STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345411	A. BUILDING _____ B. WING _____	C 03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	**516 WALL STREET WAYNESVILLE, NC 28786**

(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 1. 483.10 (F157) at J Immediate Jeopardy began on 02/26/16 when Resident #3 told Nurse #1 she was raped by Nurse Aide (NA) #1 and neither the physician nor responsible party were notified. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually assaulted by NA #1 and neither the physician nor the responsible party were notified. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to notification of a significant change. 2. 483.13 (F223) at J Immediate Jeopardy began on 02/25/16 when Resident #3 was raped by Nurse Aide (NA) #1. Immediate Jeopardy began for Resident #4 on 02/28/16 when she told Nurse #2 she was sexually assaulted by NA #1. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to resident rights to be free from abuse.	F 000		

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

Electronically Signed | 04/18/2016

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F 000	Continued From page 1 3. 483.13 (F225) at J Immediate Jeopardy began on 02/26/16 when after Resident #3 alleged rape to Nurse #1, neither Nurse #1 nor the DON informed the Administrator of the abuse allegation or called the police. The DON did not fax the 24 hour initial report to the HCPR until 02/29/16. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, neither Nurse #1 nor Nurse #2 called the police and neither nurse nor the Director of Nursing (DON) called the Administrator. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to informing the Administrator of allegations of abuse, informing law enforcement of the suspicion of a crime and making reports to the HCPR within 24 hours of an allegation of abuse. 4. 483.13 (F226) at J Immediate Jeopardy began on 02/26/16 when Resident #3 told Nurse #1 she had been raped by Nurse Aide (NA) #1 and the Director of Nursing (DON) allowed the perpetrator to remain in the building without supervision for 3 additional hours. Neither Nurse #1 nor the DON informed the Administrator of the abuse allegation, called the police, or sought medical attention for Resident #3. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, neither	F 000		

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F 000	Continued From page 2	F 000		

Nurse #1 nor Nurse #2 called the police or medically assessed Resident #4, and neither nurse or the Director of Nursing (DON) called the Administrator. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused and following the abuse policy.

5. 483.75 (F490) at J
Immediate Jeopardy began on 02/25/16 when Resident #3 was sexually assaulted by Nurse Aide (NA) #1. Resident #3 told Nurse #1 she had been raped by NA #1 and the Director of Nursing (DON) allowed the perpetrator to remain in the building without supervision for 3 additional hours. Neither Nurse #1 nor the DON informed the Administrator of the abuse allegation, called the police, called the responsible party, or called the physician. In addition, the 24 hour initial report was not faxed to the HCPR within the required 24 hours. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, and neither Nurse #1, Nurse #2, or the DON called the police, the administrator immediately, the responsible party, or called the physician. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for

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F 000	Continued From page 3 more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused, notifying the physician and responsible parties and following the facility's abuse policy and procedure.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		5/4/16

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F 157	Continued From page 4 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on resident interviews, responsible party interviews, staff interviews, physican interviews and record reviews, the facility failed to inform the responsible parties and the physician when 2 of 4 sampled residents alleged sexual abuse by a staff member (Residents #3 and #4). Immediate Jeopardy began on 02/26/16 when Resident #3 told Nurse #1 she was raped by Nurse Aide (NA) #1 and neither the physician nor responsible party were notified. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually assaulted by NA #1 and neither the physician nor the responsible party were notified. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to notification of a significant change. The findings included: 1. Resident #3 was admitted to the facility on 12/11/14. Her diagnoses included chronic obstructive pulmonary disease, anxiety disorder, fibromyalgia, manic episode without psychotic symptoms, and major depressive disorder single	F 157	F157 Actions taken for the identified residents Resident #3□'s physician was notified on 2/29/16 of allegation of abuse. Resident #3 is responsible for her own affairs and she notified her family on 2/29/16. Resident #4'□s physician was notified on 2/29/16 regarding allegation of abuse. Resident #4 is responsible for her own affairs and she notified her responsible party on 2/28/16. Resident #3 and Resident #4'□s physician will be notified of all changes in resident□s' condition. Action taken for residents with the potential to be affected: Licensed nurses were educated by the Area Staff Development coordinator and the Director of Nursing on 3/22/16 regarding the facility policy for Physician/Responsible Party notifications. On 3/24/16, Nursing Assistants were educated by the Area Staff Development coordinator and the Unit Manager regarding notification to the nurse of any concerns, incidents, changes of condition and allegations of abuse/neglect. Social Service Director completed interviews by 3/3/16, with residents who	

