Received via email on 09/17/20.

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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030009	A. BUILDING: _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOCKSVILLE SENIOR LIVING & MEMORY CARE	337 HOSPITAL STREET MOCKSVILLE, NC 27028

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D 000	Initial Comments The Adult Care Licensure Section and Davie County Department of Social Services conducted a Complaint Investigation and Follow-up survey on 07/07/21 through 07/09/21. The complaints were initiated by the Davie County Department of Social Services on 06/25/21.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alledged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report: the Plan of Correction is prepared soley as a matter of compliance with State Law.	
D 457	10A NCAC 13F .1212 (h) Reporting Of Accidents And Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to immediately report to law enforcement an incident of physical assault of a resident (Resident #1) by a staff (Staff F). The findings are: Review of Resident #1's current FL2 dated 02/09/21 revealed diagnoses included Alzheimer's disease, hypertension, coronary artery disease, and hyperlipidemia. Review of Resident #1's progress note date 04/26/21 at 5:43pm revealed: -The progress note was a follow up from the 04/22/21 incident. -An incident report was added. -The Eexecutive Director (ED) was aware and	D 457	10A NCAC 13F .1212 (h) Reporting of Accidents and Incidents. The facility will immediately report any assault resulting in harm to a residen or other person in the facility to the local law enforcement authority. Incident reports will be completed for behavioral incidents that result in physical aggression towards another resident or staff. Training for staff on behaviors and resident's rights in the Special Care Unit will be conducted on-site once a quarter. Supervisors on duty will be responsible for making reports to the local law enforcment authority. The Resident Care Director and the Executive Director will be responsible for ensuring staff trianing is completed. Keisha Banks 09/24/21	07/28/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tracy L Smith | TITLE: Executive Director | (X6) DATE: 7/28/21

Reviewed and Acknowledged with an addendum on page 1. Keisha Banks 09/24/21

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D 457	Continued From page 1 would follow up with Resident #1's responsible party. Review of Resident #1's Accident/Incident report dated 04/26/21 at 5:34pm revealed: -The incident was Resident #1 hitting, kicking, screaming, and threatening Staff F which took place in the hallway of the Special Care Unit (SCU). -The incident occured on 04/22/21. -Staff observed Staff F and Resident #1 yelling at each other. -The observing staff tried to redirect Resident #1 and the resident became agitated and hit staff. -Resident #1 stated Staff F walked up and hit her, and she did not know why Staff F did that to her because she did not even know her. -Resident #1 did not complain of pain and there was no injury noted. -Resident #1 was not taken to the hospital, hospitalized or seen by the provider on 04/22/21. -Staff were to monitor Resident #1's status for 72 hours, from 04/22/21 through 04/25/21, and document progress notes daily. Review of a handwritten statement by the Medication Aide (MA) who witnessed the incident on 04/22/21 revealed: -The statement was undated. -She was on break when the incident took place between Resident #1 and Staff F. -When she came back to the SCU, she observed Resident #1 hitting at Staff F. -She stepped in and tried to redirect Resident #1 by taking her hands and walking her into her room away from Staff F. -When Resident #1 got into her room, she tried to hit the MA. -She went to get another staff who was on duty and Resident #1 attempted to hit the other staff	D 457		

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D 457	Continued From page 2 with a hairbrush. -An incident report was completed, Resident #1's PCP was and the SCU Coordinator were notified. -Resident #1 kept saying she was going to kill Staff F and kept trying to go after her. -She switched Staff F with a staff in assisted living to get Staff F off the SCU. -Resident #1 talked about hitting Staff F the remainder of the night. -The ED was notified on 04/22/21 of her observations. Interview with the MA who documented the incident accident report (04/22/21) on 07/08/21 at 4:51pm revealed: -She had stepped out of the SCU briefly and when she returned, she heard Resident #1 and Staff A yelling at each other. -She got Resident #1 away from Staff F and asked Staff F to step off the SCU and to go get another staff. -Another staff came to the SCU to work and Staff F worked on the assisted living side. -Resident #1 kept saying, "I'm going to get that expletive." -Staff F said Resident #1 hit her with a broom. -She assessed Resident #1 on 04/22/21 and there were no visible bruises or knots. -She notified Resident #1's physician and responsible party. -She thought Resident #1 was having a behavior and did not know at the time Staff F physically assaulted Resident #1. -She found out later that there was video which revealed Staff F physically assaulted Resident #1. -She did not know if the police had been contacted. Review of a handwritten statement by Staff F revealed;	D 457		

