STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BLDG _____ B. WING _____ AUG 28 2012	C 08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRAYBRIER NURS & RETIREMENT CT	CODE 116 LANE DRIVE TRINITY, NC 27370

(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 000	INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Licensure and Certification Section, conducted a complaint investigation from August 8, 2012 through August 10, 2012. Immediate Jeopardy began in 483.25 on June 28, 2012. It was removed on August 10, 2012 when the facility provided and implemented an credible allegation of compliance.	F 000	*1.* Regarding the incident on 6/28/12, the attending nurse removed the aggressive resident from the scene of the incident, thereby separating the two residents. All of the residents involved were physically assessed by the Attending Nurse, Donnet Frank, LPN, and no injuries or harm were found. No other aggressive behaviors were noted for the rest of the day. Seroquel was administered to the resident with aggressive behaviors and was effective due to no further behaviors.	6/28/12
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, administrative staff interviews, family interview and staff interviews the facility failed to provide supervision to prevent resident to resident altercations for one (1) of one (1) residents with aggressive behaviors (Resident #1) exhibited towards four (4) other residents. (Residents #2, #5, # 6 and # 7). The immediate jeopardy (IJ) for Resident #1 began on June 28, 2012 when Resident #2 and #5 were in a physical altercation and were hit by Resident #1. The Assistant Administrator and Director of Nursing were notified of Immediate Jeopardy on 8/9/12 at 1:55 PM. The IJ was removed on 8/10/12, at 5:20 PM after Credible	F 323	Regarding the incident that occurred on 7/12/12, the attending nurse separated the two residents involved in the incident. The Attending Nurse, Donnet Frank, LPN, physically assessed both residents and found no injuires or harm. Seroquel was administered to the resident with aggressive behaviors and was effective due to no further behaviors. On the evening of 7/13/12, the nurse in the secure unit, Stephanie Forrester, immediately separated two residents involved in a physical altercation. Resident #2 was taken out of the dining room and to her room; her glasses were replaced on	7/12/12 7/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | 6/28/12(X6) DATE

Administrator · of · Record 8/24/2012

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 323	Continued From page 1 Allegation of Compliance was validated through staff interviews and record reviews. The facility was left out of compliance at no actual harm, with potential for more than minimal harm that is not immediate jeopardy, to allow for completion of employee training. The findings were: Review of the "Resident Abuse Policy & Procedure" with revised date of 2/07 revealed "6. ....If Resident-to-Resident Abuse occurs, the residents will be separated and removed from the area until the investigation is complete. " Resident #1 was admitted to the facility on 6/14/12 with diagnoses including Dementia, Low Potassium, Hypertension, Chronic Obstructive Pulmonary Disease and Coronary Heart Disease. Review of the North Carolina Medicaid FL2 dated 6/14/12 revealed an assessment of Mood Indicators - Behavioral Symptoms. Resident #1 was assessed as being " Dangerous to Self, Others, or Property: Yes " . Further review of this document revealed under " Additional Information or Comments " Resident #1 " does have a hx (history) of agitation and behaviors when agitated per family. " Review of the medications ordered upon admission revealed an antipsychotic medication, Seroquel 25 milligrams to be taken twice a day for possible dementia. There were no other medications for mood or behaviors ordered on admission. Review of the Minimum Data Set, 5 day Assessment, dated 6/22/12 revealed Resident #1	F 323	her face. Resident #1 was given Ativan, PRN, for which he had a physician's order; he was redirected away from Resident #2 and no further behaviors were noted. The nurse, Stephanie Forrester and Mary Harris, CNA, continued to visually monitor Resident #1 through the evening by circulating the halls to ensure the resident did not display further aggressive behaviors. They continued to keep Resident #1 and #2 separated, and checked on those residents during rounds. Stephanie Forrester completed physical assessments on both residents involved to evaluate them for physical injury and/or harm. On 7/13/12, the primary physician was notified, and responsible parties were notified. Family members of Resident #2 came to the facility following notification of the incident. Resident #1 did not show any other behaviors on the evening of 7/13/2012. Incident reports were completed on 7/14/12 by JoAnne Porter. On 7/14/12, Resident #1 became angry when staff redirected the resident. PRN Ativan was administered at 9:00am with no effective results at 10:00 am. Cathy Causey, DON, was made aware on 7/14/12 at 10:00 am from the Quality	7/14/12