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F 157	Continued From page 5 episode. The annual Minimum Data Set (MDS) dated 12/11/15 coded her with having intact cognition. She was coded as understanding others and being understood with clear speech and no communication problems. She was coded as having no behaviors, no signs of delirium, feeling tired 2-6 days over the previous 2 weeks, and requiring supervision of one person physical assistance for most activities of daily living skills including bed mobility, transfers, walking, toileting and hygiene. Nursing notes dated 02/26/16 at 7:20 PM, written by Nurse #1, revealed Resident #3 asked to speak to this nurse privately. During this conversation, Resident #3 told Nurse #1 that Nurse Aide (NA) #1 "stuck it in" her and her genital area hurt. Resident #3 refused to have the police called or to go to the hospital. The note did not indicate any notification of the physician or the responsible party. Review of an incident report dated 02/26/16 revealed at 7:20 PM Resident #3 "made allegations of being sexually assaulted by (NA #1). Initially she indicated that she said no (to pain/hurt) and she was just scared. Then she complained of vaginal pain & said he penetrated her." This incident report was completed by Nurse #1. The incident report noted the physician's name but not the date or time of contact and no indication the responsible party was notified. Interview with Nurse #1 on 03/21/16 at 2:35 PM revealed that when she spoke to Resident #3 on 02/26/16, Resident #3 began crying and pointed	F 157	were alert, oriented and able to answer questions to verify any other unreported allegations of abuse. On 3/23/16, Social Service Director completed interviews with families and responsible parties for those residents unable to participate in the prior interviews to verify if any other unreported allegation of abuse occurred. On 3/3/16, the Administrator, Social Services Director, District Director of Operations and the district Director of Care Management completed interviews with facility staff to verify if any other unreported allegations of abuse occurred. On 3/23/16, the Administrator completed and audit of all previously reported allegations of abuse or neglect for the past six months to validate Physician and Responsible Party notification was completed. No further notifications were required as a result of these interviews. There were no new allegations of abuse/neglect. System in place to ensure the alleged deficient practice does not recur: Licensed nurses were educated by the Area Staff Development coordinator and the Director of Nursing on 3/22/16 regarding the facility policy for Physician/Responsible Party notifications. On 3/24/16, Resident Care Specialist	

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F 157	Continued From page 6 to her genital area stating it hurt. She stated NA #1 stuck it in her, which Nurse #1 stated referred to his penis. Nurse #1 called the Director of Nursing (DON) from her office. The DON told Nurse #1 she would take care of the issue and instructed the nurse to have NA #1 call her. Nurse #1 stated she was not given instructions other than making sure NA #1 did not go back into Resident #3's room. Nurse #1 stated she did not call the physician because the DON said she would handle everything. Upon follow up interview on 03/22/16 at 3:59 PM, Nurse #1 stated she asked the DON if she should call anyone else when she spoke to her on 02/26/16 and the DON stated no. Nursing notes dated 02/27/16 at 1:30 PM written by Nurse #2 revealed Resident #3 stated a nurse aide (not identified in the note) helped her to the bathroom, pushed her against the wall and put his penis in her vagina. She stated that she then moved away and the nurse aide kissed her forcefully. The police department was called and Resident #3 was sent to the hospital for a rape kit and exam. The note did not indicate notification of the physician or responsible party. A phone interview was conducted with Nurse #2 on 03/21/16 at 3:21 PM. Nurse #2 stated she arrived for work on 02/27/16 and Resident #3 told her that 2 days prior, NA #1 asked if she needed to go to the bathroom and she walked independently to the bathroom. Resident #3 stated he followed her into the bathroom, closed the door, locked the door, pushed her against the wall, over the toilet where she grabbed the grab bar and he put his penis between her legs, moved around a bit and then actually penetrated	F 157	were educated by the Area Staff Development coordinator and the Unit Manager regarding notification to the nurse of any concerns, incidents, changes of condition and allegations of abuse/neglect. Newly hired nurses and Nursing Assistants will receive education regarding notification of the above mentioned during orientation and prior to working the floor. Unit Managers/designee will audit residents□ records with change of condition, incident reports or allegations of neglect or abuse to verify MD and Responsible Party notification. The audits will be conducted 5 times a week for 4 weeks and then 3 times a week for 2 months. DON will validate with Unit Managers/designee that MD has been notified on change of condition, incident reports and allegations of neglect/abuse. These audits will be performed 5 times per week for 4 weeks, then 3 times a week for 2 months. Results will be reviewed monthly during QAPI. Quality Assurance measures in place to ensure the practices are sustained. The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes	

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her. Nurse #2 stated Resident #3 told her NA #1 had kissed her about 15 times previously and recently bought her perfume. Nurse #2 called the DON about the allegation. The DON stated she would handle it. Nurse #2 stated the DON told her they needed to keep everyone out of the issue and when Nurse #2 told the DON that she was not ok with that, the DON agreed for the police to be called. Once the police arrived, the officer and Nurse #2 agreed it was appropriate to send Resident #3 to the hospital.