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D 457	Continued From page 3 -The statement was received by the ED on 04/26/21. -She was working in the SCU on 04/22/21. -She was in the process of taking a resident to bed when Resident #1 started cursing at her and smacked her in the face with a broom handle for no reason. -She grabbed the broom from Resident #1's hands. Resident #1 smacked her in the face twice and called her names. -Resident #1 grabbed her by the arms and left cuts and scrapes on her arms as well as broke one of her nails. -She grabbed Resident #1 by the arms and pushed her against the wall to restrain her and to keep Resident #1 from hitting her. -When she let go of Resident #1 to walk away, Resident #1 came after her, tripped, and fell backwards hitting her head on the floor. -She called the MA who was on the SCU with her and when the MA came, Resident #1 hit, kicked, and bit the MA. -Resident #1 kept slamming her bedroom door. -Another MA went to Resident #1's room to administer her evening medications and Resident #1 hit the MA with a hairbrush. -Resident #1 threatened to kill her so she was asked to switch from the SCU to assisted living. Attempted interview with Staff F on 07/08/21 at 10:16am was unsuccessful. Review of documentation by the ED dated 04/26/21 revealed: -She interviewed several staff regarding the incident on 04/22/21. -She received a statement from Staff F and had concerns. -She reviewed camera footage after staff reported a suspected physical assault to Resident	D 457		

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D 457	Continued From page 4 #1 by Staff F. -She observed Resident #1 and Staff F fighting over a broom and pushing back and forth. -Staff F pushed Resident #1 hard up against the wall. -Resident #1 and Staff F continued pushing and pulling and fell into the breezeway. Review of the Investigation Report to the Health Care Personnel Registry dated 04/30/21 revealed: -The incident date was 04/22/21 and the facility became aware to the incident on 04/26/21. -The ED was made aware by the SCU Coordinator that there were conflicting reports about a behavior incident that happened on 04/22/21. -The accused staff provided a written statement admitting to pushing the resident against the wall to restrain her from hitting. -The accused staff was put on suspension pending the investigation. -The resident was assessed by the Licensed Health Professional Support (LHPS) nurse consultant and the SCU Coordinator on 04/26/21 and the assessment revealed a greenish/purple bruise on the resident's right shoulder, a purple bruise on the resident's left hand between the thumb and the index finger, a knot on the resident's forehead with greenish/purple bruising, and a knot on the right side of the back of the resident's head. -It was determined that the accused staff used excessive force to restrain the resident to retrieve the broom involved in the incident. -The accused employee admittedly pushed the resident up against the wall -The incident resulted in physical injury/harm or substantial risk of injury/harm. -The resident was upset when repeating the story	D 457		

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D 457	Continued From page 5 and continued to tell staff "That hussy was mean, and she better not come back here anymore." -The allegation was substantiated, and the accused staff's employment was terminated related to the allegation on 04/22/21 -Law enforcement was not notified. Review of Resident #1's LHPS evaluation dated 04/26/21 revealed: -Resident #1 was alert, forgetful, and cooperative. -Resident #1 ambulated independently without assistive devices. -Resident #1 had multiple discolorations to her upper body in various stages of healing. -No changes or follow up were recommended to meet Resident #1's needs. Attempted interview with the LHPS nurse who completed the evaluation for Resident #1 on 07/08/24 at 9:24am was unsuccessful. Interview with the local law enforcement agency on 07/06/21 revealed there had been no report made of any incident involving a resident at the facility on 04/22/21. Interview with Resident #1 on 07/07/21 at 4:03pm revealed: -She had been hit twice by staff and had a great big knot on the right side of her forehead and a knot on the back of her head. -She did not remember hitting her head on a door or wall. -She had been checked out several times and she was fine. -She thought the incident happened about 2 years ago. Interview with Resident #1's responsible party on 04/08/21 at 9:53am revealed:	D 457		

