PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345298	A. BUILDING ______ B. WING ______	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL STREET BURGAW, NC 28425

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F 000	INITIAL COMMENTS The complaint investigation survey was started on 3/5/2015 through 3/7/2015. The survey team returned to the facility on 3/9/2015 to complete the survey tasks.	F 000		
F 226 SS=J	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 record review and staff interview, the facility failed to implement protective measures to protect 1 of 1 resident (#7) from 1 of 1 resident (#3) from sexually inappropriate behavior. Immediate Jeopardy began on 1/6/15 and was identified on 3/6/15 at 3:30 PM. Immediate Jeopardy was removed on 3/7/15 at 5:15 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete training on abuse for 100% of the staff and to implement the monitoring of its corrective action. The findings included: A document titled "Abuse Prevention Program Guidelines" update 10/14/14 read in part: "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion."	F 226	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/09/2015 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facilityKs credible allegation of compliance. Tag F226 For Resident #7, Resident #3, and All Other current in-house and future residents that may have been/may be affected:	3/25/15

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

Electronically Signed — 03/25/2015

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 226	Continued From page 1 The document also read that the abuse prevention program included protection of residents during investigations by the following measures: 1. If the alleged abuse involved another resident, the accused resident will not be permitted to make visits to other residents ' rooms unattended. 2. If resident to resident abuse is observed, the aggressor will be removed from the situation and a plan of care developed to prevent the recurrence of such incidents. Resident #7 was admitted to the facility on 8/30/2013 from the community with diagnosis that included Dementia, Depression, Muscle weakness, Anxiety and Congenital Blindness. Review of the most recent Annual MDS dated 7/24/14 and the most recent Quarterly Minimum Data Set (MDS) dated 1/21/15 revealed Resident #7 was presently moderately cognitively impaired. The MDS revealed the Resident required limited assistance with bed mobility and transfers. Resident #3 was admitted to the facility on 4/15/14 and had diagnosis including Cerebral Vascular Accident (CVA) with left sided weakness, Diabetes, Depression and Dementia. Review of the Annual MDS dated 4/22/2014 revealed Resident #3 was moderate cognitively impaired. The MDS revealed the Resident required extensive one person assistance in transfer and limited one person assistance in locomotion on unit. No observations were made of Resident #3 walking. He was impaired on one side in upper and lower extremities. Review of the most recent quarterly MDS dated 12/17/14 revealed Resident #3 was moderate cognitively impaired. The MDS revealed the Resident required limited one person assistance for transfer, locomotion on unit and walking in	F 226	*On January 6, 2015 Charge LPN, and Floor LPNS (3) responsible for care of Residents #1 and #2 at time of incident in serviced by Director of Nursing on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended until the development of a plan of care to prevent reoccurrence. *Floor LPN #1 responding to residents at time of first incident involving Resident #7 and Resident #3 will be counseled by Director of Nursing on March 7, 2015 for failure to implement fully facility policy Abuse Prevention Program Guidelines as related to resident to resident abuse, with additional displinary action as deemed appropriate. *In servicing of all facility staff initiated by Director of Nursing/Designee on March 6, 2015 of facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. Any facility staff not in serviced by March 7, 2015 will be in serviced via phone or in person by Director of Nursing/Designee at beginning of their next scheduled shift.	

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F 226	Continued From page 2 room and corridor. He was impaired on one side in upper and lower extremities. The Resident used a wheelchair or walker to ambulate. Review of the first report titled, " Situation, Background, Assessment, Recommendation/Response " (SBAR) dated 1/6/15 revealed Resident #3 was found in Resident #7 room grabbing and trying to tear Resident #7 ' s brief off. Resident #3 was observed fondling her breast and trying to push her on the bed into a lying position. Resident #3 was removed from Resident #7 room and brought back to Resident #3 ' s room. Review of the Director of Nursing (DON) summary report dated 1/8/15 revealed on 1/6/15 at 7:45 AM Nursing Assistant (NA) #1 heard Resident #7 yelling out for help. NA #1 entered the room and Resident #3 was observed with his hands on her breast and pulling at her brief. NA #1 called out help and Nurse #1 entered the room. Nurse #1 immediately removed Resident #3 from the room. Nurse #1 then ensured Resident #7 was safe and went to alert administrative staff. The nursing staff were advised to initiate 1:1 supervision on Resident # 3 but before the staff could initiate one-on-one supervision Resident #3 was observed in Resident #7 room with his hand in Resident #7 genital area as per witness statement by NA #2. NA #2 removed Resident #3 from the room and he remained with a staff member after this time. His room was also changed from across the hall from Resident #7 to a private room by the Nurses station for closer monitoring. During an interview on 3/7/15 at 10:04 AM, the FNP stated her expectations of the facility staff would be to have removed Resident #3 from the area, follow the facility's protocol and provide one on one staff care.	F 226	*All newly employed staff will be educated during Employee Orientation by Staff Development Coordinator/Designee on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. *Effective March 8, 2015, Random Auditing of 25% of facility staff as to their understanding of the facility policy Abuse Prevention Program Guideline (to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence) to be conducted by SDC/Designee weekly times 4 weeks to total 100% of facility staff then 25% of facility staff monthly thereafter. *Area Ombudsman to be contacted by Administrator/Designee on March 7, 2015 for scheduling of Resident Rights/ Resident Abuse Staff in-service with ongoing Resident Rights/Resident Abuse in servicing of staff at least annually thereafter by Director of Nursing/Staff Development Coordinator/Designee. Inservice scheduled for April 7, 2015. *All alert and oriented interviewable	