During an interview with Resident #3 on 03/21/16 at 9:53 AM, Resident #3 stated that she was "raped" by NA #1. She stated she was lying in bed when NA #1 suggested she go to the bathroom before her roommate returned from a smoke break. NA #1 followed Resident #3 into the bathroom, locked the door, and placed the tip of his penis in her vagina. Resident #3 stated she returned to bed and did not tell anyone until the next day when she told a nurse. Resident #3 cried during this interview.

On 03/23/16 at 9:15 AM, Resident #3 stated during a follow up interview, she called her responsible party herself to report what had happened to her.

On 03/23/16 at 11:41 AM, the responsible party (RP) was interviewed via phone. She stated that she was the emergency contact for Resident #3. She stated the facility never contacted her about the alleged rape or that Resident #3 was sent to the hospital for a rape test. The RP stated she learned of the incident because Resident #3 called and told her. The RP stated the facility called her asking about a room change after the incident. She further stated she would have

identified to ensure continued compliance.

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wanted to be called.

Notes taken by the DON on 02/26/16 and 02/27/16 presented by the Administrator, revealed no notes related to notification of the RP or the physician.

Follow up interview with the DON on 03/22/16 at 9:26 AM revealed she spoke to the Detective on the phone on 02/27/16 who informed the DON they were going to transport Resident #3 to the hospital for a rape kit. The DON stated Resident #3 was her own responsible party and the nurses should call the responsible party if the resident requested it. During follow up interview with the DON on 03/22/16 at 3:46 PM, the DON stated she thought Resident #3's physician had been notified since her name was listed on the incident report.

The Administrator was interviewed on 03/22/16 at 2:57 PM. The Administrator stated he was unaware if the physician or family were notified of the incident. The Administrator stated the physician should have been notified of the accusation. He further stated since Resident #3 was her own responsible party, the staff should have inquired if Resident #3 wanted her RP notified of the situation.

A telephone interview was conducted with Resident #3's physician, who was also the Medical Director of the facility on 03/22/16 at 4:09 PM. The physician stated that she learned of the abuse situation on Sunday 02/28/16. The physician stated she received a call from her office assistant who was in the facility gathering information for the next physician's visit. The office assistant heard about another resident's

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(Resident #4) allegation of abuse and called the physician to make sure she was aware of what was happening in the facility. The physician stated she then spoke to Nurse #2 who informed her Resident #3 had gone to the hospital for an evaluation. The physician stated at this time, she was not sure the police had been called so she took it upon herself to call the police and adult protective services.

2. Resident #4 was admitted to the facility on 03/24/15. Her diagnoses included cerebral infarct without residual deficits, acute respiratory failure, chronic obstructive pulmonary disease, and anxiety disorder.

The quarterly Minimum Data Set (MDS) dated 11/18/15 coded her with intact cognition and being understood and understanding with no communication issues. She was coded as requiring supervision of one staff for most activities of daily living skills (ADL) including bed mobility, toileting and hygiene, and being continent of bowel and bladder. She was coded as feeling bad about herself 2-6 days over the last 2 weeks, having no behaviors and no signs of delirium.

The annual MDS dated 02/12/16 coded her with intact cognition, having no behaviors, no communication problems, no signs of delirium, feeling bad about herself 2- 6 days over the last 2 weeks, and requiring set up or limited assistance with ADL.

A phone interview with Nurse #2 was conducted on 03/21/16 at 3:43 PM. Nurse #2 stated on 02/28/16 she was asked by Resident #8 to talk with Resident #4. Resident #4 stated NA #1 had

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been kissing her while she slept. It occurred multiple times. Then the resident stated about 2-3 weeks ago, NA #1 was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported he had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 called the physician who agreed not to send her to the hospital for an exam.

There were no nursing notes written by Nurse #2 about the allegations made by Resident #4. or any notification to the physician or Resident #4's responsible party.

Nursing notes dated 02/28/16 at 11:00 AM, written by Nurse #1 revealed she received a call from Nurse #2 who reported that Resident #4 had made an allegation that Nurse Aide (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 this had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then 3 to 4 days later she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom, NA #1 returned and as she turned to get into the wheelchair, he put his hand on her back where she was over the chair, her pants had not been pulled up yet, he pulled his pants down but could not get his penis in her vagina so he ejaculated between her inner thighs. This note did not indicate notification to her physician or responsible party.

Interview with Nurse #1 on 03/21/16 at 2:38 PM revealed she received a call from Nurse #2 on 02/28/16 at 11:00 AM who stated Resident #4

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claimed she was assaulted by NA #1. Nurse #1 stated she told Nurse #2 to complete an incident report and concern form. Nurse #1 stated she went to the facility and got a statement from Resident #4 and then the police arrived. Nurse #1 stated she was not sure exactly what Nurse #2 had done and she told Nurse #2 to make sure everything was in order and she left after the police.

