STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DURHAM NURSING & REHABILITATION CENTER	**411 S LASALLE STREET DURHAM, NC 27705**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and physician interviews, the facility failed to follow the abuse policy by not immediately reporting an allegation of abuse and by not immediately suspending a staff member that had been accused of alleged abuse for 1 of 3 residents (Resident #1) reviewed for abuse. Findings include: The facility's abuse and neglect prohibition policy, revision date August 2017 read in part, any observations or allegations of abuse , neglect or mistreatment must be immediately reported to the administration. Additionally, the policy stated, any employees who are alleged to be involved in any instance of abuse will be suspended immediately and will not be permitted to work only after the allegation of abuse has been unsubstantiated. Resident #1 was readmitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed, the resident was severely cognitively impaired, could rarely make self-understood and could rarely understand others. The resident had no [MEDICAL CONDITION] or exhibited any behaviors. The resident was coded as being totally dependent with one-person physical assistance to complete her activities of daily living (ADL). The assessment also had documentation of receiving antianxiety and antipsychotic medication for 7 of 7 days of the look back period. The care plan last revised on 9/10/20 revealed the resident had a care plan for behaviors due to dementia, resident combative with staff, kicking/hitting and disrobing. The resident was also care planned for resistive to care and ADL self-care performance deficit. The goals included the resident to have fewer disruptive behavior, will cooperate with care and will maintain current level of functioning. The interventions included anticipating and meeting resident's needs, reporting all refusal for behavior to nurse supervisor, diverting attention and approaching calmly. When resident resisted care , staff to reassure the resident, leave and return back in 5- 10 minutes and try later. Review of the initial 2-hour report dated 9/8/20 revealed, on 9/8/20 at 3:20 PM the facility was made aware of the allegation that Resident # 1 was struck by a Nurse aide (NA). Review of the 5-day investigation report dated 9/14/20 revealed the allegation of abuse occurred on 9/3/20 and the facility was made aware of this allegation on 9/8/20. The report read in part, Resident has a ventriculoperitoneal shunt (VP shunt - a medical device that relieves pressure on the brain caused by fluid accumulation.) to the left side of the head that traces down back od head. Resident # 1 was examined by the physician on 9/8/20. No redness, discoloration, open area and no sign of injury to the resident during the examination. The report also indicates the resident has a known history of combative behaviors, while staff attempts to provide care to the resident. During an interview on 9/21/20 at 4:09 PM, Nurse Aide (NA) #2 stated she was assigned to the resident on 9/3/20 from 3 PM - 11 PM. On 9/3/20 at around 3:30 PM, NA #2 indicated the resident's door was closed, and after a quick knock, she entered the room. Upon entering the resident's room, she observed NA # 3 providing incontinent care to the resident. The resident's bed was raised, and the resident was lying on the bed. NA # 2 indicated, NA # 3 was observed holding the resident's right arm at the wrist with her left hand and was striking the resident's head with her right hand. NA #2 stated she observed NA # 3 hit the resident twice on her head. NA #2 stated she immediately reported the incident to Nurse #2 who was in the hallway. NA # 2 further stated she was directed by Nurse #2 to report the incident to Nurse # 3 who was Resident's #1 assigned nurse. NA #2 indicated Nurse # 3 went into the resident's room. NA #2 indicated on 9/5/20, she sent text messages to the facility assistant director of nursing (ADON) about the alleged abuse. NA # 2 stated when she returned to work on 9/7/20, she noticed NA # 3 was passing ice to residents in the hallway, where Resident # 1 resided. NA #2 stated on 9/8/20, the administrator had questioned her for the first time about the abuse allegation. Review of the staffing scheduled revealed the NA #3 was assigned to the resident on 9/5/20 and 9/7/20. A telephone interview was conducted with NA # 4 on 9/22/20 at 5:30 PM. NA #4 was working on 9/3/20 from 3 PM - 11 PM and had witnessed NA #2 report the alleged abuse to Nurse # 3. NA #4 further stated she went into the resident room along with Nurse #3. Upon entering the room, she had observed NA #3 was trying to assist the resident with incontinent care, the resident was screaming and yelling at the staff member. NA# 3 had indicated to them that that she had requested NA # 2 for assistance as the resident was resisting care. NA #4 stated the resident was assisted with care. NA#4 further stated she did not see any bruising or swelling on resident's head or body. NA #4 indicated Nurse #3 had also assessed the resident . During an interview on 9/21/20 at 5 :00 PM, Nurse # 3 stated she was assigned to the resident on 9/3/20 from 3 PM- 11 PM. Nurse # 3 denied NA #2 had reported Resident # 1 being abused by NA # 3. Nurse # 3 further stated she was informed by NA #2 that Resident #1 was resisting care and staff needed assistance with care. Nurse # 3 indicated she assisted NA # 3 with resident's care. The resident was combative and was resisting to be changed. Nurse # 3 further indicated that NA # 3 has informed her that the resident was hitting and biting the nurse aide and pulling of her brief during incontinent care. Nurse # 3 indicated as she was not informed about any abuse, hence she did not report any abuse allegations to the administrator. Nurse # 2 was interviewed on 9/21/20 at 3:55 PM. During the interview, Nurse # 2 confirmed that NA #2 had reported the alleged physical abuse on 9/3/20, however when he observed Resident # 1's assigned nurse in the hallway, he had directed NA #2 to report the incident to Nurse # 3. Nurse #2 stated he did not report the incident to the Director of Nursing (DON) or administrator as he was not the assigned nurse and had expected Nurse # 3 to assess the resident and report the incident to the administrator. On 9/21/20 at 11:48 AM, the assistant director of nursing (ADON) was interviewed. The ADON confirmed he received around 10 text messages from NA # 2 on 9/5/20. The ADON stated that these messages were sent continuously and appeared to be similar messages. The ADON indicated he read a couple of lines from the first text, which appeared to be like a poetic text and mistook it to be a poem. He stated he just scrolled through the messages and did not pay much attention to these messages. The ADON stated he did not perceive these messages as though the NA was reporting abuse. The ADON's cell phone messages were reviewed. Ten different texts with almost similar messages were sent from 1:27 PM to 2:33 PM on 9/5/20. Review of the first text messages sent to the ADON's cell phone dated 9/5/20 at 1:27 PM indicated NA # 2 had witness physical abuse. It does not indicate the name of the resident or staff member. The messages also talks about how God would forgive a co-worker. The last text messages at 2:33 PM indicated the alleged abuse was reported to Nurse # 2 and Nurse # 3 on 9/3/20 and Nurse #4 on 9/4/20. The message also identifies the resident room number and the staff accused of the allegation. During an interview on 9/21/20 at 3:41 PM, Nurse # 4 indicated she was assigned to Resident #1 on 9/5/20 and 9/7/20 from 3 PM to 11 PM. Nurse # 4 indicated she was not reported about any alleged abused to Resident # 1 by NA # 2. Nurse # 4 stated , on 9/5/20 around dinner time, she did hear a verbal argument between NA # 2 and NA # 3. Nurse #4 stated NA #2 was accusing NA#3 of physically abusing Resident #1 a few days prior. Nurse # 4 stated she did report the alleged abuse allegation to her supervisor (Nurse #7) who asked her to write a report and place it under the DON's office door. Nurse #4 indicated she did write a report and placed it under the DON's office door that evening. She further indicated she did not call and notify the DON or administrator about the accusation as it did not happen on that day, but the incident had occurred few days prior. A telephone interview was conducted on 9/23/20 at 12:35 PM. Nurse # 7 stated she was working on 9/7/20 on medication cart, when Nurse # 4 approached her and informed about the argument between the 2 NA's. During that argument one of the NA's had accused the other of abusing a resident few days ago. Nurse # 7 stated she did inform the nurse to write a stated and report it to the DON immediately. Nurse # 7 further stated she was not working as a supervisor

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