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F 323	Continued From page 2 had poor short term memory recall and was combative with care. Resident #1 was assessed as being ambulatory on and off the unit. Review of the Care Area Assessments dated 6/22/12, completed by Social Worker #1 revealed Resident #1 was confused to time and situation, unable to make safe, consistent decisions independently and wandered throughout the secure unit. Resident #1 was easily redirected, and could become agitated with care and redirection. Review of the care plan dated 6/22/12 revealed problems of short term memory recall, combative towards staff at times, wanders daily going in and out of other ' s rooms and will get easily agitated during redirection, and dementia with use of antipsychotic medication. The approaches for these problems included the following: - Redirect inappropriate behaviors with use of diversional activities such as offering snack, toileting. - Involve social worker as needed. - Consult with MD related to behaviors as needed. - Redirect resident to an activity when restless and anxious - Remove resident from a situation that causes increased anxiety. - Reorient resident as necessary - Monitor and document behaviors. Review of the nurse's notes signed by licensed nurse #1, dated 6/28/12 at 6:15 PM the nurse documented she was informed by a family member Resident #1 had hit two residents (Residents #2 and #5) and attempted to hit a	F 323	Assurance Nurse, JoAnne Porter. After being made aware, the DON had the resident sent to the hospital immediately. The Quality Assurance Nurse, an Administrative nurse, began investigating the incident on 7/14/12 after being made aware of the incident that occurred on 7/13/12. The QA nurse arrived to the facility at 6:20am. The Medical Director, Dr. Betts was notified at 10:00am, an order was written to send the resident to the hospital. The QA Nurse also initiated one-on-one monitoring until EMS arrived to the facility. She notified EMS to transport the male resident to High Point Regional Hospital Emergency Department at 10:00am, with instructions not to send the resident back until a mental evaluation could be completed in the hospital. As general practice, the local police are notified when there is a report of abusive behaviors; police were utilized to give assistance to EMS to get the resident into the ambulance. Resident #1 left the facility via EMS at 10:30am. The QA nurse interviewed the staff members that were on duty: Stephanie Forrester, LPN, nurse on duty in the secure	7/14/12

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F 323	Continued From page 3 third resident (Resident #7). The three residents were seated in the dining room. Resident #1 walked up to the two residents and hit them. The nurse responded, separated the residents, and removed Resident #1 from the dining room. This incident was not reported to administrative personnel, an incident report was not completed, the physician was not notified and the social worker was not notified. Review of the social work progress note dated 6/27/12 revealed Resident #1 " gets easily agitated with redirection and assistance. " Resident #1 had been " combative towards staff. " He would " kick staff when they attempted to redirect him and assist him. " Resident #1 was assessed as " Res (resident) physical behaviors can be harmful to others. " Review of the nurse's notes dated 7/1/12 at 2:00 PM, signed by licensed nurse #2, revealed the nurse took a shoe away from Resident #1. The nurse observed Resident #1 with a shoe in his hand and " rared back to hit " resident # 7. This is the second incident with a physical threat displayed to Resident #7 by Resident #1. This incident was not reported to administrative personnel, the physician was not notified and the social worker was not notified. Review of the nurses notes dated 7/4/12 at 11:00 PM, signed by licensed nurse #3, revealed Resident #1 was angry with staff at the nurse ' s station. The door was locked and he could not get behind the nurse ' s station. The licensed nurse documented Resident #1 threw the tray of snacks and papers on top of the station to the floor. Resident #1 was assisted to bed. The	F 323	unit, Heather Byerly, CNA, and Heather Roberston, CNA, nurse aides on the secure unit; she reviewed the charts of Residents #1 & 2 and contacted the Responsible Parties of these residents Incidents that occurred on 7/12/12 & 7/13/12, involving Resident #1 were reported to NCDHSR Complaint Intake Unit via fax on 8/9/2012. **2.** When the DON arrived to the facility on 7/15/12 at 9:30am, she observed all units for resident behaviors; all primary nurses on duty reported to Cathy Causey that no residents were currently having aggressive or combative behaviors; this was to ensure that there were no other potential or actual behaviors that needed further interventions. The DON assessed Resident #2 and no mental anguish was observed. Through investigation, the DON realized a previous incident occurred between Resident #2 and Resident #1 that was not reported to anyone in the facility; this incident occurred on 6/28/12. The incident was discovered in the nurses' notes for Resident #2.	8/9/12 7/15/12