There was no incident report or concern form completed related to Resident #4's allegation of sexual assault.

An interview with Resident #4 was conducted on 03/21/16 at 10:19 AM. Resident #4 stated she was assaulted by NA #1 3 times. The first time she was sound asleep and woke to his tongue being in her mouth. Crying, she referred to this incident as a "violation" that took place a month ago. The second time, she was in the bathroom, had gotten up, pulled her pants up, he grabbed hold of her, pulled her to him and started gyrating against her. The third time she was in the bathroom, had not pulled her pants up yet and he came into the bathroom pushed her forward and bent her over and ran his hands between her legs and tried to put his penis inside her. She stated his penis was too floppy to penetrate her so he finished by putting his penis between her thighs and ejaculated. He then brought her wash cloths with soap and water and instructed her to clean up.

Follow up interview with Resident #4 on 03/23/16 at 8:24 AM revealed she definitely wanted her responsible party RP called about the incident. Resident #4 stated she asked the DON if her RP was called, was told no, so she called the RP

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herself.

Phone interview with Resident #4's RP on 03/23/16 at 11:34 AM revealed she learned about the abuse from Resident #4 on Monday 02/29/16 as the facility never called her. She further stated she absolutely wanted to be called about the incident.

Follow up interview with the DON on 03/22/16 at 9:45 AM revealed on Sunday (02/28/16), Nurse #2 called her and informed her that Resident #4 had called the police because NA #1 "got her also." The DON stated she talked to Resident #4 via phone who stated it happened a long time ago. The DON stated the resident was her own responsible party and if she wanted the family to be called the nurse should call the family.

The Administrator provided notes written by the DON relating to what she did once she received the allegation about Resident #4 on 02/28/16. The note indicated the DON made phone calls to the Administrator, several corporate staff and Resident #4's physician. The note did not indicate the physician's response or if the responsible party was notified.

The Administrator was interviewed on 03/22/16 at 2:57 PM. The Administrator stated he was unaware if the physician or family were notified of the incident. The Administrator stated the physician should have been notified of the accusation. He further stated the staff should have inquired if Resident #4 wanted her RP notified of the situation.

A telephone interview was conducted with Resident #4's physician, who was also the

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Medical Director of the facility on 03/22/16 at 4:09 PM. The physician stated that she learned of the abuse situation on Sunday 02/28/16. The physician stated she received a call from her office assistant who was in the facility gathering information for the next physician's visit. The office assistant heard about Resident #4's allegation of abuse and called the physician to make sure she was aware of what was happening in the facility. The physician stated she then spoke to Nurse #2. The physician stated she felt it was too late and there was no need to send Resident #4 to the hospital. The physician stated at this time, she was not sure the police had been called so she took it upon herself to call the police and adult protective services.

On 03/22/16 at 4:46 PM, the Administrator and the DON were informed of Immediate Jeopardy. The Administration provided a credible allegation of compliance on 03/24/16 at 6:32 PM.

Brian Center Waynesville respectfully submits the following allegation of compliance for F 157:

1. On 02/29/16 the Director of Nursing notified the Physician of Resident # 3 regarding the allegation of abuse received on 02/26/16. Resident #3 is responsible for her own affairs and she notified her family on 02/29/16. On 02/29/16 the Director of Nursing notified the Physician of Resident #4 regarding the allegation of abuse received on 02/28/16. Resident #4 is responsible for her own affairs and she notified her responsible party on 02/28/16.

2. Current Residents have the potential to be affected by the same alleged deficient practice.

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By 03/03/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to verify no other unreported allegations of abuse occurred. On 03/23/16 the Social Services Director completed an audit of families and responsible parties for those resident unable to participate in the prior interviews to verify no other unreported allegations of abuse occurred. On 03/03/16 the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. On 03/23/16 the Administrator completed an audit of all previously reported allegations of abuse or neglect received during the last 6 months to validate Physician and Responsible Party notification was completed. No further Physician notifications were required as a result of these interviews as no new allegations were identified. These audits and interviews were completed on 03/23/16.