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D 457	Continued From page 6 -She was made aware of the incident involving a physical assault of Resident #1 by Staff F on 04/26/21. -She did not remember any discussion regarding notifying law enforcement of the incident. Interview with the SCU Coordinator on 07/07/21 at 9:36am revealed: -There was an altercation between Staff F and Resident #1 on 04/22/21. -She had been made aware of a behavior incident on 04/22/21 between Staff F and Resident #1. -She viewed video footage for 04/22/21 in the SCU of Staff F and Resident #1 arguing over a broom. -Resident #1 thought she worked at the facility and often swept the floors. -Both Staff F and Resident #1 had their hands on the broom and were struggling for the broom. -It looked like Staff F pushed Resident #1 against the wall with the broom. -Resident #1 had bruising on her head which appeared a few days after the incident. -The ED was responsible for completing the report to the HCPR and to the police. -She did not know if there was a police report made. Interview with the ED on 07/8/21 at 2:25pm revealed: -She was notified by staff on 04/22/21 that Resident #1 was having outbursts, attacked Staff F and became upset when she saw Staff F. -There was no indication of a physical exchange between Staff F and Resident #1 so she told the staff to complete a behavior report and to call Resident #1's family. -On 04/23/21, she told Staff F to write a statement and she received the statement from	D 457		

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D 457	Continued From page 7 Staff F on Monday, 04/26/21. -She watched video footage from the SCU on 04/26/21, but the video footage automatically taped over itself every 5 days. -She observed Staff F and Resident #1 tussle over a broom. -Both Resident #1 and Staff F had both their hands on the broom in front of them, Staff F swung Resident #1 into the wall, and they both fell. -The other staff who was on the hall came back to the SCU after Staff F got up from the fall. -The staff reported to her she had no idea Staff F was aggressive towards Resident #1 because she only witnessed Resident #1 being the aggressor. -She had not contacted the police because the facility's corporate staff told her the facility could not press charges unless they were the guardians. Only the resident's guardian could press charges against the staff. -The ED was not aware of the facility's obligation to report any assault resulting in harm to a resident to the local law enforcement.	D 457		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a	D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation and training Staff files will be audited to ensure that all current staff have completed orientation and training for Special Care Unit. Business Office Manager will ensure that the Special Care Unit Orientaiton and Training is completed within the first week of employment and 20 hour training is completed according the DHHS regulation. Executive Director/Designee to audit 3 PCA/CNA/MT files per week to ensure training/task validation is up to date. 1x week for 4 weeks and then reevalute for frequency.	08/16/2021

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D 468	Continued From page 8 plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 6 of 8 sampled staff (Staff A, B, C, D, F, and G) who worked in the Special Care Unit (SCU) completed 6 hours of SCU orientation training within the first week of hire and an additional 20 hours of training within the first 6 months of employment. The Findings are: Review of the facility's Special Care Unit (SCU) Policy (not dated) revealed: -All staff involved in the SCU will be trained in Alzheimer's and related dementia behavior. -All staff will receive no less than 6 hours of training during their first week of employment specific to the nature and needs of the residents residing in the SCU. -All staff will receive an additional 20 hours of	D 468		

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D 468	Continued From page 9 training specific for dementia care. 1. Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired on 04/23/21. -There was documentation Staff A completed 2.41 hours of 6 hours of Special Care Unit (SCU) training within the first week of hire, leaving her short by 3.59 hours of training. Telephone interview with Staff A on 07/09/21 at 12:35pm revealed: -She worked in the SCU. -She completed some trainings through an on-line training program but did not know if she had completed 6 hours. -The SCU Coordinator and the Executive Director (ED) were responsible to make sure all staff completed their SCU training. Refer to interview with the Special Care Unit (SCU) Coordinator on 07/09/21 at 11:17am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 1:05pm. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:00pm. 2. Review of Staff B's, personal care aide (PCA)/medication aide (MA) personnel record revealed: -Staff B was hired on 03/25/21. -There was documentation Staff B completed 0.5 hours of 6 hours of Special Care Unit (SCU) training within the first week of hire leaving her short by 5.5 hours of training. Interview with Staff B on 07/09/21 at 11:15am revealed:	D 468		