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F 323	Continued From page 4 physician nor the social worker were notified of this incident. Review of the behavior documentation flowsheet for July 2012 revealed Resident #1 exhibited behaviors of "Yelling and screaming (#4) and Clear threats of violence towards others and/or staff (#5) on 7/9/12 at two different times. Review of this document for the dates of 7/10/12 revealed Resident #1 "Swings at others/staff" and "grabs others hair. " Review of the social work progress note dated 7/11/12 revealed Resident #1 " gets easily annoyed c (with) other residents more recently & (and) gets agitated c (with) staff. " Resident #1 was assessed as " wander in/out others rooms & plunders in their things ... gets angry when staff redirect him. " Resident #1 was assessed as " resistive of care & redirection. " Review of the nurse's notes dated 7/12/12 at 6:00 PM, signed by licensed nurse #1, revealed Resident #1 had an altercation with a resident in her room (Resident #6). The nurse was called to the room by an aide. The nurse documented the female resident #6 was found on the floor, Resident #1 was behind her wheelchair, with his hands on the handles. Resident #6 complained Resident #1 " hit me hard, in my head and jerked my chair out from under me. " The Director of Nursing was notified on the morning of 7/13/12 of the incident. An incident report was completed by licensed nurse #1, who worked on 7/12/12. Review of the Resident Incident Report that was completed on 7/12/12 revealed Resident #6 was noted to have a red area on the left side of her	F 323	The DON immediately created and initiated an internal Plan of Correction (PoC) on 7/15/12 to prevent any reoccurrence of the incident and maintain regulatory compliance. This internal PoC/Allegation of Compliance included the development of the "Resident Altercations/Potential Altercations Follow-Up" tool, which is used to document and monitor any actual or potential altercations. The Administrators, QA nurse, DON, or ADON will document on the tool. Documentation included on the tool includes interventions (offer toileting, fluids/ food, activities, supervision, monitor for discomfort, and/or one-on-one monitoring), medication changes, lab discrepancies, intervention effectiveness, and notifications of Responsible Party and Physician. The tool will be stored in the Administrator's office. Beginning on 8/9/12, a team of staff members, consisting of Administrative Nurses and other Administrative staff members were assembled to audit each Resident's chart throughout the facility. Nurses' notes and Mood & Behavior Sheets were used to determine if there were any other behaviors that needed to	7/15/12 8/10/12

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F 323	Continued From page 5 head. There were no other injuries documented on the incident report. Review of this incident report revealed the Director of Nursing signed the incident report was reviewed by her on 7/13/12. Review of the physician's orders dated 7/13/12 revealed an order for an anti-anxiety medication, Ativan 0.5 milligrams orally, to be given every six hours as needed. Review of the nurse's notes dated 7/13/12 at 6:45 PM, signed by licensed nurse #2, revealed Resident #1 had an altercation with a female resident (Resident #2). This was the second altercation with Resident #2. Resident #1 hit the Resident #2 in the face twice, with a closed fist. He then took her glasses off, and put them on his face. An incident report was completed by licensed nurse #2 for Resident #2, the family was notified, a note was left in the physician ' s book. An incident report was not completed for Resident #1. Review of the Medication Administration Record revealed the first dose of Ativan was administered on 7/13/12. Review of this documentation did not reveal the time of administration, or if it was effective. Resident #2 that was hit in the face had a bruise on the lower lip. Review of the nurse's notes dated 7/14/12 at 9:00 AM, signed by licensed nurse #2, revealed Resident #1 was hitting staff, tried to pull the blankets off the roommate and yelling at residents. The licensed nurse notified the Director of Nursing and physician. Ativan was administered on 7/14/12 at 9:00 AM and was documented as being " no effective 10A. " An order was obtained to send Resident #1 to the	F 323	be addressed. Interventions and effectiveness were recorded on the "Resident Altercations/Potential Altercations Follow-Up" tool. Some residents were found with behaviors; in each scenario where behaviors were noted, interventions were in place and effective. Each chart was audited from 7/1/12 to present for any behavior changes that could result in future combative behaviors or resident altercations. Care plans will be updated for residents displaying aggressive behaviors to address behaviors. **3.** All Nursing staff members scheduled on 7/15/12 were educated on resident-to-resident altercations/interventions. All other available licensed and unlicensed staff members were in-serviced by 7/18/12. In-servicing instructs staff on immediately reporting incidents including resident-to-resident altercations and abuse, after interventions are put into place. Incidents should be reported to the resident's Responsible Party, Physician, and one of the following: DON, ADON, or Administrator. Interventions include immediate separation (staff members should	8/10/12 7/18/12