3. Measures put in place to ensure the alleged deficient practice does not recur include
All Licensed nurses were re-educated by the Area Staff Development Coordinator and the Director of Nursing on 03/22/16 regarding the facility's policy for Physician and Responsible Party Notification as it relates to:
*A Change in Resident Condition
*When an Incident or Accident occurs
*When an allegation of abuse or neglect occurs.
On 03/24/16 All Resident Care Specialists (CNAs) were re-educated by the Area Staff Development Coordinator and the Unit Manger regarding notification of Licensed nurses of any concerns, incidents or accidents, significant

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F 157	Continued From page 15 change of condition, or when an allegation of abuse or neglect occurs. Resident Care Specialists shall not be allowed to work before receiving this re-education. All new Resident Care Specialists will be educated on notification of Licensed Nurses of any concerns, incidents or accidents, significant change of condition, or when an allegation of abuse or neglect occurs This education will be completed by the Area Staff Development Nurse or the Director of Nursing during orientation. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when interviews with nursing staff and administrative staff confirmed they had received in-service training on notification of the RP and physician related to allegations of abuse or any change in condition.	F 157		
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on resident interviews, record review and staff interviews, the facility failed to maintain 2 of 4 sampled residents' right to be free of sexual abuse (Residents #3 and #4).	F 223	F223 Actions taken for the identified residents: On 2/26/16, immediately following the	5/4/16

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F 223	Continued From page 16 Immediate Jeopardy began on 02/25/16 when Resident #3 was raped by Nurse Aide (NA) #1. Immediate Jeopardy began for Resident #4 on 02/28/16 when she told Nurse #2 she was sexually assaulted by NA #1. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to resident rights to be free from abuse. The findings included: 1. Resident #3 was admitted to the facility on 12/11/14. Her diagnoses included chronic obstructive pulmonary disease, anxiety disorder, fibromyalgia, manic episode without psychotic symptoms, and major depressive disorder single episode. The annual Minimum Data Set (MDS) dated 12/11/15 coded her with having intact cognition, scoring a 15 out of 15 on the Brief Interview for Mental Status, which measures long and short term memory and temporal orientation. She was coded as understanding others and being understood with clear speech and no communication problems. She was coded as having no behaviors, no delirium, feeling tired 2-6 days over the previous 2 weeks, and requiring supervision of one person physical assistance for most activities of daily living skills including bed mobility, transfers, walking, toileting and hygiene.	F 223	notification from Nurse #1, the Director of Nursing removed NA #1 from the resident care assignment and was suspended pending the facility investigation. NA #1 was terminated on 3/15/16. Resident #3 was transferred to the hospital for medical evaluation and treatment. Resident # 3 received psych services on 2/29/16 for ongoing emotional support. Resident # 4 refused to go to the hospital for evaluation or treatment. Resident #4 received psych services on 3/9/16 and 3/23/16 for ongoing emotional support. Resident #3 and Resident #4 was educated on the definition of abuse and who to report to on 3/24/16. The police were notified of the allegations of abuse for Resident #3 on 2/27/16. The police were notified of the allegations of abuse for Resident #4 on 2/28/16. The Director of Nursing informed the Administrator on 2/27/16 of the allegation of abuse for Resident #3. Director of Nursing informed the Administrator on 2/28/16 of the allegation of abuse for Resident #4. A 24 hour report for was submitted by the Director of Nursing on 2/29/16 regarding Resident #3. The 5 day report was submitted by the Administrator on 3/4/16. A 24 hour report was submitted on 2/29/16 by the Director of Nursing regarding Resident #4. The 5 day report was submitted for	

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F 223	Continued From page 17 She was coded as always being continent of bowel and bladder. Nursing notes dated 02/26/16 at 7:20 PM, written by Nurse #1, revealed Resident #3 asked to speak to this nurse privately. During this conversation, Resident #3 told Nurse #1 that Nurse Aide (NA) #1 "stuck it in" her and her genital area hurt. Review of an incident report dated 02/26/16 revealed at 7:20 PM Resident #3 "made allegations of being sexually assaulted by CNA (named NA #1). Initially she indicated that she said no (pain/hurt) and she was just scared. Then she complained of vaginal pain & said he penetrated her." This was completed by Nurse #1. Interview with Nurse #1 on 03/21/16 at 2:35 PM revealed that when she spoke to Resident #3 on 02/26/16, Resident #3 began crying and pointed to her genital area stating it hurt. She stated NA #1 stuck it in her, which Nurse #1 stated referred to his penis. Nurse #1 told NA #1 to not return to Resident #3's room and called the Director of Nursing. Nurse #1 asked the resident if she could call the police or send her to the hospital but Resident #3 stated she only wanted Nurse #1 to call the DON or the Administrator. Nurse #1 stated that Resident #3 had never made any allegations against this nurse aide or others related to treatment or other types of abuse. Nurse #1 described the resident as not always stable and further explained that she would have outbursts verbally over very simple things. She stated she took the allegation Resident #3 made about NA #1 very seriously.	F 223	Resident #4 on 3/4/16 by the Administrator. Nurse #1 was educated by the Director of Nursing on the facility's policy for Abuse Prohibition and the Elder Justice Act. Nurse #2 is no longer employed with the facility. The Administrator and the Director of Nursing, who were employed at Brian Center Waynesville at the time of the alleged incident, were terminated. Actions taken for those residents with the potential to be affected: By 3/3/16, the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to determine any other unreported allegations of abuse occurred. On 3/24/16, the Social Services Director completed interviews of families and responsible parties for those residents unable to participate in the prior interviews to determine if any other unreported allegations of abuse occurred. On 3/3/16, the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to determine if any other unreported allegations of abuse occurred. No new allegations were identified as a	