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F 226	Continued From page 3 During an interview on 3/6/15 at 9:15 AM the DON stated on 1/6/15 around 8:10 AM the night shift (11-7 nurse) met her at the entry to the facility and informed her about the incident with Resident #3 and Resident #7. The DON stated staff reported that Nurse #1 left Resident #3 and went back into Resident #7 ' s room to make sure she was safe with no immediate injuries. The DON stated Nurse #1 was in the process of notifying administrative staff concerning the incident. The DON instructed Nurse #1 to immediately place Resident #3 on one-on-one supervision. Nurse #1 went back down to arrange the one-on-one supervision and was called back to Resident #7 room by NA#2. NA#2 reported that she went into Resident #7 room to check on her and Resident #3 was again at her bedside and his hand was on genital area. He was observed in his wheelchair and was removed out of Resident #7 room. The DON stated that NA#2 remained with Resident #3 until NA #1 relieved her for one-on-one supervision. The DON stated Resident #3 was moved to private room. The DON stated she would expect her staff when there was a resident to resident altercation to have immediately done 1 on 1 with Resident #7. The DON also stated that NA #1 stayed with Resident #7 while Nurse #1 took Resident #3 to his room. NA #1 left Resident #7 to pass out breakfast trays. There was no staff watching Resident #3 after the first incident. The DON stated she would expect her staff in a case like that to have immediately done 1 on 1 with Resident #3. They thought since they were all on the hall they would have enough people to closely supervise until directed to do something. Facility did immediate in-service on the facility's abuse protocol for the nurses at the facility at that time. DON stated that the facility had not done a full	F 226	in-house residents interviewed by Director of Nursing/Designee on 3/6/2015 for any potential previously unreported allegations of Resident to Resident Abuse as it may relate to the January 6, 2015 incident. Any reported allegations of abuse from these interviews will be investigated per facility abuse policy. *Audit of all in-house residents Medical Records to be conducted by Director of Nursing/Designee on March 7, 2015 for review of Significant Change Documentation/SBAR Documentation from January 6, 2015 thru March 7, 2015 for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. *Effective March 8, 2015, Random Auditing of 25% of in-house residents Medical Records to be conducted by Director of Nursing/Designee for review of Significant Change Documentation/SBar Documentation for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline weekly times 4 weeks to total 100% of in-house residents then 25% of in-house residents audited monthly thereafter. *Facility Grievance Logs and 24/5 day reports for January 7, 2015 thru March 7, 2015 will be reviewed by Administrator/Designee on March 7, 2015 for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. *Effective March 8, 2015, Facility	

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F 226	Continued From page 4 plan of correction after the resident to resident abuse on 1/6/15 or have any discussion of the incident in their monthly QA meeting. The administrator was notified of the immediate jeopardy on 3/6/15 at 3:30 PM. Immediate jeopardy was removed on 3/7/15 at 5:15 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy: For Resident #7, Resident #3, and All Other current in-house and future residents that may have been/may be affected: *On January 6, 2015 Charge LPN, and Floor LPNS (3) responsible for care of Residents #3 and #7 at time of incident in serviced by Director of Nursing on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended until the development of a plan of care to prevent reoccurrence. *Floor LPN #1 responding to residents at time of first incident involving Resident #7 and Resident #3 will be counseled by Director of Nursing on March 7, 2015 for failure to implement fully facility policy Abuse Prevention Program Guidelines as related to resident to resident abuse, with additional disciplinary action as deemed appropriate. *In servicing of all facility staff initiated by Director of Nursing/Designee on March 6, 2015 of facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring	F 226	Grievance Logs and 24/5 days reports will be reviewed weekly times 4 weeks then monthly by Administrator/Designee for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. *Results of all audits completed by/on March 7, 2015 and subsequent indicated Audits and results will be reviewed at next scheduled Quality Assurance Committee Meeting and again at the following quarterly Quality Assurance Committee Meeting with determination at that time for continued need for monitoring. Completion Date: March 25, 2015	