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

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F 323	Continued From page 6 emergency room for evaluation due to behaviors. Interview on 8/9/12 at 11:50 AM with the Director of Nursing revealed she was not informed by the nursing staff Resident #1 was difficult to redirect. The first incident that occurred on 6/28/12 was not reported to her and an incident report was not completed. The incidents on 7/1/12 and 7/4/12 were not reported to her. She was first informed of the aggressive behaviors on the morning of 7/13/12. The incident of 7/12/12 was shared with the other department heads and assistant administrator in the " stand up meeting " on 7/13/12. After the incident on 7/13/12, the Director of Nursing requested the Quality Assurance nurse to investigate the incident on 7/14/12. On the morning of 7/14/12 the Quality Assurance nurse assisted the licensed nurse with sending Resident #1 out to the hospital. Interview on 8/9/12 at 10:59 AM was conducted with licensed nurse #1. This staff member was the nurse working on 6/28/12. Licensed nurse #1 recalled being informed by someone, could not remember who, that she was needed in the dining room. When she entered the dining room, she was informed Resident #1 had hit two other residents. There was nothing that provoked the incident. She checked the two residents for injuries and had staff take Resident #1 down the hall. Continued interview with licensed nurse #1 revealed she was working on 7/12/12. She remembered a staff member calling for her to come to a resident's room. The female resident was on the floor, and Resident #1 was holding onto her wheelchair. The female resident was	F 323	request additional staff assistance as needed), offering re-direction, toileting, food, fluids, quiet time, and/or one-on-one supervision. The DON explained, via in-servicing, the factors that can lead to escalating aggressive behaviors including the need for toileting, food, fluids, pain, or other wants/needs. All new hires will be inserviced on "Resident Abuse Policy & Procedure and "Reporting Reasonable Suspicion of a Crime in a LTC Facility." Staff will report any occurrence to the primary nurse. The primary nurse will assess residents involved for injury and/or harm and treat as necessary. Further attempts of altercations will result in PRN medication administration (with order), additional medication orders, one-on-one monitoring, and family may be requested to monitor and/or intervene as needed. Once interventions are successful, altercations must be reported to the Responsible Party and Physician; altercations will also be reported to the DON, ADON or Administrator. The nurse will complete incident reports on each resident involved in the occurrence. Covered individuals that have a reasonable suspicion of a crime committed against a	

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F 323	Continued From page 7 removed first, then Resident #1. When questioned when would she call the physician about aggressive physical behaviors, she responded " probably after the second incident. " Further interview confirmed the physician had not been notified on 7/12/12. Interview on 8/9/12 at 12:00 PM with the Director of Nursing regarding interventions the staff would be expected to take for aggressive behaviors would include redirection, offering snacks, removal from the situation, toileting, activities or medication if ordered. Further interview revealed she would expect staff to obtain assistance from other staff members in the building when needed. One to one supervision could be provided, but on a temporary basis. During this interview, it was asked how the staff monitored Resident #1. The response was during rounds, while providing care and at activities. One to one supervision or assistance from other staff members was not obtained for Resident #1 to her knowledge. Interview on 8/9/12 at 12:15 PM with MDS nurse #1 revealed she was aware Resident #1 was aggressive towards residents and staff. This staff member was not a personal witness to his physical aggressiveness. . During interview, this staff member did remember discussing Resident #1 during the care plan meetings. The care plan interventions were to redirect the resident, do diversional activities, toileting, snacks or activities. Redirection was effective at times, and other times it was not effective. Further interview revealed she did not have an answer for what staff were to do if redirection did not work.	F 323	Resident of the facility will report the incident according to the guidelines of Statute 1150B. The DON, ADON, or QA Nurse will investigate cases of abuse or alleged abuse. All licensed and unlicensed staff members were in-serviced on "Resident Abuse Policy & Procedure and Reporting Reasonable Suspicion of a Crime in a LTC Facility" by Administrative Nurses. Any unavailable staff members received phone messages regarding the in-servicing and will not be permitted to work another shift until education on the Abuse policy is received. Every staff member was contacted, in some form, on 8/10/12. Residents who are showing a pattern of behaviors that could escalate to an incident will be discussed in weekly QI meetings. Incident reports involving resident-to-resident altercations and aggressive incidents will be reported from the QA Nurse during weekly QI meetings. The Social Worker will report on behaviors that escalate in between MDS assessments. The QA Nurse, DON, or ADON will use the "Resident Altercations/Potential Altercations Follow-Up" tool at the	8/10/12 8/13/12