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F 223	Continued From page 18 Nursing notes dated 02/27/16 at 1:30 PM written by Nurse #2 revealed Resident #3 stated a nurse aide helped her to the bathroom, pushed her against the wall and put his penis in her vagina. She stated that she then moved away and the nurse aide kissed her forcefully. The police were called and Resident #3 was sent to the hospital for a rape kit and exam. Review of the hospital records revealed Resident #3 was seen in the Emergency room on 02/27/16 at 3:13 PM for reported sexual assault and assault by bodily force. Laboratory tests were drawn and post exposure prophylaxis were ordered. A phone interview was conducted with Nurse #2 on 03/21/16 at 3:21 PM. Nurse #2 stated she arrived for work on 02/27/16 and Resident #3 asked who her nurse aide was for the day, around 10:00 AM. When told NA #1 was scheduled, Resident #3 started crying. When asked what was wrong, Nurse #2 stated Resident #3 told her that 2 days prior NA #1 asked if she needed to go to the bathroom and she walked independently to the bathroom. Resident #3 stated he followed her into the bathroom, closed the door, locked the door, pushed her against the wall, over the toilet where she grabbed the grab bar and he put his penis between her legs, moved around a bit and then actually penetrated her. Nurse #2 stated Resident #3 told her NA #1 had kissed her about 15 times and recently bought her perfume. Nurse #2 called the Director of Nursing who reluctantly agreed for the police to be called. During an interview with Resident #3 on 03/21/16 at 9:53 AM, Resident #3 stated that she was	F 223	result of these interviews. These audits and interviews were completed on 3/24/16. The facility's Abuse Prohibition Policy was reviewed by the District Director of Operations, District Director of clinical Services, Director of Nursing and the Administrator. The facility residents were educated on the definition of abuse and who to report to. Education was completed by 3/24/16. The facilities staff was educated on the facility's Abuse Prohibition policy addressing: allegations of abuse to be reported to the Administrator, Law enforcement officials if suspicion of a crime, reporting to the Health Care Personnel Registry within 24 hours of the allegation of abuse, and Physician and Responsible Party notification. This was completed by 3/24/16. Systems in place to ensure the alleged deficient practice does not recur: Unit Managers/Interdisciplinary Team will audit residents on abuse prevention to determine satisfaction and staff treatment of residents 5 times a week x 4 weeks then 3 times a week x 2 months and will report results to the monthly QAPI meeting for review. On 3/24/16, the Interim Administrator and	

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F 223	Continued From page 19 "raped" and stated it occurred the day before she told the nurse (02/25/16). She stated she was lying in bed when NA #1 suggested she go to the bathroom before her roommate returned from a smoke break. NA #1 followed Resident #3 into the bathroom, locked the door, and placed the tip of his penis in her vagina. Resident #3 stated she returned to bed and did not tell anyone until the next day when she told a nurse. Resident #3 cried during this interview. Follow up interview with Resident #3 on 03/23/16 at 9:15 AM, revealed in the past, NA #1 had kissed her and touched her breast. She stated she liked his friendliness. He then bought her perfume she really liked. She stated she did not report the sexual assault because she was afraid he would not buy her more perfume which she really liked. Crying, Resident #3 stated she had to make a decision about getting perfume and being raped and she decided she did not want to be raped again so she reported it. During an interview with Nurse #3 on 03/23/16 at 9:48 AM, she described Resident #3 as alert and oriented. Her mental stability was less steady as she would have sudden outburst saying the world was coming to an end. One minute she would be happy and the next she would be mad. Nurse #3 described her as having manic episodes. She continued saying that Resident #3 never reported staff for mistreatment, or being "ugly" to her. She would say "I hate her" referring to staff but give no specific complaints. Nurse #3 stated there was no indication she had problems with NA#1, no previous complaints about him and she never said she did not like him. Interview with NA #4 on 03/23/16 at 1:18 PM	F 223	Interim Director of Nursing were educated by the District Director of clinical Services regarding Abuse Prohibition Policy, timely completion of 24 hour and 5 day reports to HCPR and the Elder Justice Act. On 3/23/16, the Nursing Department, Business Office Staff, Housekeeping, Dietary and Therapy staff were educated by the Director of Nursing, Unit Manager and Area Staff Development coordinator regarding the Abuse Prohibition Policy and the Elder Justice Act. Staff were educated and instructed regarding the immediate notification to the Administrator regarding allegations of abuse or neglect. Newly hired staff will receive education regarding the Abuse Prohibition Policy, the Elder Justice Act and the immediate notification to the Administrator for any allegation of abuse or neglect. Education regarding the Abuse Prohibition Policy and the Elder Justice Act will continue annually for all employees. Quality Assurance Measures in place to ensure the practice is sustained: As part of the facility's ongoing Quality Assurance program, a schedule has been established for unannounced resident care rounds to be completed by either the Administrator, Director of Nursing, District Director of Clinical Services, District Director of Operations or members of the facility management team. These scheduled visits will occur weekly during	