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F 226	Continued From page 5 by staff of accused resident until the development of a plan of care to prevent reoccurrence. Any facility staff not in serviced by March 7, 2015 will be in serviced via phone or in person by Director of Nursing/Designee at beginning of their next scheduled shift. *All newly employed staff will be educated during Employee Orientation by Staff Development Coordinator/Designee on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. *Area Ombudsman to be contacted by Administrator/Designee on March 7, 2015 for scheduling of Resident Rights/ Resident Abuse Staff in-service with ongoing Resident Rights/Resident Abuse in servicing of staff at least annually thereafter by Director of Nursing/Staff Development Coordinator/Designee. *All alert and oriented interviewable in-house residents interviewed by Director of Nursing/Designee on 3/6/2015 for any potential previously unreported allegations of Resident to Resident Abuse as it may relate to the January 6, 2015 incident. Any reported allegations of abuse from these interviews will be investigated per facility abuse policy. *Audit of all in-house residents Medical Records to be conducted by Director of Nursing/Designee on March 7, 2015 for review of Significant Change Documentation/SBAR Documentation from January 6, 2015 thru March 7, 2015 for indication of reports of resident to resident abuse	F 226		

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F 226	Continued From page 6 to ensure implementation of facility policy Abuse Prevention Program Guideline. *Facility Grievance Logs and 24/5 day reports for January 7, 2015 thru March 7, 2015 will be reviewed by Administrator/Designee on March 7, 2015 for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. Immediate Jeopardy was lifted on 3/7/15 at 5:15 PM. On 3/6/15, the facility provided evidence of all staff presently working had been in-serviced on the facility ' s Abuse Prevention Program Guideline policy, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. Any facility staff not in-serviced by March 7, 2015 will be in-serviced via phone or in person by the Director of Nursing/Designee at the beginning of their next scheduled shift. Alert and oriented residents were interviewed regarding feeling safe in your living environment and there were no issues identified. Interviews with all staff involved in resident care presently working at the facility on 3/6/15 at revealed they were aware of the Abuse policy that included implementing supervision for a resident identified with inappropriate behaviors.	F 226		
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	F 323		3/25/15

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F 323	Continued From page 7 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, police report review, resident, Family Nurse Practitioner and staff interviews the facility failed to implement interventions to prevent reoccurrence of sexually inappropriate behavior for one of one resident with sexually inappropriate behaviors (Resident #3) toward one of one resident (Resident #7). Immediate Jeopardy began on 1/6/15 when staff became aware Resident #3 acted sexually inappropriately toward Resident #7. The administrator was notified of the immediate jeopardy on 3/6/15 at 3:30 PM. Immediate jeopardy was removed on 3/7/15 at 5:15 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete training on abuse for 100% of the staff and to implement the monitoring of its corrective action. The findings included: Resident #7 was admitted to the facility on 8/30/2013 from the community with diagnoses that included Dementia, Depression, Muscle weakness, Anxiety and Congenital Blindness. Resident #7 was in the facility at the time of the survey. Review of the most recent Annual Minimum Data Set (MDS) dated 7/24/14 and the most recent Quarterly MDS dated 1/21/15 revealed Resident #7 was moderately cognitively impaired and	F 323	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 03/09/2015 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facilityKs credible allegation of compliance. F323 For Resident #7: *On January 6, 2015, at approximately 7:50am Resident #3 was removed from room of Resident #7 by floor Cnas and was redirected to his room. * On January 6, 2015, at approximately 8:20 am Resident #3 was removed from room of Resident #7 by floor CNA and Resident #3 was immediately placed on one on one observation by Director of Nursing, and remained on this observation status until discharge on January 7, 2015, not being allowed to visit	

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F 323	Continued From page 8 required limited assistance with bed mobility and transfers. The Care Area Assessment Summary (CAAS) dated 8/20/14 for Communication revealed the resident could verbally make her needs known and although she could not see, she would turn towards vocalization. The Resident stated she could see light in the room and could see some shapes but was unable to see detail. The Care Area Assessment for Activities of Daily Living (ADL) revealed the Resident required limited assistance with bed mobility and was able to ambulate with her walker with the assistance of one person. The Resident ' s Care Plan most recently updated on 2/11/2015, revealed Resident #7 required supervision and cueing with daily decision making related to her dementia and blindness. She required limited to extensive assistance with her ADLs related to blindness and limited mobility. Resident #3 was admitted to the facility on 4/15/14 and discharged from facility 1/7/15 with diagnosis including Cerebral Vascular Accident (CVA) with left sided weakness, Diabetes, Depression and Dementia. A review of the Annual MDS dated 4/22/2014 revealed Resident #3 was moderate cognitively impaired. The Resident had no psychosis, moods, delirium or acute change of behavior during the 7 day observation period. He required extensive one person assistance in transfer and limited one person assistance in locomotion on unit. He was impaired on one side in upper and lower extremities. The Care Area Assessment Summary dated 4/28/2014 for cognitive loss/dementia revealed Resident #3 had cognitive deficit and impaired short term memory. He had slurred speech but was able to make himself understood. He	F 323	Resident #7's room or any other residents room. *Resident #3 also had an immediate room change following the 8:20 am incident for relocation into another wing of facility, removed from room area of Resident #7. * Floor LPN for Resident #7 notified Attending Physician/Medical Director of incident on January 6, 2015 at approximately 8:30 am, with examination of resident by Attending Physician immediately following notification, new orders received. Communication by Attending Physician with Responsibility Party regarding visit/examination occurred on January 6, 2015 as documented in visit note. Follow-up visit by Attending Physician on January 8, 2015 with new orders received and implemented, to include Mental Health Consult, with continued follow-up by Attending Physician as needed *Responsible Party was notified of incident by Nursing Home Administrator and Director of Nursing on January 6, 2015 of incident. *24 Hour report submitted to Health Care Personnel Registry by Director of Nursing/Designee on January 6, 2015, with completed 5 Day Investigation Report submission on January 8, 2015 by Director of Nursing/Designee. *Local Law Enforcement notified of incident and responded to facility on January 6, 2015, initiating legal investigation. *Resident #3 was discharged from facility to care of Responsible Party on January 7, 2015.	