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F 323	Continued From page 8 Interview conducted on 8/9/12 at 12:30 PM with a family member who has a relative on the Alzheimer's unit. Interview with the family member revealed she was aware of who Resident #1 was, and she visits daily on the unit. During this interview, it was revealed she had witnessed Resident #1 push a resident in a wheelchair and the wheelchair rolled several feet, and just missed another resident standing in the hallway. Further interview revealed staff had been informed they needed to keep Resident #1 away from her relatives. Interview conducted on 8/9/12 at 2:30 PM with licensed nurse #2 revealed she could not remember the events of 7/1/12. Resident #1 did not like to be approached by other residents. On 7/13/12, licensed nurse #2 was off the unit. Upon return, an aide told her Resident #1 had come up to Resident #2, took her glasses and said the glasses were his. Further interview revealed Resident #2 had not done anything to provoke Resident #1. Both residents were in the dining room, and Resident #1 punched Resident #2 in the face. Licensed nurse #2 explained she separated the two residents, checked Resident #2 for injuries and Resident #1 was easily redirected. Interview conducted on 8/9/12 at 2:30 PM with licensed nurse #2 revealed she worked on 7/14/12 on the unit. Resident #1 was agitated, tried to hit an aide, or did hit an aide in the back due to refusing care. The medication Ativan was administered with no effect. Licensed nurse #2 spoke with an administrative nurse about the behaviors. Resident #1 was sent to the hospital	F 323	weekly QI meetings to monitor altercations and potential altercations. During weekly QI meetings, the MDS Coordinator and the Social Worker will review and discuss residents' current care plans to evaluate the need to make adjustments regarding aggressive behaviors. The QI team members will evaluate residents with multiple behaviors, effectiveness of interventions, current interventions and discuss the need for further interventions and preventive measures on residents with behaviors and/or residents involved in resident-to-resident altercations. Incidents involving resident-to-resident altercations, cases of abuse, and cases of alleged abuse will be reported in daily Stand-Up meetings, so that immediate follow-up will occur from Administrative staff members. The "Resident Abuse Policy & Procedure" was edited on 8/9/2012 to include resident-to-resident cases of abuse or alleged abuse; reporting of cases of abuse and alleged cases of abuse not pertaining to staff members. Nursing staff will observe and	8/9/12 8/10/12

