STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dahlia Gardens Center for Nursing and Rehabilitati	915 Pee Dee Road Aberdeen, NC 28315

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on observation, record review, resident and staff interviews, the facility failed to place a resident's (Resident #83) call light within reach to allow for the resident to request staff assistance this was for 1 of 7 residents reviewed for accommodation of needs. The findings included: Resident #83 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) affecting left side, need for assistance with personal care, and type 2 diabetes mellitus. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #83 was cognitively intact. He was dependent on staff for toileting hygiene, transfers, and dressing. He required maximum assistance with shower/baths, bed mobility, and dressing and moderate assistance with personal hygiene. He was always incontinent of bowel and bladder. He had functional limitation with range of motion of one side of his upper extremities. Resident #83 ' s care plan, last reviewed on 07/18/24, indicated he had an activities of daily living (ADL) self-care performance deficit related to hemiplegia and stroke. The interventions included for staff to encourage the resident to use bell to call for assistance. Another focus read Resident #83 had an actual fall and was at risk for further falls related to poor trunk control. The interventions included for staff to ensure resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needs a prompt response to all requests for assistance. A continuous observation was conducted on 08/05/24 from 12:11 PM through 12:32 PM of Resident #83. Resident #83 was lying in bed watching television. His lunch tray was brought in by Nursing Assistant (NA) #1. NA #1 raised the head of the bed up and assisted Resident #83 with setting his meal tray up and then exited the room. Resident 83 ' s call bell was on the floor out of his reach. An interview was conducted on 08/05/24 at 12:45 AM with Resident #83. He stated his call bell falls to the floor a lot and staff often forget to give it to him. He explained that he would wait for the nurse (continued on next page)

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to bring in his medications or he would yell when he saw someone in the hall if he needed assistance. He also stated the call bell doesn ' t do any good if it was on the floor and it made him uneasy when he couldn ' t reach it. An observation and interview were conducted with Nursing Assistant (NA) #1 on 08/05/24 at 2:41 PM. He verified he was the direct care NA for Resident #83. He also verified the call bell in Resident #83 ' s room was on the floor beside the bed and out of his reach. He explained that he was in his room to give him his lunch try earlier but forgot to check call bell placement at that time. NA #1 then stated he did not realize Resident #83 ' s call bell was on the floor. He indicated he usually checks the call bell before leaving the rooms. NA #1 could not recall when Resident #83 last had his call bell. An interview was conducted on 08/07/24 at 12:43 PM with the Administrator and the Director of Nursing. They both stated the call bell should always be within the residents ' reach.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record review, resident and staff interviews, the facility failed to protect 1 of 4 residents (Resident #19), for his right to be free from physical abuse as evidence by another resident (Resident #9) slapping him with an open hand to the side of his head. The findings included: Resident #9 was admitted to the facility on [DATE] with diagnoses that included schizophrenia and hemiplegia and hemiparesis of the left non-dominant side. Resident #9 ' s quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated his cognition was intact. He exhibited no behavior during the look-back period. Resident #9 ' s care plan, last reviewed on 07/29/24 revealed a focus that read he was verbally aggressive related to poor impulse control. Resident was verbally aggressive and threatened bodily harm to staff and other residents. The interventions included when Resident #9 became agitated for staff to intervene before agitation escalated, guide him away from source of distress, and engage calmly in conversation. Resident #19 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, depression, and manic depression (bipolar disease). Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated his cognition was intact. He exhibited no behavior during the look-back period. Resident #19 ' s care plan, last reviewed on 07/19/24 revealed a focus for him having a behavior problem. Resident #19 was easily agitated, episodes of refusing care, and hitting self when agitated. The interventions included he had episodes noted where he would yell out, [NAME], [NAME], bang, bang at inappropriate times and for staff to monitor behavior episodes and attempt to determine underlying cause. Another focus read that he had a communication problem related to him usually understanding verbal content, he usually understood others, and he had unclear speech. The interventions included to ensure/provide a safe environment and avoid isolation. The Facility Reported Incident (FRI) dated 07/22/24, revealed Resident #19 was witnessed striking his roommate, Resident #9. The report indicated the residents were immediately separated and an investigation began. The report also indicated there was no physical or mental injury or harm. Law enforcement was notified on 07/22/24 at 10:50 AM. A Behavior note dated 07/21/24 revealed Nursing Assistant (NA) #3 was walking past Resident #19 & #9 ' s room and witness Resident #19 slap Resident #9 in the face. Resident #19 stated he slapped Resident #9 because he wanted him to shut up. Resident #19 was educated to keep his hands to himself and stay on his side of the room. Attempts to interview NA #3 were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement written by Nursing Assistant #3 dated 07/22/24 revealed on 07/21/24 as she was walking down the hall, she could hear Resident #9 talking to himself as he did every night. She stopped at the room door and witnessed Resident #19 at Resident #9 ' s bed and he yelled, shut the f**k up. She immediately went into the room to intervene but before she could get to the residents Resident #19 slapped Resident #9 with an open hand on his right hand/forearm. Resident #9 ' s right arm was up near his face and when his arm came down it hit his face. She yelled for the nurse to assist. A phone interview was conducted on 08/08/24 at 4:20 PM with Nurse #2. She verified she was the nurse for Resident #19 and #9 on 07/21/24. She stated the Nursing Assistant (NA) #3 informed her Resident #19 slapped Resident #9 and she immediately separated the two residents. Nurse #2 explained Resident #19 stated he slapped Resident #9 because he would not stop talking. She moved Resident #9 to a different room. She indicated prior to the incident Resident #9 was talking to himself while he was in bed. He was not yelling or cussing. An interview with Resident #19 was conducted on 08/06/24 at 11:40 AM. He explained that Resident #9 was cussing him on 07/21/24 so he got up from his bed and slapped him across the head. He further explained Resident #9 just kept repeating the same words over and over and would not shut up, he was tired of hearing him. He stated he was not trying to hurt Resident #9 he just wanted him to be quiet. An interview with Resident #9 was conducted on 08/06/24 at 11:55 AM. His speech was very hard to understand due to talking very low and he mumbled at times. He answered yes and no questions appropriately. He stated Resident #19 slapped him with an open hand but did not explain why or any other details. He denied being in pain or being fearful when Resident #19 slapped him or afterwards. Interview with the Administrator was conducted on 08/07/24 at 12:43 PM. She indicated the residents had been a good match for roommates up until that point and she never expected an altercation would occur. She stated Nurse #2 moved Resident #9 to a different room immediately and the nurse started the investigation, which was what she would expect the nurse to do. She further stated Resident #19 and Resident #9 have continued to reside at the facility on different halls. However, the nurse should have called her to notify her of the incident.

