STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING ______ B. WING ______	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	**208 MERCER MILL ROAD ELIZABETHTOWN, NC 28337**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/22/2024 through 09/26/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # XJGK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/22/2024 through 09/26/2024. Event ID# XJGK11. The following intakes were investigated NC00221901, NC00218307, NC00214599, NC002112939, NC00211605, and NC00208463. 4 of the 16 complaint allegations resulted in a deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		10/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/16/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility a. failed to repair broken floor linoleum in resident rooms (215), b. failed to remove the black substance and caulk commode bases in resident rooms (100, 104, 209, 212, 301, and 403), c. failed to repair a broken free standing clothes cabinet door or handles in resident rooms (107B, 211B, and 304) d. failed to replace broken or missing bathroom door threshold strip in resident rooms (104, 106, 111, 113, 201, 203, 207, 209, 211, 211, 215, 307, and 308), e. failed to replace broken metal bathroom shelf in resident room (412), f. failed to repair resident's overhead light covers in room (100B and 108A, B, C), g. failed to replace broken window blinds in resident rooms (105 and 212), h.	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F584: A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal	

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F 584	Continued From page 2 failed to clean and replace residents window air conditioner vent in resident rooms (406B, and 412B), i. failed to repair broken floor shower tile in shower room number 2 by floor drain, and j. failed to repair loose floor base boards in room/bathroom in rooms (100, 207, 213, and 405). These failures occurred on 4 of 4 hallways (100, 200, 300, and 400 Halls) observed for a safe, clean, homelike environment. Findings included: a. An observation on 09/22/24 at 12:40 PM revealed broken floor linoleum in resident rooms (215). b. An observation on 09/22/24 at 12:40 PM revealed black substance and missing caulking from commode bases in resident rooms (100, 104, 209, 212, 301, and 403). c. An observation on 09/22/24 at 12:40 PM revealed broken standing clothes cabinets, with one having 2 of 6 door hinges broken, and two had broken handles in resident rooms (107B, 211B, and 304). d. An observation on 09/22/24 at 12:40 PM revealed broken or missing bathroom door threshold strip in resident rooms (104, 106, 111, 113, 201, 203, 207, 209, 211, 211, 215, 307, and 308), which could potentially be a tripping hazards to residents and staff. e. An observation on 09/22/24 at 12:40 PM revealed a bent down broken metal bathroom shelf in resident room (412). f. An observation on 09/22/24 at 12:40 PM revealed missing overhead light covers in room (100B and 108A, B, C). g. An observation on 09/22/24 at 12:40 PM revealed broken window blinds in resident rooms	F 584	belongings to the extent possible. Corrective action for the failures to the environment, an alleged deficient practice that occurred on 4 of 4 hallways (100, 200, 300, and 400 Halls) observed for a safe, clean, homelike environment. A. The broken floor linoleum in resident room (215) was immediately repaired by the Maintenance Director. B. The black substance and missing caulk on the commode bases in resident rooms (100, 104, 209, 212, 301, and 403) immediately cleaned of the black substance and recaulking of those stated rooms by Maintenance Director. C. The broken free-standing clothes cabinet door or handles in resident rooms (107, 211B, and 304) was immediately corrected by the Maintenance Director. D. The broken or missing bathroom door threshold strip in resident rooms (104, 106, 111, 113, 201, 207, 209, 211, 215, 307, and 308) were immediately repaired by the Maintenance Director. E. The broken metal bathroom shelf in resident room (412) was immediately replaced by the Maintenance Director. F. The broken resident's overhead light covers in rooms (100B, 108A, 108B and 108C) were immediately replaced by the Maintenance Director. G. The broken window blinds in resident rooms (105 and 212) were immediately replaced by the Maintenance Director. H. The dirty and broken window air conditioner vents in resident rooms (406B and 412B) were replaced by the	