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F 323	Continued From page 9 for evaluation. Further interview revealed this nurse did what she thought was in her best nursing judgment on 7/13/12. After the inservice conducted by the Director of Nursing, she would have called the physician and the Director of Nursing. The Assistant Administrator and Director of Nursing were notified of Immediate Jeopardy on 8/9/12 at 1:55 PM. The Allegation of Compliance was received on 8/10/12 at 11:30 AM. The Allegation of Compliance was accepted on 8/10/12 at 4:09 PM. The Corrective Plan of Action: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - Regarding the incident on 6/28/12, the attending nurse #1 removed the aggressive resident (Resident #1) from the scene of the incident, separating the two residents. The two residents in between two residents were physically assessed by the attending nurse, and no injuries or harm were found. No other aggressive behaviors were noted for the rest of the day. Seroquel was administered to the resident with aggressive behaviors and was effective due to no further behaviors. - Regarding the incident that occurred on 7/12/12, the attending nurse #1 separated the two residents involved in the incident. (Resident # 1 and Resident #6) The attending nurse physically assessed both residents and found no injuries or harm. Seroquel was administered to the resident with aggressive behaviors and was effective due to no further behaviors. - On the evening of 7/13/12 the nurse in the	F 323	document in the Nurses notes, any abusive and aggressive behaviors on new admissions to the facility. Nursing staff should request additional information from the family and contact the MD within 24 hours of admission for any resident displaying abusive or aggressive behaviors. Any aggressive and abusive behaviors noted should be reported to the DON and/or Administrator to review. Residents that display aggressive behaviors that were not present on admission will be evaluated through the "Resident Altercations/Potential Altercations Follow-Up" tool. Within 24 business (Mon-Fri) hours of a resident's admission to the facility, a Social Worker will complete a social history, which has been revised to include questions related to past behaviors and/or abuse. If during this process, it is discovered that this resident has a history of abuse or other aggressive behaviors, the Director of Nursing will be notified immediately. A guide, "Admissions for Individuals with Behaviors" has been developed for the Admissions Director to utilize to better screen potential residents	8/24/12 8/24/12

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	345330	A. BLDG. _____ B. WING _____	C 08/10/2012

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F 323	Continued From page 10 secure unit (nurse #2), immediately separated two residents involved in a physical altercation. Resident #2 was brought out of the dining room and taken to her room; her glasses were replaced on her face. Resident #1 was given Ativan PRN, for which he had a physician's order, the resident was redirected away from resident #2179 and no further behaviors were noted. The nurse, and C N A continued to visually monitor resident #1 through the evening by circulating the halls to ensure resident #1 and resident #2 separated, and checked on those residents during rounds. The nurse completed physical assessments on both residents involved to evaluate residents for physical injury and/or harm. On 7/13/2012 the primary physician was notified, and responsible parties were notified. Family members of resident #2 came to the facility following notification of the incident. The resident did not show any other behaviors on the evening of 7/13/12. Incident report were completed on 7/14/12 by the Quality Assurance nurse. On 7/14/12 resident #1 became angry when staff redirected the resident. PRN Ativan was administered at 9:00 am, with no effective results at 10:00 am. The DON was made aware on 7/14/12 at 10:00 am from the Quality Assurance nurse; after being made aware, the DON had the resident sent out to the hospital immediately - The Quality Assurance nurse, and administrative nurse, began investigating on the incident on 7/14/12 after being made aware of the incident that occurred on 7/13/12. The QA nurse arrived to the facility at 6:20 am. The medical director was notified at 10:00 am, an order was written to send the resident to the hospital. QA nurse also initiated one on one monitoring until the EMS arrived to the facility. She notified EMS	F 323	who might have existing or the potential for future problematic behaviors within the nursing facility.The use of this guide will be an effort to ensure that the facility is taking extra precaution to prevent the admission of abusive and/or combative residents. Activity Interventions for residents who have Alzheimers and/or Dementia has been developed by the Activity Director. These interventions include the creation and use of "Activity boxes" that will provide independent, one-on-one, or small group gatherings with more person-centered interests. By focusing on activities that are specific to these residents, a calmer atmosphere is the end goal; thereby decreasing the likelihood for aggressive and combative behaviors. ***4.*** Chart audits will be conducted for residents having aggressive behaviors with each occurrence. Residents displaying aggressive behaviors, discovered from the 24-hour reports, which are completed by all floor nurses documenting resident conditions during a 24-hour	8/24/12 8/10/12