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D 468	Continued From page 10 -She worked in the SCU. - She was hired in March 2021. -She thought she had completed some SCU training, but when she checked the computer system, she had only completed one training because the other dementia trainings were locked. -She did not realize the dementia trainings were locked and she could not access them. -She thought all the trainings she needed would pre-populate on the system. Refer to interview with the Special Care Unit (SCU) Coordinator on 07/09/21 at 11:17am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 1:05pm. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:00pm. 3. Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 12/14/20. -There was no documentation Staff C completed 6 hours of Special Care Unit (SCU) within the first week of hire. -There was documentation Staff C completed 14.10 hours of 20 hours of SCU orientation training during her first 6 months of employment, leaving her short by 5.9 hours of training. Telephone interview with Staff C on 07/09/21 at 3:00pm revealed: -She was hired in December 2020. -She worked in the SCU. -She completed 26 hours of SCU training at the facility, but she did not remember when. -Some of the training was on the old system the facility used and some was on the new system	D 468		

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D 468	Continued From page 11 the facility recently changed to. -She thought the SCU Coordinator and the Executive Director (ED) kept up with the number of training hours for the SCU staff. Refer to interview with the Special Care Unit (SCU) Coordinator on 07/09/21 at 11:17am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 1:05pm. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:00pm. 4. Review of Staff D's, medication aide (MA) personnel record revealed: -Staff D was hired on 04/01/20. -There was no documentation Staff D completed 6 hours of Special Care Unit (SCU) orientation training within the first week of hire. -There was documentation Staff D completed 3 hours of 20 hours of SCU training during her first 6 months of employment, leaving her short by 17 hours of training. Interview with Staff D on 07/09/21 at 11:00am revealed: -She was hired in April 2020. -She worked in the SCU. -She thought she had completed more than 26 hours of SCU training. -Some of her training was in the old system. -The facility had recently switched to a new system. Refer to interview with the Special Care Unit (SCU) Coordinator on 07/09/21 at 11:17am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 1:05pm.	D 468		

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D 468	Continued From page 12 Refer to interview with the Executive Director (ED) on 07/09/21 at 12:00pm. 5. Review of Staff F's, personal care aide (PCA), personnel record revealed: -Staff F was hired on 08/19/20. -There was no documentation Staff F completed 6 hours of Special Care Unit (SCU) orientation training within the first week of hire. -There was documentation Staff F completed 3.25 hours of 20 hours of SCU training during her first 6 months of employment, leaving her short by 16.75 hours of training. Telephone interview with Staff F on 07/09/21 at 12:38pm revealed: -She was hired in August 2020. -She worked in the SCU. -She thought she had completed more than 33 hours of SCU training. -Some of her training was in the old system. -The facility had recently switched to a new system. -The Executive Director (ED) was responsible for making sure staff received their SCU training hours, but she did not know how many training hours were required. Refer to interview with the Special Care Unit (SCU) Coordinator on 07/09/21 at 11:17am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 1:05pm. Refer to interview with the Executive (ED) on 07/09/21 at 12:00pm. 6. Review of Staff G's, personal care aide (PCA) personnel record revealed:	D 468		

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D 468	Continued From page 13 -Staff G was hired on 10/2720. -There was no documentation Staff G completed 6 hours of Special Care Unit (SCU) orientation training within the first week of hire. -There was documentation Staff G completed 19.6 hours of 20 hours of SCU training during her first 6 months of employment, leaving her short by 0.4 hours of training. Attempted telephone interview with Staff G on 07/09/21 at 12:31pm was unsuccessful. Refer to interview with the Special Care Unit (SCU) Coordinator on 07/09/21 at 11:17am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 1:05pm. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:00pm. Interview with the SCU Coordinator on 07/09/21 at 11:17am revealed: -The facility had recently switched online training programs. -The new online system training program had not been assigning the dementia training correctly. -She and the ED were responsible for ensuring staff completed their dementia training, but she did not have access to staff records to track their training. Interview with the BOM on 07/09/21 at 1:05pm revealed: -All staff were cross trained so all must have 6 hours of dementia training their first week of hire and an additional 20 hours within their first 6 months of hire. -The previous BOM was responsible for keeping up with staff dementia training hours, but she did	D 468		