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F 584	Continued From page 3 (105 and 212). h. An observation on 09/22/24 at 12:40 PM revealed dirty vent areas with black colored debris and broken vent covers in resident rooms (406B, and 412B). i. An observation on 09/22/24 at 12:40 PM revealed broken floor shower tiles in shower room number 2 by floor drain. j. An observation on 09/22/24 at 12:40 PM revealed loose floor base boards in room/bathroom in rooms (100, 207, 213, and 405). An interview and follow-up facility tour were conducted on 09/25/24 at 9:45 AM with the Maintenance Director. The Maintenance Director agreed during the tour that there were multiple areas and room items on the 100, 200, 300, and 400 halls that still needed to be addressed, repaired, or replaced. He stated he had one and a half assistants but was keeping up with facility repairs. He said maintenance was responsible for repairing or replacing items in the facility. During the tour with the Maintenance Director, the environmental areas identified on the previous list were pointed out to the Maintenance Director, who agreed the items observed needed to be addressed. The Maintenance Director stated he would correct all the environment issues observed by cleaning, repairing, or replacing the issues that were pointed out to him during the tour observation. A follow-up facility tour was conducted on 09/25/24 at 10:00 AM of the facility with the Administrator. The tour revealed: Black substance around the base of resident commodes, in rooms (100, 104, 209, 212, 301, and 403), and broken tile in number 2 shower	F 584	Maintenance Director prior to survey exit with new PTACs. I. The broken floor shower tile in shower room number 2 was repaired using concrete covering the missing tile space and floor drain. This repair was completed prior to survey exit on 9/25/24 by the Maintenance Director. The facility has taken an additional step to have the entire floor in shower room number 2 restored. TRI Solutions Floor will install new flooring. J. The loose floor base boards in room / bathroom in rooms (100, 207, 213, and 405) were immediately corrected by Maintenance Director prior to survey exit on 9/26/2024. Corrective action for the identified failures with the potential to be affected by the deficient practice: A. The Maintenance Director audited 100% of resident room floor tiles in facility on October 1, 2024. All affected areas were corrected by the Maintenance Director and / or floor staff on or before October 26, 2024. B. The Maintenance Director audited 100% of commode bases in resident bathrooms. The Maintenance Director corrected all of 300 Hall during the week of survey 9/22 - 9/26/24. Additional areas noted were corrected by the Maintenance Director on or before October 26, 2024. C. The Administrator and Maintenance Director audited 100% of free-standing clothes cabinets door / handles in resident rooms. No repairs needed.	

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F 584	Continued From page 4 room, missing or broken threshold strips, above bed lights without covers, broken bathroom metal shelving, broken resident clothing cabinet door and handles, and broken blinds. She stated the areas pointed out on the 100, 200, 300, and 400 halls would be addressed and fixed, and it was her expectation for all the residents to have a safe and homelike environment that was clean and in good repair.	F 584	D. The Administrator and Maintenance Director audited 100% of bathroom thresholds for missing or broken strips. Additional areas were noted during audit. The Maintenance Director will correct on or before October 26, 2024. E. The Administrator and Maintenance Director audited 100% of all bathroom shelves. All shelves were intact. F. The Maintenance Director audited 100% of all overhead light covers in rooms. Twenty-three (23) additional beds require the newer light fixture. (100A, 101A, 101B, 102A, 102B, 103A, 103B, 104A, 104B, 105A, 105B, 106A, 106B, 107A, 107B, 109A, 109B, 110A, 110B, 111A, 111B, 113A, and 113B). The Maintenance Director will correct on or before October 26,2024. G. The Administrator and Maintenance Director audited 100% of resident rooms for broken window blinds. Additional rooms noted to have broken blinds. The Maintenance Director will correct on or before October 26,2024. H. The Administrator and Maintenance Director audited 100% of air conditioners for cleanliness and broken vents. The Maintenance Director will replace units with broken vents on or before October 26, 2024. I. The Administrator and Maintenance Director audited 100% of all shower rooms. Floor in shower rooms (2) will be replaced. J. The Maintenance Director and Floor Crew audited 100% of all baseboards in resident rooms. Additional areas noted during audit were corrected by the	