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F 323	Continued From page 9 answered questions appropriately but required some coaxing to answer detailed questions. The Care Area Assessment for ADL revealed Resident #3 had declined in functional mobility and ability to complete ADL ' s as a result of new CVA. He had left sided weakness. He was able to turn and reposition himself in the bed for the most part and rise from lying to sitting position without assistance. He required one person assistance for sit to stand and transfers to and from his wheelchair. A review of the most recent quarterly MDS dated 12/17/14 revealed Resident #3 was moderate cognitively impaired. The Resident had no psychosis, moods, delirium or acute change of behavior during the 7 day observation period. He required limited one person assistance for transfer, locomotion on unit and walking in room and corridor. He required extensive assistance with bed mobility. He was impaired on one side in upper and lower extremities. The Resident used a wheelchair or walker for mobility. The Care Plan dated 5/5/14 and last updated 12/17/14 revealed Resident #3 required cueing to enhance daily decision making skills related to his CVA with short term memory loss. Review of the first report titled, " Situation, Background, Assessment, Recommendation/Response " (SBAR) revealed that on 1/6/15 at 7:50 AM Resident #3 was found in Resident #7 room grabbing and trying to tear Resident #7 ' s brief off. Resident #3 was observed fondling Resident #7 ' s breast and trying to push her on the bed into a lying position. Resident #3 was removed from Resident #7 ' s room and brought back to Resident #3 ' s room. Review of the second report titled, " Situation, Background, Assessment, Recommendation/Response " (SBAR) revealed	F 323	For Resident #3: *On January 6, 2015, at approximately 8:20 am Resident #3 was removed from room of Resident #7 by floor CNA and Resident #3 was immediately placed on one on one observation by Director of Nursing , and remained on this observation status until discharge on January 7, 2015. not being allowed to visit Resident #7's room or any other residents room. *Resident #3 also had an immediate room change following the 8:20 am incident to relocation into another wing of facility, removed from area of Resident #7. *floor LPN notified Attending Physician of incident on January 6, 2015 at approximately 8:30 am. Resident was assessed by Attending Physician following notification. *Responsible Party was notified of incident by Nursing Home Administrator and Director of Nursing on January 6, 2015. *24 Hour report submitted to Health Care Personnel Registry by Director of Nursing/Designee on January 6, 2015, with completed 5 Day Report submission on January 8, 2015 by Director of Nursing/Designee. *Local Law Enforcement notified and responded to facility on January 6, 2015, initiating legal investigation. *Resident #3 was discharged from facility to care of Responsible Party on January 7, 2015. For Resident #7, Resident #3, and All	

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F 323	Continued From page 10 that on 1/6/15 at 8:20 AM Resident #3 was observed in Resident #7 ' s room with his hand on Resident #7 ' s vagina and trying to push her down. Resident #3 was removed from Resident #7 ' s room and was placed on 1 on 1 supervision. A review of Resident #7 ' s Weekly Skin Observation on 1/3/15 on 7 AM to 3 PM shift revealed she had no redness or bruising to her breast or perineal area. A review of Resident #7 ' s Weekly Skin Observation on 1/6/15 at 8:30 AM done by Nurse #1 and Nurse #2 revealed she had redness and a slight abrasion to her pubic area and redness at the bottom of her left breast. Review of Family Nurse Practitioner (FNP) assessment note dated 1/6/15 at 2:14 PM revealed Resident #7 was seen by the FNP for a follow-up of report from staff that she had been found with a male resident ' s hand in her brief and had tried to push her back in bed. The report revealed she had redness under her left breast and in her upper perineum. Upon examination the resident had redness under and on the bottom of her left breast with no bruising. Her Genitourinary area had redness on her upper labia and clitoris/urethral area with no pain on exam. There was no vaginal drainage or broken skin or bleeding. Review of the incident report dated 1/6/15 (no time documented) revealed Nurse #1 documented that Resident # 3 was observed in Resident #7 ' s room with his hands on her vagina after he tore her briefs off of her. The report also stated Resident # 7 was observed yelling for help and trying to stop him. The report revealed no injury to Resident #3. Review of NA #1 ' s Record Statement of Witness	F 323	Other current in-house residents that may have been affected: *Resident #3 placed on one-on-one observation until discharge from facility on January 7, 2015. *On January 6, 2015 Charge LPN, and Floor LPNS (3) responsible for care of Residents #1 and #2 at time of incident in serviced by Director of Nursing on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended until the development of a plan of care to prevent reoccurrence. *24 Hour report submitted to Health Care Personnel Registry by Director of Nursing/Designee on January 6, 2015, with completed 5 Day Report submission on January 8, 2015 by Director of Nursing/Designee. *Floor LPN #1 responding to residents at time of first incident involving Resident #7 and Resident #3 will be counseled by Director of Nursing on March 7, 2015 for failure to implement fully facility policy Abuse Prevention Program Guidelines as related to resident to resident abuse, with additional displinary action as deemed appropriate. *All alert and oriented interviewable in-house residents interviewed by Director of Nursing/Designee on 3/6/2015 for any potential previously unreported allegations of Resident to Resident Abuse as it may relate to the January 6, 2015 incident.	