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D 468	Continued From page 14 not know if dementia training hours were tracked because there were no certificates for the training in the staff records. -Currently there was no system in place to track dementia training hours. -She and the ED were responsible for ensuring the training including SCU training was completed by staff. Interview with the ED on 07/09/21 at 12:00pm revealed: -The former BOM should have worked with the SCU Coordinator to ensure required trainings including SCU trainings were completed prior to staff working independently, but she did not. -SCU trainings should have been completed by staff during new hire orientation. -The facility changed to a new online program for completing training. -The old online system was no longer available so she was not able to access any training completed in that system so if the certificates were not printed and placed in the staff record, there would not be a record for the training. -Some staff had a 7-hour class back in April 2020 she thought would count as some of the hours for dementia training. -There was no system in place to track dementia training hours. -She and the BOM were responsible for ensuring staff completed the required dementia training hours.	D 468		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her	D911	G.S. 131D-21 (1) Declaration of Residents' Rights Administrator will ensure that training for staff on Dementia and Aggressive Behaviors, Restraints and Resident Rights is conducted with current staff. Business Office Manager/Designee will ensure that all staff are educated on Resident's Rights and Agressive Behaviors during orientation.	08/16/2021

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D911	Continued From page 15 individuality and right to privacy. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure a resident (#1) was treated with respect and dignity by a staff (Staff A) who held the resident's wrist during a period of agitation. The findings are: Review of Resident #1's current FL2 dated 02/09/21 revealed: -Resident #1's current level of care was Special Care Unit (SCU) -Diagnoses included Alzheimer's disease, hypertension, coronary artery disease, and hyperlipidemia. -Resident #1 was constantly disoriented and wandered. Review of Resident #1's progress notes dated 06/24/21 revealed: -Resident #1 was being combative with staff. -Resident #1 kicked Staff A and used foul language. -Staff A documented a conversation with the Executive Director (ED) where she explained to the ED that Resident #1 became combative when Staff A told her she could not assist another resident. -Resident #1 hit Staff A once and attempted to hit Staff A a second time when Staff A grabbed Resident #1's hands to keep her from hitting Staff A again. -Staff A called for a personal care aide (PCA) who was working on the SCU to help calm Resident #1 down and take her out of the other resident's room.	D911		

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D911	Continued From page 16 Review of Resident #1's Accident/Incident Reports revealed there was no report dated 06/24/21. Review of an Accident/Incident report dated 07/08/21 at 4:33pm revealed: -There was a staff/resident altercation in a resident's room on 06/24/21 at 10:00am. -Resident #1 struck staff and attempted to strike another resident. -The resident did not complain of pain. -There was bruising, but no indication where the bruising was. -After further investigation of the event on 06/24/21 between Resident #1 and Staff A, it was determined that Staff A used physical restraint in attempts to protect the other resident involved in the interaction and herself. -The staff was suspended on 07/08/21 pending further investigation. Review of the ED documentation dated 06/24/21 regarding the 06/24/21 incident with Resident #1 revealed: -Staff reported Resident #1's family member had a window visit with Resident #1 after the incident on 06/24/21. -Resident #1 told the family member a staff was talking to her rude, and the family member asked Resident #1 if the staff hit her and Resident #1 responded yes. -The ED interviewed Staff A involved in the incident on 06/24/21 and Staff A told her she passed a resident's room and saw Resident #1 bent over trying to put the other resident's shoes on. -Staff A told Resident #1 she needed to leave the other resident alone and Resident #1 could not get the other resident out of her chair. -Resident #1 started yelling at Staff A, told Staff A	D911		

