STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF FAYETTEVILLE	2461 LEGION ROAD FAYETTEVILLE, NC 28306

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 04/22/24 through 04/25/24. Event ID# OPSK11. The following intakes were investigated NC00216225, NC00216173, and NC00215956. 3 of the 3 complaint allegations did not result in deficiency.	F 000		
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 reviews and resident, staff and physician interviews, the facility failed to thoroughly investigate an allegation of staff to resident physical abuse for 1 of 3 residents reviewed for abuse (Resident #1). The findings included:	F 610	1. Immediate action(s) taken for the resident(s) found to have been affected include: Immediately after resident #1 alleged and identified CNA #1 hit him in the stomach on 4/16/24, the employee was suspended pending the outcome of the investigation.	5/14/24

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

Electronically Signed | 05/15/2024

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F 610	Continued From page 1 Review of the facility's Abuse, Neglect and Exploitation policy, last revised 03/20/23, read in part, "V. Investigation of Alleged Abuse, Neglect and Exploitation: B4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. B6. Providing complete and thorough documentation of the investigation." Resident #1 was admitted to the facility on 12/18/23. A review of the facility's Initial Allegation Report, completed by the Administrator and sent to the State Agency on 04/16/24 revealed that Resident #1 informed the facility that an employee in blue scrubs hit him in the stomach on 04/16/24. The report indicated the facility presented two employees to the resident and Resident #1 identified Nursing Assistant (NA) #1 as the person who hit him in the stomach. The report indicated the facility became aware of the incident on 04/16/23 at 6:45 p.m. and that the facility notified the local police department and Adult Protective Services and suspended NA #1 and began an investigation of the allegation. A review of the facility's Investigation Report, completed by the Administrator on 04/17/24, revealed, "during the investigation, resident [Resident #1's] roommate [Resident #2] stated 3 times that nothing ever happened." The report stated that the incident did not result in physical injury or harm to Resident #1, nor did it result in mental anguish for the resident. The report indicated Resident #1 had "no emotional response noted. Resident does have	F 610	APS and law enforcement were notified of the allegation on 4/16/24. The Initial Allegation Report was completed and sent to the State Agency on 4/16/24. A skin assessment on resident #1 was completed and no issues were noted. Skin assessments and resident interviews were completed on 4/17/24 for all residents on CNA #1 work assignment for 4/16/24. Additional interviews and skin assessments were completed with residents residing in rooms adjacent to her assignment. HR reviewed CNA #1 employee record and no issues were noted. An Ad-hoc QAPI meeting was held on 4/17/24 to review the allegation and findings and the allegation was deemed unsubstantiated. CNA was allowed to return to work. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. On 4/23/24 and 4/24/24 skin assessments on residents with a BIMS less than 13 and resident interviews for ones with a BIMS of 13 or higher were conducted facility wide. No issues were noted. 3. Actions taken/systems put into place	

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F 610	Continued From page 2 manipulative and attention seeking behaviors." The Investigation Report indicated Human Resources reviewed the employee record of NA #1 and there had been no issues noted in it. Corrective actions following the incident included skin assessments and resident interviews as well as an Ad-hoc Quality Assurance Performance Improvement (QAPI) meeting on 04/17/24 was completed to deem compliance and unsubstantiate the allegation. A review of the summary of the incident, written by the Administrator and undated, read as follows: "On 4/16/2024 at approximately 6:45 p.m. Chief Clinical Officer was notified that resident [Resident #1] said someone hit him in the stomach. Resident initially described a nurse in blue scrubs with short hair. The nurse that fit that description was presented to the resident and he laughed and stated no. The assigned Certified Nursing Assistant [CNA] was called back to the facility and presented to the resident and he stated yes. CNA did not meet the description provided by resident. Resident had a skin assessment completed with no issues noted. Resident's roommate [Resident #2] (BIMS 15) [brief interview for mental status which scores a resident's cognition] was interviewed and stated he did not hear or see anything occur that day. Nurse interviewed alert and oriented residents on the hall (BIMS 13 or higher) with no issues noted. Nurse completed skin assessments on resident with BIMS less than 13 on hall with no issues noted. [Resident #1] is care planned for manipulative and attention seeking behaviors. Due to inconsistencies of story and other interviews, facility unsubstantiates the allegation of abuse."	F 610	to reduce the risk of future occurrence include: The Administrator, Interim DON and ADON, were in-serviced on 5/13/24 by the Corporate Nurse Consultant regarding the facility policy on abuse allegation investigation to include sufficient sample size for resident interviews and assessments. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Corporate Clinical Team will monitor 100% of abuse allegations for 3 months. Audit records will be reviewed by the Quality Assurance Committee until such time as consistent substantial compliance has been achieved and confirmed by the QAPI committee. Corrective action completion date: 5/14/24	