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F 323	Continued From page 11 she documented that on 1/6/15 (No time on statement) she went down to the Skilled Hall to get Resident #3 for breakfast and heard Resident #7 screaming for help and her room door was observed to be closed. NA #1 opened the door and observed Resident #3 in front of Resident #7 who was sitting up on the side of the bed. NA #1 documented that she observed Resident #3 trying to pull off Resident #7 ' s brief and that Resident #7 was holding onto her brief with her legs tightly closed. NA #1 documented that she immediately called for Nurse #1 ' s assistance. A review of the witness statement by NA #2 dated 1/6/15 at 8:20 AM revealed she was passing out breakfast to the residents on the skilled hall and she heard a female resident (Resident #7) yelling for help. NA #2 first went to check to see if Resident #3 was in his room. He was not and then she immediately went to Resident #7 ' s room. The door was observed to be closed. NA #2 opened the door and observed Resident #3 touching Resident #7. Resident #3 was observed with his hands inside her brief. Resident #7 was observed screaming and trying to push his hand away. Review of the Director of Nursing (DON) summary report dated 1/8/15 revealed on 1/6/15 at 7:45 AM, Nursing Assistant (NA) #1 heard Resident #7 calling for help. NA #1 entered the room and Resident #3 was " observed with his hands on her breast and pulling at her brief. " NA #1 called for help and Nurse #1 entered the room. Nurse #1 immediately removed Resident #3 from the room. Nurse #1 then ensured Resident #7 was " safe and went to alert administrative staff. " The nursing staff were advised (by DON) to initiate 1 on 1 supervision on Resident # 3 but before the staff could initiate 1 on 1 supervision, Resident #3 was observed in	F 323	There were no allegations of Resident to Resident Abuse. *Audit of all in-house residents Medical Records to be conducted by Director of Nursing/Designee on March 7, 2015 for review of Significant Change Documentation/SBar Documentation from January 6, 2015 thru March 7, 2015 for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. Audit did not identify any indications of reports of resident to resident abuse. *Audit of all in-house residents Medical Records to be conducted by Director of Nursing/Designee on March 7, 2015 for review of Significant Change Documentation/SBar Documentation from January 6, 2015 thru March 7, 2015 for indication of tendency toward verbal or abusive behaviors by resident. Audit did not identify any indications of these behaviors. *Effective March 8, 2015, Random Auditing of 25% of in-house residents Medical Records to be conducted by Director of Nursing/Designee for review of Significant Change Documentation/SBar Documentation for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline weekly times 4 weeks to total 100% of in-house residents then 25% of in-house residents audited monthly thereafter. *Facility Grievance Logs and 24/5 day reports for January 7, 2015 thru March 7, 2015 will be reviewed by	

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F 323	Continued From page 12 Resident #7 ' s room with his hand in Resident #7 ' s genital area as per witness statement by NA #2. The DON summary report stated Resident #3 saw NA #2 entering the room and removed his hand. NA #2 removed Resident #3 from the room and he was supervised by staff continually after the incident. Resident #3 room was changed from across the hall from Resident #7 to a private room on a different hall near the Nurses station for closer monitoring. The report also revealed that the Police Department was notified and an investigation initiated. On 1/6/15 at 8:30 AM Resident #7 received a head to toe assessment from Nurse #1 and Nurse #2. The report stated they noted redness to her pubic area as well as redness to her left breast. The Family Nurse Practitioner (FNP) assessed Resident #7 on 1/6/15 and noted there were no penetrating injuries. The DON stated in her report that Resident #3 was assessed as alert and oriented with periods of confusion. He could recall the incident when questioned by facility staff and reported to Nurse #1 that he was trying to help Resident #7 button her blouse. When law enforcement interviewed Resident #3, he stated he did go into Resident #7 room to talk to her but did not touch Resident #7. Resident #3 ' s wife was notified of the incident and law enforcement was involved. The DON summary stated that the Police Department notified the facility that they had a warrant for Resident #3 ' s arrest (regarding incident on 1/6/15) and picked Resident #3 up and brought him to jail. Resident #3 returned to the facility the evening of 1/6/15 with an unsecured bond and 1 to 1 supervision was reinstated. Resident #3 was issued an immediate discharge notice to maintain safety of other residents. He was picked up by his family to attend his court hearing on 1/7/15 and	F 323	Administrator/Designee on March 7, 2015 for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. No Grievances or 24/5Day reports indicated reporting of resident to resident abuse. *Effective March 8, 2015, Facility Grievance Logs and 24/5 days reports will be reviewed weekly times 4 weeks then monthly by Administrator/Designee for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. *In servicing of all facility staff initiated by Director of Nursing/Designee on March 6, 2015 of facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. Any facility staff not in serviced by March 7, 2015 will be in serviced via phone or in person by Director of Nursing/Designee at beginning of their next scheduled shift. *All newly employed staff will be educated during Employee Orientation by Staff Development Coordinator/Designee on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from	