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F 584	Continued From page 5	F 584	Maintenance Director and / or floor crew on or before October 26, 2024. Systemic Changes: On October 5, 2024, the Administrator educated the Leadership Team (Director of Nursing, Staff Development Coordinator, Minimum Data Set Nurse, Support Nurse, Health Information Manager, Activities Director, Dietary Manager, Treatment Medication Aide and Maintenance Director) on how to conduct the Environmental Services Focused Rounds. The rounds will be completed weekly and submitted weekly to the Administrator for review. Areas identified will be noted on the weekly Environmental Services Focused Rounds sheet with Administrator validation with Maintenance Director for correction. The Leadership Team will complete a work order for the Maintenance Director. The Maintenance Director will review the identified concern timely (within 48 hours). The Administrator will inspect the repair or replacement when it is completed and add it to the QA monitoring tool to be reviewed during the next scheduled QA meeting. Quality Assurance: Beginning October 26, 2024, the Administrator or designee will monitor compliance using the QA tool, Environmental Services Focused Rounds. An audit will be completed of resident specific rooms by each member of the	

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F 584	Continued From page 6	F 584	leadership team (as stated above) weekly for three months. Focused rounding will continue as deemed necessary by the QAPI committee and corrective action initiated as appropriate. Date of Compliance: October 26, 2024	
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. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

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F 607	Continued From page 7 §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 and staff interviews, the facility failed to implement their abuse policy for staff to promptly report an allegation of staff to resident abuse to the facility management as soon as the allegation was communicated to the staff member. This occurred for 1 of 2 residents (Resident #21) reviewed for abuse. Findings included: The facility policy titled, "Abuse Prohibition", last reviewed on 02/2024, indicated it was the responsibility of their employees, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source and theft or misappropriation of resident property, to facility management. All reports of resident verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property shall be promptly and thoroughly investigated by facility management. A facility 24-Hour Initial Report dated 09/10/24 documented the following allegation description: On Monday 09/10/24 at 11:30 AM, Resident #21, with moderately impaired cognition, told the housekeeper, who reported to the Director of Nursing (DON), that the nurse aide swiped a rag across her face Saturday night and grabbed her mouth and tried to pour water in her mouth. The resident had a history of vascular dementia and	F 607	Past noncompliance: no plan of correction required.	

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was an unreliable source. She had a history of attention seeking behavior. The report was sent to the State Agency at 919-733-3207 by the DON.

A facility 5-Working Day Report dated 09/16/24 documented Resident #21 was not interviewable due to vascular dementia and alert only to self. Allegation details reiterated the description of the allegation described in the 24-Hour Initial Report and added body audits were done on all residents on that hallway and no issues were found. Interviews were conducted and no concerns were noted by any alert and oriented residents. Administration was not able to identify the staff person the resident described after multiple interviews with Resident #21. Local law enforcement and the Department of Social Services were notified of the allegation. The facility did not substantiate the allegation. The report was sent to the State Agency by the DON.

Review of the undated summary of the investigation documented by the DON revealed the DON had spoken with a family member of Resident #21 on 09/09/24 who informed her that she (the family member) had reported the allegation of abuse to Nurse #1 on Sunday, 09/08/24. The DON interviewed Nurse #1 who stated that she had received the allegation on Sunday, 09/08/24 but didn't report it to administration because of the resident's repeated attention seeking behaviors. Nurse #1 was suspended for the rest of her shift on Monday, due to not reporting this shift, pending the rest of the investigation.