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D911	Continued From page 17	D911		

that the other resident was her baby, called Staff A names, and started swinging at Staff A.
-Staff A yelled for the PCA who was working to come to assist.
-When the PCA came in the room, Resident #1 was trying to hit the Staff A, so the PCA stood in front of Resident #1 and tried to talk her into going out of the room.
-Resident #1 kicked at Staff A again, but she kicked the PCA instead.
-The PCA was able to get Resident #1 out of the other resident's room and into her room.
-Resident #1 slammed the door so hard, the door popped back open, so Resident #1 slammed the door again.
-The ED asked Staff A where she thought the bruise on Resident #1's head came from and Staff A stated she was not sure because she had not seen the bruise prior to Resident #1 visiting with her family member.
-Resident #1 may have gotten the bruise when the door popped back open after she slammed it.
-The ED interviewed the PCA involved in the incident on 06/24/21 and the PCA told her the incident happened before lunch as they were getting residents ready for lunch.
-The PCA was in the bathroom toileting a resident when she heard the exchange between Resident #1 and Staff A.
-Resident #1 was yelling at Staff A, calling Staff A names, and telling Staff A to get out of her way.
-The PCA heard Staff A yell for her and when she was done with the other resident, she went into the room to assist Staff A.
-When the PCA went into the room, Staff A was holding Resident #1's arm and Resident #1 was swatting at Staff A.
-The PCA tried to get Resident #1 to go with her and tried to distract her by getting in front of her, but Resident #1 kicked at Staff A, missed, and

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D911	Continued From page 18 ended up kicking the PCA. -The PCA was able to get Resident #1 out of the room, but Resident #1 continued to call Staff A names and slammed the room door. -The PCA did not see any bruises on Resident #1's head prior to being brought to her attention by the ED. -The ED contacted Resident #1's family member on 06/24/21 to inform of the incident. Observation of Resident #1 on 07/07/21 at 4:03pm revealed there was no bruising or discolorations on Resident #1's skin. Interview with the SCU Coordinator on 07/07/21 at 9:36am revealed: -On the morning of 06/24/21, Resident #1 was verbally aggressive towards her, but not physically aggressive. -On the afternoon of 06/24/21, there was an incident between Resident #1 and Staff A. -When the PCA walked into the room, Staff A had Resident #1 in a "restraint," but she did not have any further details. Interview with the local county APS staff on 07/07/21 at 10:56am revealed: -Resident #1 had a history of being aggressive. -There were several APS reports made regarding Resident #1 prior to her admission to the facility. -She saw yellowing along the right-side of the hairline of Resident #1's forehead as if there was a healing bruise, but did not observe any other bruises or injuries. Interview with Staff A at 11:50am revealed: -She was completing her rounds on the afternoon of 06/24/21 when she noticed Resident #1 in the room of another resident trying to assist the other resident up from a chair.	D911	G.S. 131D-21 (1) Declaration of Residents' Rights Administrator will ensure that training for staff on Dementia and Aggressive Behaviors, Restraints and Resident Rights is conducted with current staff. Business Office Manager/Designee will ensure that all staff are educated on Resident's Rights an anddur ing new hire orientation	08/16/2021

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D911	Continued From page 19 -She told Resident #1 she would assist the other resident up from the chair. -As she was assisting the other resident, Resident #1 hit her in the back with a hanger and called her names. -She called for a PCA to assist her, but the PCA was in a room with another resident. -Resident #1 began swinging at her and hit her in the upper body. -She grabbed both of Resident #1's wrists and the other PCA came in to get Resident #1 out of the room. -Resident #1 walked out of the room with the other PCA. -Resident #1 sometimes had periods of agitation. -Resident #1 thought other residents were her babies and liked to try to assist them. -She sometimes got agitated when she was not allowed to assist other residents. -After lunch, Resident #1 had a family visit through the screen in the dining hall. -She heard Resident #1 say to the family member, "They hit me." -She had not noticed any injuries to Resident #1. -Resident #1 slammed the door to the other resident's room several times and it could have popped back and hit her, but she did not witness any injuries. Observation of the Staff A on 07/07/21 at 11:53pm revealed: -Staff A demonstrated on the local county staff how she held Resident #1 on 06/22/21. -Staff A stood in front of the local county staff and clasped both hands around the wrists of the local county staff. Interview with the PCA on 07/07/21 at 3:37pm revealed: -Resident #1 was pleasant most of the time, but	D911		