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F 323	Continued From page 13 discharged from the facility with home health services on 1/7/15 in care of his family. Review of the Police Report submitted 1/6/15 at 11:41 AM, revealed a complaint was called into dispatch on 1/6/15 at 8:20 AM, regarding a male subject (Resident #3) who sexually assaulted a female subject (Resident #7) 1/6/15 at 7:30 AM. The last time known that everything was okay was 1/6/15 at 7 AM. Resident #7 had minor injuries. Resident #7 was listed as a victum of second degree sexual offense and sexual battery. The suspect (Resident #3) used personal weapons (hands, feet, teeth etc). The Police Report stated that on 1/6/15 at approximately 9:36 AM, an officer went to the facility in reference to an assault. The Officer interviewed the DON, Resident #3, Resident #7, NA #1, and NA #2. The social progress note on 1/6/15 at 4:45 PM, stated that an immediate discharge notice was given to Resident #3 and family due to the incident on 1/6/15. The social progress note on 1/7/15 at 2:30 PM, stated the wife and son of Resident #3 were given discharge information and all questions and concerns were addressed. During an interview on 3/6/15 at 10:00 AM, NA #1 stated she was a Restorative Aid and on 1/6/15 she was going to assist Resident # 3 in restorative dining. She stated on 1/6/15 between 7:30 to 8:00 AM Resident #3 was observed in his wheelchair at the nurses station. NA#1 further stated when the breakfast food trays came out she went to look for him and he was not in his room. She stated she heard Resident #7 yelling for help. When she entered Resident #7 ' s room she observed Resident #3 sitting in his wheelchair and he was grabbing on Resident #7 ' s brief near her pubic area. Resident #7 was	F 323	making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. *Area Ombudsman to be contacted by Administrator/Designee on March 7, 2015 for scheduling of Resident Rights/ Resident Abuse Staff in-service with ongoing Resident Rights/Resident Abuse in servicing of staff at least annually thereafter by Director of Nursing/Staff Development Coordinator/Designee. Inservice scheduled for April 7, 2015. *Effective March 8, 2015, Random Auditing of 25%of facility staff as to their understanding of the facility policy Abuse Prevention Program Guideline (to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence) to be conducted by SDC/Designee weekly times 4 weeks to total 100% of facility staff then 25% of facility staff monthly thereafter. *Results of all audits completed by/on March 7, 2015 and subsequent indicated Audits and results will be reviewed at next scheduled Quality Assurance Committee Meeting and again at the following quarterly Quality Assurance Committee Meeting with determination at that time for continued need for monitoring.	

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F 323	Continued From page 14 observed sitting up on the side of her bed facing the door. Resident #3 ' s back was observed facing the door while he was sitting in his wheelchair. NA #1 stated she immediately backed out of the room into the doorway and immediately called Nurse #1 in the hallway for assistance. NA #1 stated after Nurse #1 entered the room to handle the situation, she left the room to go assist in the restorative dining on the opposite hall. NA #1 further stated that later that morning, Resident #3 was brought to restorative dining to eat and NA #1 had to sit with him one on one. During an interview on 3/6/15 at 9:15 AM, the DON stated on 1/6/15 around 8:10 AM, the night shift (11-7 nurse) met her at the entry to the facility and informed her about the incident with Resident #3 and Resident #7. The DON stated NA #1 had heard Resident #7 yelling for help at 7:45 AM. NA #1 entered Resident #7 ' s room and observed Resident #3 in her room with his hand on her breast and pulling at her briefs. Resident #7 was observed sitting on the side of her bed. NA #1 called for help for Nurse #1 from the doorway. NA #1 and Nurse #1 entered the room together and Nurse #1 escorted Resident #3 back to his room across the hall. The DON stated staff reported Nurse #1 left Resident #3 in his room and went back into Resident #7 ' s room to make sure she was safe with no immediate injuries. The DON stated Nurse #1 was in the process of notifying administrative staff concerning the incident when the DON entered the facility. The DON instructed Nurse #1 to immediately place Resident #3 on one on one supervision. Nurse #1 went back down to arrange the one on one supervision and was called back to Resident #7 room by NA #2. NA#2 reported that she went into Resident #7 room to check on her and Resident #3 was again at her	F 323	Completion Date: March 25, 2015	

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F 323	Continued From page 15	F 323		

bedside and his hand was on Resident #7 ' s genital area. He was observed in his wheelchair and was immediately removed from Resident #7 ' s room. The DON stated that NA #2 remained with Resident #3 until NA #1 relieved her for one on one supervision. The DON stated the FNP, Police Department and family members were notified and Resident #3 was transferred to a private room. The DON stated she would expect her staff when there was a resident to resident altercation to have immediately done 1 on 1 with Resident #3.

