for 5 of 35 residents reviewed for antipsychotics, PASRR and pressure ulcer. An interview was conducted with the Administrator on 9/28/2023 at 1:13pm. During the interview the Administrator stated he was unable to provide an answer as to why the facility had not been able to achieve compliance with the repeated deficiencies. He stated all the citations would be reviewed, and a plan of correction would be put in place. The administrator continued that the Quality Assistant Assurance committee met regularly, identified areas of concern, conducted the root cause analysis,	F 867	4) The Administrator to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The QAPI Committee to review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. Regional Nurse to review all monthly QAPI Minutes x 6 months and attend QAPI Meetings Quarterly to ensure that the Committee is maintaining implemented procedures/interventions to prevent recurring non-compliance. The Administrator will be responsible for the implementation of the plan. 5) Date of Compliance 10/18/23	

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F 867	Continued From page 29 created the plan of correction, and discussed the outcome. The interdisciplinary team would continue monitoring until the deficient area of concern was resolved.	F 867		