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) but was assigned a medication cart. During an interview on 9/21/20 at 2:20 PM, the Director of nursing (DON) stated on 9/8/20, when she entered her office, she found a statement from Nurse # 4. In the statement Nurse # 4 reported about the verbal argument between NA # 2 and NA # 3. During the verbal argument NA #2 accused NA #3 of physically abusing Resident #1 a few days prior. The DON further stated the administrator, was made aware of the incident immediately. The DON indicated the administrator was the chief investigating person for any abuse allegation. The DON stated had the facility been made aware of the allegations on 9/3/30 , NA # 3 would not been scheduled to work in the facility and would have been suspended with immediate effect until the investigation was completed. On 9/22/20 at 3:20 PM, a telephone interview was conducted with the physician. He indicated he examined the resident on 9/8/20, when he was made aware of the alleged abuse. The physician stated he examined the resident's head and there was no pain or tenderness, nor was any lump or bump or bruising noted. The resident was at the base line during her examination. During an interview on 9/22/20 at 11:30 AM, the Administrator stated the investigation and the initial report were started on 9/8/20, when the facility Administrative staff was made aware of the incident. The Administrator indicated the DON found a vague statement about an abuse on her office floor on 9/8/20. The Administrator further indicated during the investigation NA #2 stated the incident occurred on 9/3/20 and the nurse was notified about the incident. The Administrator stated the incident should have been reported to her by staff on 9/3/20, when the allegation of abuse was made. The administrator indicated on 9/8/20 upon receiving the abuse allegation, the accused NA was suspended immediately. She added had the allegation been reported on 9/3/20, NA #3 would not been assigned to the resident or scheduled to work with any other resident in the facility. The NA would be suspended immediately until investigation was completed.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code two Minimum Data Set (MDS) assessments for 1 of 3 resident (Resident #1) reviewed for behaviors. Findings included: Resident #1 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Physician orders [REDACTED].#1 should be monitored for behaviors every shift. Review of Resident # 1 Medication administration record (MAR) for June 2020 revealed on 6/4/20 and 6/5/20 during the morning shift hitting/ combative behaviors were exhibited. A review of the comprehensive annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was assessed as severely cognitively impaired and had no behaviors or rejection of care. This MDS assessment did not reflect the behaviors which had been documented on the MAR for 6/4/20 and 6/5/20. Review of Resident # 1 Medication administration record (MAR) for September 2020 revealed on 9/3/20 during the evening shift, hitting/ combative behaviors was exhibited. A review of the quarterly MDS assessment dated [DATE] revealed Resident #1 was assessed as severely cognitively impaired and had no behaviors or rejection of care. This quarterly MDS assessment did not reflect the behaviors which had been documented on the MAR for 9/3/20. Review of the revised care plan dated 9/10/20 revealed Resident #1 was care planned for behaviors. During an interview on 9/21/20 at 1:00 PM, Nurse # 1 stated the resident was sometimes aggressive, combative with staff and refused medication. Nurse # 1 indicated the resident was care planned for behaviors and the resident's behaviors were documented in the MAR. During an interview on 9/21/20 at 2:05 PM, Nurse Aide (NA) #1 stated Resident # 1 sometimes exhibited behaviors during care and this was reported to the assigned nurse. During an interview on 9/21/20 at 2:20 PM , the Director of Nursing (DON) stated Resident # 1 exhibited behaviors , was combative and refused care. The DON further stated the resident was care planned for behaviors and these behaviors were documented. During a telephone interview on 9/23/20 at 12:38 PM, the MDS coordinator stated the social worker was responsible for completing the Section E on the MDS assessment. The MDS coordinator indicated she only makes sure the MDS was complete and was completed on time. During a telephone interview on 9/23/20 at 11:47 AM, the Social Worker (SW) Director indicated he was responsible for completing the behavior assessment for the MDS assessments. He indicated the resident had a history of [REDACTED].