During an interview on 3/6/15 at 10:32 AM, Nurse #1 stated on 1/6/15, she heard NA #1 yelling out for help in Resident #7 ' s room. She went in and saw Resident #3 in his wheelchair wheeling away from Resident #7 ' s bed. NA #1 informed Nurse #1 that Resident #3 had his hands on Resident #7 ' s brief and she had been yelling for help. NA #1further informed Nurse #1 she had heard yelling and had gone into Resident #7 ' s room to see what was happening. Nurse #1 stated she wheeled Resident #3 back into his room across the hall. Nurse #1 stated she transferred Resident #3 back to his bed and instructed Resident #3 to stay in his bed until they could figure out what to do. Nurse #1 stated that Resident #3 agreed to stay in his room. During the interview Nurse #1 stated Resident #3 had been seen getting out of bed and into his wheelchair by himself in the past and could easily do so. Nurse #1 stated she returned to Resident #7 ' s room and observed her breathing hard and panicky. Resident #7 requested Nurse #1 to stay with her. While talking with her, Nurse #1 said Resident #7 revealed she was sitting up and Resident #3 was trying to push her back to a laying position. Resident #3 was grabbing at her brief and fondling her breast. Nurse #1 stated

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F 323	Continued From page 16	F 323		

after she had felt Resident #7 was safe she left the room and went to notify the DON and Family Nurse Practicioner (FNP). Nurse #1 further stated that she thought she told someone to stay with Resident #7 but could not recall who. Nurse #1 stated she would have placed one on one care immediately if she had known Resident #3 was going to get up and go back into Resident #7 ' s room again.

During an interview on 3/6/15 at 11:51 AM, NA #2 stated that on 1/6/15 between 8:15 to 8:25 AM, she had heard Resident #7 yelling for help. She checked to see if Resident #3 was in his room and he was not. Resident #7 ' s door was closed and NA #2 opened the door and found Resident #3 ' s hands inside of Resident #7 ' s brief and Resident #7 was yelling for help. NA #2 further stated she called for help and stayed in the room. NA #2 asked Resident #3 what he was doing and he removed his hand out of Resident #7 ' s brief. NA#2 stated Nurse #1 came and removed Resident #3 from Resident #7 ' s room.
During an interview on 3/7/15 at 10:04 AM, the FNP stated she was called by the facility and informed that a male resident (Resident #3) had put his hands on a female resident ' s (Resident #7) female parts and it had happened twice that she recalled. The FNP stated that she was not trained to do rape exams but did a superficial exam on Resident #7 on 1/6/15. Upon assessment the FNP revealed that Resident #7 had no vaginal drainage or redness at the opening of vagina. She did have redness on her left breast and her labia/clitoris. The FNP further revealed that Resident #7 had told the FNP that Resident #3 had not penetrated her vagina and that she (Resident #7) kept trying to push him (Resident #3) off of her. The FNP stated that her

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F 323	Continued From page 17	F 323		

expectations of the facility staff would be to have removed Resident #3 from the area, follow the facility's protocol and provide one on one staff care.
On 3/6/15 at 4:30 PM, Resident #7 was interviewed and had no recall of being touched inappropriately or of recent events.
The administrator was notified of the immediate jeopardy on 3/6/15 at 3:30 PM. Immediate jeopardy was removed on 3/7/15 at 5:15 PM.
The following interventions were put into place by the facility to remove the Immediate Jeopardy:

Resident #7
Resident #3
For Resident #7:
*On January 6, 2015, at approximately 7:50am Resident #3 was removed from room of Resident #7 by floor CNA ' s and was redirected to his room.
* On January 6, 2015, at approximately 8:20 am Resident #3 was removed from room of Resident #7 by floor CNA and Resident #3 was immediately placed on one on one observation by Director of Nursing, and remained on this observation status until discharge on January 7, 2015, not being allowed to visit Resident #7's room or any other resident ' s room.
*Resident #3 also had an immediate room change following the 8:20 am incident for relocation into another wing of facility, removed from room area of Resident #7.
* Floor LPN for Resident #7 notified Attending Physician/Medical Director of incident on January 6, 2015 at approximately 8:30 am, with examination of resident by Attending Physician immediately following notification, new orders received. Communication by Attending Physician with Responsibility Party regarding

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F 323	Continued From page 18	F 323		

visit/examination occurred on January 6, 2015 as documented in visit note. Follow-up visit by Attending Physician on January 8, 2015 with new orders received and implemented, to include Mental Health Consult, with continued follow-up by Attending Physician as needed
*Responsible Party was notified of incident by Nursing Home Administrator and Director of Nursing on January 6, 2015 of incident.
*24 Hour report submitted to Health Care Personnel Registry by Director of Nursing/Designee on January 6, 2015, with completed 5 Day Investigation Report submission on January 8, 2015 by Director of Nursing/Designee.
*Local Law Enforcement notified of incident and responded to facility on January 6, 2015, initiating legal investigation.
*Resident #3 was discharged from facility to care of Responsible Party on January 7, 2015.