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D911	Continued From page 20 she had "bad" days. -She was working on the SCU on the afternoon of 06/24/21. -On the afternoon of 06/24/21, a resident was in her room in her recliner with her feet up and Resident #1 was trying to help to get her up from the chair. -She was in the next room and heard Staff A telling Resident #1 the other resident could not get up. -She heard Resident #1 yelling and cursing at Staff A. -She heard the door close a couple times. -She heard Staff A aggressively tell Resident #1, "Get out, go!" -Staff A kept yelling her name, but she could not assist immediately, because she was assisting another resident. -When she walked in the room to assist Staff A, she saw Staff A standing behind Resident #1's back with her her arms reaching around Resident #1's body and holding Resident #1's wrists in front of Resident #1's body. -As she was taking Resident #1 to her room, Resident #1 told her Staff A hit her. -A family member visited Resident #1 through the screen in the dining hall and she overheard Resident #1 tell the family member a staff hit her. -She was not aware of any instances since 06/24/21 when Resident #1 had behavior issues or had been aggressive towards staff. -Staff A was verbally aggressive at times, but she had never seen the MA be physically abusive towards a resident. -Some of the residents got irritated and agitated easily while interacting with Staff A. -She did not feel Staff A needed to work in the SCU due to her aggressive demeanor Interview with Resident #1 on 07/07/21 at 4:03pm	D911		

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D911	Continued From page 21 revealed: -She had been hit twice by staff, but she did not know which staff. -She had a great big knot on the right side of her forehead and had a knot on the back of her head. -She did not remember hitting her head on a door or wall. -She had been checked out several times and she was fine. -She thought the incident happened about 2 years ago. Second interview with the MA who completed the Incident Accident Report dated 06/24/21 on 07/07/21 at 4:32pm revealed she was standing behind Resident #1 and was reaching around Resident #1's body from the back when she held Resident #1's wrists. Interview with Resident #1's family member on 07/08/21 at 9:53am revealed: -Resident #1 had a history of being aggressive and could be very hard to handle. -She was aware of the incident on 06/24/21 between Resident #1 and staff when Resident #1 was trying to assist another resident out of a chair. -She did not want Resident #1 to be sent out to the local hospital. -She had not received an update regarding the incident on 06/24/21. Interview with Resident #1's primary care provider (PCP) on 07/08/21 at 9:38am revealed: -He saw Resident #1 one to two times a week when her behaviors were an issue and he now did not see her as often. -He had been managing Resident #1's medications and did not feel she needed a mental health provider at this time.	D911		

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D911	Continued From page 22 -He was aware of Resident #1's incidents with staff on 06/24/21 as well as on a previous date of 04/22/21 and made changes to her medications after each incident. Interview with the ED on 07/08/21 at 2:25pm revealed: -On 06/24/21, Resident #1's family member came to the facility for a window visit. -Resident #1 told the family member during the window visit that staff hit her. -The family member never talked to the ED. -There was an incident between Resident #1 and Staff A as Staff A was trying to tell Resident #1 she could not assist another resident. -A PCA came in to assist Staff A after providing care for another resident in an adjoining room. -She interviewed both the PCA and Staff A on 06/24/21, and thought the incident was more of a behavior report. -She did not continue a facility investigation as the local county staff came to the facility to conduct a complaint investigation on 06/25/21 and at that point, the facility began working with the local county staff to complete the investigation. -During her interview with Staff A and the PCA, she was not told by Staff A or the PCA that Staff A was standing behind Resident #1, reaching around Resident #1 to hold Resident #1's wrists. -Staff A holding Resident #1's wrists in front of Resident #1's body while standing behind her reminded her of a therapeutic crisis hold used when dealing with mental health patients, but it was not appropriate for interacting with residents in assisted living facilities. -Staff A should have yelled for help and then tried to remove the other resident out of the room and away from Resident #1 instead of continuing to engage with Resident #1.	D911		

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D911	Continued From page 23 -There had not been any staff training on working with residents with aggressive behaviors or any dementia specific training for aggressive behaviors since she started working at the facility about 5 months ago.	D911		