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F 323	Continued From page 11 to transport the male resident to (name of local hospital) Emergency Department at 10:00 am, with instructions not to send the resident back until a mental evaluation could be completed in the hospital. The local police are notified when there is a report of abusive behaviors; police were utilized to give assistance to EMS to get the resident in the ambulance. Resident #1 left the facility via EMS at 10:30 am. The QA nurse interviewed the staff members that were on duty, the nurse on duty in the secure unit and the nurse aides on the secure unit; she reviewed the charts of resident #2 and #1; and contacted responsible party of residents involved. - Incidents that occurred on 7/12/12 and 7/13/12 involving the male resident were reported to NCDHSR Complaint Intake Unit via fax on 8/9/12. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same efficient practice;\ - When the DON arrived to the facility on 7/15/12 at 9:30 am, she observed all units for resident behaviors; all primary nurses on duty reported to her no residents having current behaviors on this day to the DON, to ensure there were no other potential or actual behaviors currently that needed further interventions. DON assessed resident #2 and no mental anguish was observed. Through investigation, the DON realized a previous incident occurred between resident #2 and resident #1 that was not reported to anyone in the facility, this incident occurred 6/28/12. The incident was discovered in the nurses' notes for the female resident involved. -The DON created and initiated an internal Plan of Correction (PoC) on 7/15/12 to prevent any reoccurrence of the incident and maintain regulatory compliance. This internal	F 323	Period, and reviewed daily by the DON, Administrator, Assistant Administrator, ADON, or QA Nurse. All residents having aggressive behaviors will be monitored daily for 7 days, at least weekly for 4 weeks, and then random chart audits will be performed on two residents per unit (East, West, and SEA) on a monthly basis for a period of six months. In-servicing regarding revised "Resident Abuse Policy & Procedure and Reporting Suspicion of a Crime in a LTC Facility" will be provided by the Administrator, Assistant Administrator, and DON on an annual basis. Continuous Quality Assurance reporting will be completed by the QA Nurse or DON at QA meetings. The QA Nurse or DON will report on results of the audits, any reportable incidents, and any changes needed based on events that occurred during the quarter.	8/10/12 8/10/12

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F 323	Continued From page 12 PoC/Allegation of Compliance included the development of the " Resident Altercations/Potential Altercations Follow-Up " tool, which is used to document and monitor any actual or potential altercations. The QA nurse, DON, or ADON will document on the tool. Documentation included on the tool includes interventions (offer toileting, fluids/food, activities, supervision, monitor for discomfort, and/or one-on-one monitoring), medication changes, lab discrepancies, intervention effectiveness, and notifications of responsible party and physician. The tool will be stored in the QA office. See attached " Resident Altercations/Potential Altercations Follow-Up " tool. -Beginning on 8/9/12, a team of staff members, consisting of administrative nurses and other administrative staff members were assembled to audit each resident chart throughout the facility. Nurses' notes and mood and behavior sheets were used to determine any further behaviors. Interventions and effectiveness recorded on the " Resident Altercations/Potential Altercations Follow-Up " tool. Some residents were found with behaviors, in each case where behaviors were noted, interventions were in place and effective. Each chart was audited from 7/1/2012 to present for any behavior changes that could result in future combative behaviors or resident altercations. Care plans will be updated for residents displaying aggressive behaviors to address behaviors. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur: -All nursing staff scheduled on 7/15/12 were educated on resident-to-resident altercations/interventions. All other available	F 323		

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F 323	Continued From page 13 licensed and unlicensed staff were inserviced by 7/18/12. In-servicing instructs staff on immediately reporting incidents including resident to resident altercations and abuse, after interventions are put into place. Incidents should be reported to the resident responsible party, physician, and one of the following: DON, ADON or Administrator. Interventions include immediate resident separation (staff members should request additional staff assistance as needed), offering re-direction, toileting, food, fluids, quiet time, and/or one-on-one supervision; DON explained factors that can lead to escalating aggressive behaviors including the need for toileting, food, fluids, pain, or other wants/needs. All new hires will be ins-serviced on " Resident Abuse Policy & Procedure and Reporting Reasonable Suspicion of a Crime in a LTC Facility. " Staff will report occurrence to the primary nurse. The primary nurse will assess residents involved for injury and/or harm and treat as necessary. Further attempts of altercations will result in PRN medication administration (with order) additional medication orders, one-on-one monitoring, and family may be requested to monitor and/or intervene as needed. Once interventions are successful, altercations must be reported to the responsible party and physician; altercations will also be reported to the DON, ADON, or Administrator. The nurse will complete incident reports on each resident involved in the occurrence. Covered individuals that have a reasonable suspicion of crime committed against a resident of the facility will report the incident according to the guidelines of statute 1150B. The DON, ADON, or QA nurse will investigate cases of abuse or alleged abuse. - All licensed and unlicensed staff will be	F 323		