For Resident #3:
*On January 6, 2015, at approximately 8:20 am Resident #3 was removed from room of Resident #7 by floor CNA and Resident #3 was immediately placed on one on one observation by Director of Nursing, and remained on this observation status until discharge on January 7, 2015 not being allowed to visit Resident #7's room or any other resident ' s room.
*Resident #3 also had an immediate room change following the 8:20 am incident to relocation into another wing of facility, removed from area of Resident #7.
*floor LPN notified Attending Physician of incident on January 6, 2015 at approximately 8:30 am. Resident was assessed by Attending Physician following notification.
*Responsible Party was notified of incident by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345298	A. BUILDING ______ B. WING ______	C 03/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL STREET BURGAW, NC 28425

(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 323	Continued From page 19	F 323		

Nursing Home Administrator and Director of Nursing on January 6, 2015.
*24 Hour report submitted to Health Care Personnel Registry by Director of Nursing/Designee on January 6, 2015, with completed 5 Day Report submission on January 8, 2015 by Director of Nursing/Designee.
*Local Law Enforcement notified and responded to facility on January 6, 2015, initiating legal investigation.
*Resident #3 was discharged from facility to care of Responsible Party on January 7, 2015.

For Resident #7, Resident #3, and All Other current in-house residents that may have been affected:

*Resident #3 placed on one-on-one observation until discharge from facility on January 7, 2015.
*On January 6, 2015 Charge LPN, and Floor LPNS (3) responsible for care of Residents #1 and #2 at time of incident in serviced by Director of Nursing on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended until the development of a plan of care to prevent reoccurrence.
*24 Hour report submitted to Health Care Personnel Registry by Director of Nursing/Designee on January 6, 2015, with completed 5 Day Report submission on January 8, 2015 by Director of Nursing/Designee.
Floor LPN #1 responding to residents at time of first incident involving Resident #7 and Resident #3 will be counseled by Director of Nursing on March 7, 2015 for failure to implement fully facility

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F 323	Continued From page 20 policy Abuse Prevention Program Guidelines as related to resident to resident abuse, with additional displinary action as deemed appropriate. *All alert and oriented interviewable in-house residents interviewed by Director of Nursing/Designee on 3/6/2015 for any potential previously unreported allegations of Resident to Resident Abuse as it may relate to the January 6, 2015 incident. There were no allegations of Resident to Resident Abuse. *Audit of all in-house residents Medical Records to be conducted by Director of Nursing/Designee on March 7, 2015 for review of Significant Change Documentation/SBAR Documentation from January 6, 2015 thru March 7, 2015 for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. Audit did not identify any indications of reports of resident to resident abuse. *Audit of all in-house residents Medical Records to be conducted by Director of Nursing/Designee on March 7, 2015 for review of Significant Change Documentation/SBAR Documentation from January 6, 2015 thru March 7, 2015 for indication of tendency toward verbal or abusive behaviors by resident. Audit did not identify any indications of these behaviors. *Facility Grievance Logs and 24/5 day reports for January 7, 2015 thru March 7, 2015 will be reviewed by Administrator/Designee on March 7, 2015 for indication of reports of resident to resident abuse to ensure implementation of facility policy Abuse Prevention Program Guideline. No Grievances or 24/5Day reports indicated reporting of resident to resident abuse. *In servicing of all facility staff initiated by Director of Nursing/Designee on March 6, 2015 of	F 323		

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F 323	Continued From page 21 facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. Any facility staff not in serviced by March 7, 2015 will be in serviced via phone or in person by Director of Nursing/Designee at beginning of their next scheduled shift. *All newly employed staff will be educated during Employee Orientation by Staff Development Coordinator/Designee on facility policy Abuse Prevention Program Guideline, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. *Area Ombudsman to be contacted by Administrator/Designee on March 7, 2015 for scheduling of Resident Rights/ Resident Abuse Staff in-service with ongoing Resident Rights/Resident Abuse in servicing of staff at least annually thereafter by Director of Nursing/Staff Development Coordinator/Designee. Immediate Jeopardy was lifted on 3/7/15 at 5:15 PM. On 3/6/15, the facility provided evidence of all staff presently working had been in-serviced on the facility ' s Abuse Prevention Program Guideline policy, to include resident to resident abuse and the removal of the accused resident from the situation, and the keeping of the	F 323		

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F 323	Continued From page 22 accused resident from making visits to other residents rooms unattended by providing one on one monitoring by staff of accused resident until the development of a plan of care to prevent reoccurrence. Any facility staff not in-serviced by March 7, 2015 will be in-serviced via phone or in person by the Director of Nursing/Designee at the beginning of their next scheduled shift. Alert and oriented residents were interviewed regarding feeling safe in your living environment and there were no issues identified. Interviews with all staff involved in resident care presently working at the facility on 3/6/15 at revealed they were aware of the Abuse policy that included implementing supervision for a resident identified with inappropriate behaviors.	F 323		