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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** 46095 Based on record review and staff interviews, Nurse #2 failed to implement the reporting portion of the abuse policy after Nurse Aide #3 (NA #3) told her Resident #19 slapped Resident #9 on the right hand/forearm. The facility also failed to notify Adult Protective Services (APS) regarding an allegation of abuse. This was for 1 of 4 Residents (Resident #9) reviewed for abuse. The findings included: a. A review of the facility's Abuse policy, last revised 2023, revealed new employees will be educated on the reporting process for abuse during the initial orientation. The policy read in part: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. A phone interview was conducted on 08/08/24 at 4:20 PM with Nurse #2. She verified she was the nurse for Resident #19 and #9 on the night of 07/21/24. She stated at approximately 2:45 AM NA #3 informed her Resident #19 slapped Resident #9, and she immediately separated the two residents. She moved Resident #9 to a different room. She also stated Resident #9 stated Resident #19 hit him and denied pain after he was slapped. She indicated prior to the incident Resident #9 was talking to himself while he was in bed. He was not yelling or cussing. She further stated she did not call to report the incident to the Administrator because she was unaware of the facility policy. Her main concern was to keep Resident #9 safe. Review of the orientation training, dated 07/19/24 through 07/22/24, which included the abuse policy, fire safety and emergency preparedness, was signed by Nurse #2 on 07/21/24 (after the incident). An interview with the Director of Nursing was conducted on 08/06/24 at 1:15 PM. She stated Nurse #2, agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. She explained Nurse #2 did not notify the administration after the incident because she did not feel it was abuse. The DON further explained that orientation training was given to Nurse #2 on 07/21/24 (after the incident). An interview with the Administrator was conducted on 08/06/24 at 1:39 PM. She explained that Nurse #2, an agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. She stated she had Nurse #2 come to the facility on [DATE] to write a statement related to the incident. When she questioned her on why she did not notify administration after Resident #19 slapped Resident #9 Nurse #2 told her because she did not feel it was abuse. Nurse #2 was reeducated on the abuse policy at that time. The Administrator then stated she expected nursing staff to report any type of abuse to the Administrator and/or the Director of Nursing immediately. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. An interview with the Administrator was conducted on 08/06/24 at 1:39 PM. She stated she submitted an initial report of abuse to the state regulatory agency on 07/22/24 regarding Resident #19 slapping Resident #9. She explained that she did not notify APS until 07/29/24 because she was unaware that she needed to report to APS. She indicated that she recently moved to North Carolina and her former state did not have to report to APS.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record review and staff interviews, the facility failed to provide abuse training to Nurse #2 prior to her working at the facility. This was for 1 of 5 employees reviewed for abuse training. The findings included: An interview with the Director of Nursing (DON) was conducted on 08/06/24 at 1:15 PM. She stated there was an incident of resident to resident abuse on 07/21/24 at 2:45 AM. Nurse #2, agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. The DON explained Nurse #2 did not notify the administration after the incident because she did not feel it was abuse. The DON further explained that orientation training, which included the abuse policy, was given to Nurse #2 on 07/21/24. Review of orientation training, dated 07/19/24 through 07/22/24, which included the abuse policy, was signed by Nurse #2 on 07/21/24 at 7:00 PM. A phone interview was conducted on 08/08/24 at 4:20 PM with Nurse #2. She verified 07/20/24 was the first time she worked at the facility and then returned on 07/21/24 from 7:00 PM until 7:00 AM. She also verified she was the nurse for Resident #19 and #9 on the night of 07/21/24. She stated at approximately 2:45 AM on 07/21/24 Nursing Assistant (NA) #3 informed her Resident #19 slapped Resident #9 and she immediately separated the two residents. She moved Resident #9 to a different room. Nurse #2 further stated she did not call to report the incident to the Administrator because she was unaware of the facility policy regarding abuse. Nurse #2 then stated she received orientation education from the Director of Nursing which included the abuse policy on 07/21/24 at 7:00 PM. An interview with the Administrator was conducted on 08/06/24 at 1:39 PM. She explained that Nurse #2, an agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. She stated she had Nurse #2 come to the facility on [DATE] to write a statement related to the incident. When the Administrator questioned her on why she did not notify administration after Resident #19 slapped Resident #9, Nurse #2 told her because she did not feel it was abuse. Nurse #2 was reeducated on the abuse policy on 07/22/24 by Administrator. The Administrator indicated the goal was for agency staff to be provided orientation prior to working their first shift by the DON.