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F 610	Continued From page 3	F 610		

Review of NA #1's assignments on 04/08/24, 04/09/24, 04/11/24, and 04/14/24 revealed she had cared for residents on the 200 Hall. On 04/15/24, NA #1 cared for residents on the 500 Hall. Resident #1 resided on the 200 Hall and had been assigned to NA #1's care on 04/16/24.

An interview was conducted with NA #1 on 04/22/24 at 2:16 p.m. NA #1 confirmed she had worked from 7:00 a.m. until 3:00 p.m. on 04/16/24 and had been assigned to care for Resident #1. She stated after Resident #1 identified her, she left his room, and said that she had been suspended from working during the facility's investigation. She stated she was allowed to return to work after one day of suspension.

An interview was conducted with the Director of Nursing (DON) on 04/23/24 at 2:00 p.m. The DON stated she had just begun her job as DON on 04/15/24 and the abuse allegation from Resident #1 related to NA #1 was on 04/16/24. The DON stated she went to Resident #1's room to interview him about the abuse allegation he made on 04/16/24. After interviewing the resident, the DON informed the Chief Clinical Officer of her interview with the resident and then she left. The DON explained the Chief Clinical Officer had been the facility's interim DON prior to her starting at the facility and the Chief Clinical Officer took over the investigation at that point.

An interview was conducted with the Chief Clinical Officer on 04/23/24 at 2:21 p.m. The Chief Clinical Officer explained she was informed of the abuse allegation by the DON. She indicated Resident #1 identified NA #1 as the alleged perpetrator. The Chief Clinical Officer

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F 610	Continued From page 4	F 610		

explained NA #1 was immediately suspended from work at the facility pending the investigation and then she had a couple of nurses interview alert and oriented residents and perform skin assessments on residents who were not alert and oriented on NA #1's 04/16/24 assignment on the 200 hall as well as other residents who resided in close proximity to NA #1's assignment on the 200 hall. The Chief Clinical Officer explained the interviews and skin assessments did not reveal any positive abuse findings and therefore, the investigation did not expand to other areas of the facility such as the 500 hall where NA #1 had been assigned to work on 04/15/24.

An interview was conducted with the Administrator on 04/23/24 at 12:41 p.m. The Administrator explained skin assessments were performed on residents with a BIMS score of less than 13 who resided on the same hall as Resident #1, and they had no signs or symptoms of abuse. He stated interviews were conducted with residents with a BIMS score of 13 or greater who resided on the same hall as Resident #1 which were negative for abuse allegations. When asked to clarify whether he expanded the interviews (of alert and oriented residents) or skin assessments of residents (who were not alert and oriented) in other areas of the facility where NA #1 worked prior to the incident of 04/16/24, the Administrator stated he had not. He explained they had only looked at those residents who had been assigned to her care on 04/16/24 as well as other residents who resided on the 200 hall near the area of her assignment and that they had found no problems or concerns. The Administrator further explained had there been any concerns that alluded to abuse then the investigation would have expanded to other areas

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F 610	Continued From page 5 of the facility where NA #1 had worked. The Administrator stated by suspending NA #1 immediately after the allegation of abuse was made, he had removed the immediate potential threat. He also stated that the decision to not expand the investigation to other areas in the building was because there had been no positive findings from the resident interviews and skin checks. The Administrator stated after the investigation had been completed, NA #1 had been allowed to return to work.	F 610		