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F 223	Continued From page 20 revealed Resident #3 can be very cognitive intact and then confused at other times. She never complained about staff and NA #4 could not recall her ever having problems with certain staff members. She described her as demanding, wanting what she wanted immediately, and complaining if she had to wait too long. Resident #3 did not complain of any staff treatment issues. Interview with the Social Worker (SW) on 03/23/16 at 1:48 PM revealed Resident #3 always scored high on the cognitive issues but scored lower related to depression scores. SW stated she has been improving over the last 2 months. SW stated she would take things from others and claim them as her own. She stated she had never known Resident #3 to complain about staff treatment. Nurse #4 was interviewed on 03/24/16 at 10:25 PM. He stated that Resident #3 sometimes got "fuzzy" about issues but she had no complaints about particular staff or staff treatment. He further explained that Resident #3 would let little things balloon in her head. The Administrator stated during interview on 03/24/16 at 9:20 AM that although Resident #3 had some psychiatric issues, there was no documentation, complaints or indications that she fabricated stories about staff to get them in trouble. Interview with the Detective on 03/22/16 at 10:21 AM revealed this was an ongoing investigation. The Detective stated they attempted to interview NA #1 who refused to talk to the detective. She stated NA #1 had secured legal counsel and the police were trying to arrange for an interview with	F 223	off hours, weekends and holidays to assess and monitor the abuse prevention program for 6 months. A member of this leadership team will be available and rounding within the facility during regular working hours as well. The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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NA #1 and his attorney this week. The Detective stated the hospital completed a rape kit but it could be months before the results would be available. The Detective stated she preferred the surveyors not interview NA #1 prior to her being able to interview him. NA #1 had not been arrested or charged at this time but the Detective stated he most likely would be charged and arrested.

NA #1 was not interviewed. Review of the interview notes conducted by the Administrator with NA #1 dated 03/04/16 revealed NA #1 knew he was suspended as there was an accusation from Resident #3. NA #1 stated that on 02/26/16 he made Resident #3's bed. He stated she was independent and he did not help her with a shower or toileting. NA #1 denied Resident #3's accusation and denied ever making contact with her genital area or breasts. When asked about their relationship, NA #1 stated he did not joke with her and was "real serious." NA #1 stated that she would sometimes get upset with him if he could not do what she requested immediately such as wanting coffee but he could not recall anything that had occurred recently.

2. Resident #4 was admitted to the facility on 03/24/15. Her diagnoses included cerebral infarct without residual deficits, acute respiratory failure, chronic obstructive pulmonary disease, and anxiety disorder.

The quarterly Minimum Data Set (MDS) dated 11/18/15 coded her with intact cognition, scoring a 14 out of 15 on the Brief Interview for Mental Status (BIMS) (a system for measuring short and long term memory and temporal orientation), and being understood and understanding with no

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communication issues. She was coded as requiring supervision of one staff for most activities of daily living skills (ADL) including bed mobility, toileting and hygiene, and being continent of bowel and bladder. She was coded as feeling bad about herself 2-6 days over the last 2 weeks, having no behaviors and no signs of delirium.

The annual MDS dated 02/12/16 coded her with intact cognition, scoring a 13 out of 15 on the BIMS, having no behaviors, no communication problems, feeling bad about herself 2- 6 days over the last 2 weeks, and requiring set up or limited assistance with ADLs.

Nursing notes dated 02/28/16 at 11:00 AM, written by Nurse #1 revealed she received a call from Nurse #2 who reported that Resident #4 had made an allegation that Nurse Aide (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 this had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then she stated 3 to 4 days later she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom, NA #1 returned and as she turned to get into the wheelchair, he put his hand on her back where she was over the chair, her pants had not been pulled up yet, he pulled his pants down but could not get his penis in her vagina so he ejaculated between her inner thighs.

Interview with Nurse #1 on 03/21/16 at 2:38 PM revealed she received a call from Nurse #2 on 02/28/16 who stated Resident #4 claimed she was also assaulted by NA #1. Nurse #2 came

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into the facility and spoke with Resident #4 on 02/28/16 and wrote the resident's detailed account in the nursing notes. who stated NA #1 had been taking sexual advantage of her for two weeks.

