STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to follow the facility's policy in reporting an allegation of abuse for 1 (Resident #3) of 1 residents. Findings include: Review of the facilities ' Abuse Policy, revised in 02/09, reads in part: "Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the administrator." In the " Investigation section " it reads in part: " Allegations of abuse, neglect, or misappropriation of resident property and injuries of unknown origin will be investigated by the facility." Resident #3 was admitted to the facility on 06/27/10 and was readmitted on 03/08/11. Cumulative diagnoses included Parkinson ' s, hypertension, depression, altered mental status, and paranoid behavior. Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #3 had short and long term memory problems and was moderately impaired in making daily decisions. The	F 226	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	10/5/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Arlene B. Palmer	Administrator	10-5-11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 1 assessment indicated the resident had mood problems; no behaviors; was totally dependent on staff for activities of daily living; and, was on an antidepressant. The resident was also assessed to be incontinent of bowel and bladder. An interview, on 09/14/11 at 1:45 PM, was conducted with the Administrator. The Administrator relayed that she was informed of the allegation when a staff member from the Division of Social Services (DSS) came to the facility on 08/02/11 and asked about the allegation. She stated once she learned of the allegation; she began an investigation by doing interviews and taking statements from many staff members. The Administrator relayed she had asked the Assistant Director of Nursing (ADON) if she was aware of the allegation and the ADON indicated she was not. The Administrator relayed when she called Resident #3 ' s Responsible Party (RP), the RP stated the resident had told her of the allegation on 08/01/11. The Administrator indicated the RP shared the resident had voiced the similar types of allegations at times when at home. She relayed the staff of the facility was not aware of the behavior until informed by the RP that day, but was aware of the resident's paranoia. An interview, on 09/14/11 at 2:30 PM, was conducted with the Director of Nurses (DON). The DON confirmed she was aware of an allegation made by Resident #3 regarding an incident that was to have occurred on 07/31/11 during the 3 - 11 shift. She stated she related the allegation to behaviors the resident displayed at times. The DON relayed she had instructed the nurse to write a report and document the	F 226	**F226** 1) The initial 24 hour abuse allegation report for Resident #3 was faxed to the North Carolina DHSR-Health Care Personnel Registry on 8/2/11 by the Administrator. The final report of the investigation was reported to the North Carolina DHSR- Health Care Personnel Registry on 8/5/11 by the Administrator. 2) Interviews of 100% of the alert and oriented residents regarding issues of abuse were completed by the Admissions Coordinator on 8/4/11 and on 10/3/11. There were no issues to be addressed based on those interviews. 3) 100% of all staff was trained by the Staff Development Coordinator regarding the facility abuse and abuse reporting policies on 8/2/11 and 9/14/11. The Staff Development Coordinator will provide training of staff every 6 months on abuse and abuse reporting policies. New employees will receive this training during orientation.	**10/5/11**

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F 226	Continued From page 2 information of the allegation in the resident ' s medical record. She stated when the administrator called her on 08/02/11 regarding the incident she learned the nurse had not completed the documentation. The DON revealed the nurse had been a long term employee but had been discharged related to other issues. On 09/14/11 at 2:40 PM, the Administrator shared she had verbally counseled the DON per phone regarding reporting any allegation of abuse to her. The Administrator indicated there was no documentation since it was completed over the phone. A phone interview, on 09/14/11 at 3:30 PM, was conducted with Nurse Aide (NA) #1. NA #1 stated Resident #3 was very confused, agitated, and screaming during the evening of 07/31/11. The NA relayed the resident made a statement of a staff member taking picture of her (private area). She indicated two nurses went into the room to try to calm the resident, but the resident remained agitated. The NA stated the resident could get agitated like that sometime when she had not had a bowel movement for a few days. Review of a written statement, dated 08/05/11, and signed by the nurse, who had been discharged and was not available to be interviewed. The statement read in part: "On August 1, 2011 at 6:30 AM, (named) CNA reported that (Resident #3) told her that the nurse and nurse aides held her down last night and took pictures of her (private area). She told the NA she yelled for help and no one came. I approached name (Resident #3) and asked her	F 226	**F226 (continued)** 4) The Staff Development Coordinator or designee will complete random staff interviews regarding abuse and abuse reporting policies monthly x 3 and then quarterly x 3. Results of the interviews will be documented on the audit tool and reviewed by the Administrator. Action will be taken immediately on any reported incidents upon notification of the Administrator and Director of Nursing. The results of the audits will be reported to the Quarterly Executive QI Committee and action taken as necessary.	10/5/11

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F 226	Continued From page 3 to tell me what happened. She told me the same thing but attempted to call the staff by name referring to a 'male CNA' and 'the little black girl (name)'. She told me she did not see a camera or a flash. She (Resident #3) told (the nurse) her son was a police officer and that she would have to report this to him when he came on Friday. I told her I would make my supervisor aware today. I advised my DON that AM (morning) of the allegation." On 09/15/11 at 9:30 AM, the written statement, dated 07/31/11 Monday 6:30 AM, by NA #2 was reviewed with the DON. The DON relayed the NA had worked the night shift and started at 11:00 PM on 07/31/11; and, that Monday 6:30 AM would have been 08/01/11. Review of a written statement by NA #2, dated 07/31/11 Monday 6:30 AM, read in part: "Resident #3 asked me to listen to what she had to say; she said a man came in her bedroom and she screamed for help and no one came to help her. When I asked what happened she described a male aide and said he took a picture of her (private area)." The writer of the statement was contacted by phone on 09/15/11 at 9:52 AM and verified the accuracy of the statement. An interview, on 09/15/11 at 10:45 AM, was conducted with the Administrator. The Administrator stated she would have expected for the evening shift nurse to have documented the behaviors of the resident on that shift; the night nurse would have documented the information the resident relayed, and the DON, upon receiving the information would have notified her of the allegation. She relayed she had been off	F 226		

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F 226	Continued From page 4 that day allegation was reported, but was available by phone 24 hours a day.	F 226		