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F 323	Continued From page 14 in-serviced on " Resident Abuse Policy & Procedure and Reporting Reasonable Suspicion of a Crime in a LTC Facility " by 8/10/12. Any unavailable staff members will be required to complete in-service on " Resident Abuse Policy & Procedure and Reporting Reasonable Suspicion of a Crime in a LTC Facility " before returning to work. - Residents who are showing a pattern of behaviors that could escalate to an incident will be discussed in weekly QI meetings. Incident reports involving resident-to-resident altercations and aggressive incidents will be reported from the QA nurse during weekly QI meetings. The Social Worker will report on behaviors that escalate in between MDS assessments. The QA nurse, DON, or ADON will use the " Resident Altercations/Potential Altercations Follow-Up " tool at the weekly QI meetings to monitor altercation and potential altercations. During weekly QI meetings the MDS Coordinator and the Social Worker will review and discuss residents ' current care plan to evaluate the need to make adjustments regarding aggressive behaviors. The QI team members will evaluate on residents with multiple behaviors, effectiveness of interventions, current interventions and discuss the need for further interventions and preventive measures on residents with behaviors and/or residents involved in resident-to-resident altercations. Incidents involving resident-to-resident altercations, cases of abuse, and cases of alleged abuse will be reported in daily stand up meetings. - The " Resident Abuse Policy & Procedure was edited on 8/9/2012 to include resident-to-resident cases of abuse or alleged abuse; reporting of cases of abuse and alleged cases of abuse not	F 323		

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F 323	Continued From page 15 pertaining to staff members were also addressed with the policy change. - Nursing staff will observe and document in the residents nurses note any abusive and aggressive behaviors on new admissions to the facility. Nursing staff should request additional information from the family and contact the MD within 24 hours of admission for any resident displaying abusive or aggressive behaviors. Any aggressive and abusive behaviors noted should be reported to the DON and/or Administrator to review. Residents that display aggressive behaviors that were not present on admission will be evaluated through the " Resident Altercations/Potential Altercations Follow-Up " tool. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. - Chart audits will be conducted for residents having aggressive behaviors with each occurrence. Residents displaying aggressive behaviors will be collected from the 24-hour reports, which are completed by all floor nurses documenting resident conditions during a 24-hour period, and reviewed daily by the DON, Administrator, Assistant Administrator, ADON or QA nurse. All residents having aggressive behaviors will be monitored daily for 7 days, at least weekly for 4 weeks, and then random chart audits will be performed on two residents per unit (East, West and SEA) on a monthly basis for a period of six months.	F 323		

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F 323	Continued From page 16 - In-servicing regarding revised " Resident Abuse Policy & Procedure and Reporting Reasonable Suspicion of a Crime in a LTC Facility " will be provided by the Administrator, Assistant Administrator, and DON on an annual basis. - Continuous Quality Assurance reporting will be completed by the QA nurse or DON at Quality Assurance meetings. The QA nurse or DON will report on results of the audits, any reportable incidents, and any changes needed based on events that occurred during the quarter. Beginning at 4:55 PM on 8/10/12, interviews were conducted with staff members in various departments, and in nursing to determine compliance. Interviews revealed staff had been provided the inservices, were able to repeat the reporting procedures, and steps to take if aggressive behaviors did re-occur. Interviews were conducted with the social worker and MDS nurse for their role in follow with residents who have aggressive and/or abusive behaviors. These staff members knew their role and what action to take for these altercations. Information was reviewed that was used in the inservice training, the signature lists of all staff, chart audits completed by administrative nursing staff members on 8/9/12, and careplans for residents identified as having behaviors which required interventions. The revised " Resident Abuse Policy & Procedure " was reviewed. Attachment A of this policy directs staff to follow in a numbered sequence for resident-to-resident abuse guidelines. Other information reviewed consisted of the QI tool " Resident Altercations/Potential Altercations	F 323		

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F 323	Continued From page 17 Follow-Up for two residents. These were completed and reviewed by the Director of Nursing with no resident to resident altercations occurring. As of 8/10/12 at 5:20 PM Immediate Jeopardy was lifted. The severity of the citation was lowered to no actual harm with potential for more than minimal harm that is not immediate jeopardy	F 323		