An interview was conducted with Nurse #1 on 9/26/24 at 8:10 AM. She stated a family member came to the facility during her shift and told her

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F 607	Continued From page 9 that the night before a staff person had pinched Resident #21's facial cheeks together and popped her with a wet washcloth. Nurse #1 did not remember the date the family member reported the allegation to her. Nurse #1 could not remember why she did not report it to Administration but stated she had not. Nurse #1 recalled she had been suspended for the day and was re-educated regarding the abuse policy. She stated from now on she would report any allegations of abuse immediately. An interview was held with the DON on 9/25/24 at 3:39 PM. She stated the housekeeper came to her 09/09/24 and reported Resident #21 told her that the nurse aide swiped her across the face with a washcloth and tried to hold her mouth open to put water in it. She and the Staff Development Director interviewed Resident #21, and she reported the same allegation the housekeeper had reported. Resident #21 was asked to describe the nurse, and she described a blonde curly haired white girl. They talked to the roommate also and she said she didn't see anything and didn't want to talk about it. The roommate described the aide that night as having brown hair and being white. She called the family member on Monday, 09/09/24, who told her she had reported the incident to Nurse #1 on Sunday, 09/08/24. She interviewed Nurse #1 on 09/09/24 who said the allegation was told to her but thought it was attention seeking behavior and didn't report it. The DON stated she sent Nurse #1 home on suspension, pending the outcome of the investigation. The DON stated body audits were done on the 200-hall along with interviews with alert and oriented residents. Immediate abuse education was completed including the reporting of allegations. The DON reported she	F 607		

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F 607	Continued From page 10 started audits to assess for any concerns or neglect x 5 residents and nonverbal residents x 6 weekly x 2 weeks then monthly x 3 months. The DON adjusted the care plan to advise staff to take someone into the room with them when providing care to Resident #21 as resident had attention seeking behavior by making false statements regarding accusations against the staff. She expected all staff to report any allegations of abuse immediately to either the supervisor or herself. The corrective action for the noncompliance dated 09/12/24 was as follows: 1. Immediately suspended Licensed Nurse #1 on 09/09/24 by the DON for not reporting the fact that a resident ' s family member reported to her that she stated that she was slapped in the face overnight with a washcloth, and her mouth was held open and the aide tried to pour water in it. She stated she did not report it to anyone because she thought the resident was just having more of her "attention seeking behaviors." Immediately re-educated licensed Nurse #1, 09/09/24, by the DON on how to report abuse allegations, and how to report them in a timely manner. DON immediately assessed resident for signs and symptoms of abuse. 2. Re-education of all employees regarding timeliness of abuse reporting (i.e. immediately) to the abuse coordinator/Licensed Administrator, this re-education was completed by the Staff Development Director. All employees were re-educated on or before September 12, 2024. Alert and oriented residents were interviewed by the Staff Development Director regarding	F 607		

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F 607	Continued From page 11	F 607		

concerns associated with mistreatment by staff, this was completed on September 10, 2024, with no further skin findings of concern.
All residents with a BIM ' s (Brief Interview for Mental Status) score of >12 were interviewed the DON and or the Staff Development Director on or before September 10, 2024 with no further findings of concern shared.

3. The DON and or the Administrator are ensuring through weekly monitoring that staff continue to be compliant with reporting any allegations of abuse (physical, sexual, and verbal), neglect, misappropriation of property to ensure compliance with immediately reporting. The monitoring was initiated the week of September 16, 2024 and is ongoing until the QAPI (Quality Assurance Process Improvement Committee) deem no longer necessary, however, for a minimum of 3 months and then ongoing based on results of the monitoring. The DON is responsible to ensure the results of the monitoring are brought to the monthly QAPI meeting.

4. The QAPI committee met on September 12, 2024 to review the concern and actions taken, along with the planned monitoring, this meeting was led by the Administrator and included the AQPI team members.

The alleged date of compliance was 09/13/24.

Validation of the corrective action plan was completed on 09/26/24. This included staff interviews and in-service training that was received to ensure understanding and knowledge of the training provided. Staff interviews revealed following in-service training they had a better

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING ______ B. WING ______	C **09/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	**208 MERCER MILL ROAD** **ELIZABETHTOWN, NC 28337**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 12 understanding of the reporting requirement related to abuse allegations. The initial interviews were verified. Audits were documented and verified. There were no concerns identified. The last QAPI meeting was held on 09/12/24 where audit results were discussed. The corrective action plan was validated to be completed as of 09/13/24.	F 607		