There was no incident report or concern form completed related to Resident #4's allegation of sexual assault.

A phone interview with Nurse #2 was conducted on 03/21/16 at 3:43 PM. Nurse #2 stated on 02/28/16 she was asked by Resident #8 (who was friends with Resident #4) to talk with Resident #4. Nurse #2 stated Resident #4 felt comfortable talking since Resident #3 had come forward with allegations of abuse. Resident #4 stated NA #1 had been kissing her while she slept. It occurred multiple times then about 2-3 weeks ago, he was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported he had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 then stated after talking to the Director of Nursing via phone, Nurse #2 told Resident #4 to call the police. Nurse #2 stated because the incident happened a couple of weeks prior to the report, there was no need to send her to the hospital as evidence would be gone. Nurse #2 called the physician who agreed not to send her to the hospital for an exam.

An interview with Resident #4 was conducted on 03/21/16 at 10:19 AM. Resident #4 stated she was assaulted by NA #1 3 times. The first time she was sound asleep and woke to his tongue being in her mouth. Crying, she referred to this incident as a "violation" that took place a month

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ago. The second time, she was in the bathroom, had gotten up, pulled her pants up, he grabbed hold of her, pulled her to him and started gyrating against her. The third time she was in the bathroom, had not pulled her pants up yet and he came into the bathroom pushed her forward and bent her over and ran his hands between her legs and tried to put his penis inside her. She stated his penis was too floppy to penetrate her so he finished by putting his penis between her thighs and ejaculated. He then brought her wash cloths with soap and water and instructed her to clean up.

Follow up interview with Resident #4 on 03/23/16 at 8:24 AM revealed she did not tell anyone for fear and that it happened often. She stated she finally felt comfortable when she told Resident #8 what NA #1 did to her and Resident #8 told her either she had to tell someone about it or he would tell someone about NA #1.

Nurse #3 was interviewed on 03/23/16 at 9:52 AM. Nurse #3 described Resident #4 as being alert and oriented with some lethargy with pain medication. She stated Resident #4 has never complained about any staff including NA #1.

NA #3 was interviewed on 03/23/16 at 1:15 PM. NA #3 stated sometimes Resident #4 had some confusion. She did not recall any time Resident #4 complained about staff or staff treatment. In addition, Resident #4 never said she disliked any staff member.

NA #4 was interviewed on 03/23/16 at 1:18 PM. NA #4 described Resident #4 as being mentally together and never complained about any staff.

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The Social Worker (SW) was interviewed on 03/23/16 at 1:48 PM. SW stated Resident #4 was highly cognitively intact and her psychiatric issues involved self harm. Her emotional well being has improved since coming to this facility. SW stated she may fabricate in order to get something accomplished medically. SW attributed this as needing some control.

Nurse #4 was interviewed on 03/24/16 at 10:25 AM. Per Nurse #4 Resident #4 has never complained or made allegations against any staff member.

The Administrator stated during interview on 03/24/16 at 9:20 AM that although Resident #4 had some psychiatric issues, there was no documentation, complaints or indications that she fabricated stories about staff to get them in trouble.

Interview with the Detective on 03/22/16 at 10:21 AM revealed Resident #4 called the police herself. The Detective stated this was an ongoing investigation, NA #1 had secured legal counsel and the police were hoping to arrange for an interview with NA #1 this week. The Detective stated she preferred the surveyors not interview NA #1 prior to her being able to interview him. NA #1 had not been arrested or charged at this time but the Detective stated he most likely would be charged and arrested.

NA #1 was not interviewed. Review of the information gathered by the Administrator when he interviewed NA #1 (no date specified) revealed he denied ever putting his tongue in her mouth or kissing or hugging her. He stated he had not taken her to the bathroom as she took herself.

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He denied ever helping her dress and denied making contact with her body when asked about rubbing her breasts and groin area. He denied trying to put his penis in her vagina and ejaculating on her stating she was lying.

On 03/24/16 at 9:20 AM, the Administrator and the District Director of Clinical Services were informed of Immediate Jeopardy. The Administration provided an acceptable credible allegation of compliance on 03/24/16 at 6:32 PM.

Brian Center Waynesville respectfully submits the following allegation of compliance for F223:

1. Nurse #1 notified the DON of an allegation of abuse related to Resident #3 on 02/26/16. Resident #3 alleged that NA#1 raped her Thursday 02/25/2016. On 02/26/16, immediately following the notification from Nurse #1 the Director of Nursing removed NA #1 from the Resident Care Areas. The accused did not return to the facility and was terminated on 03/15/2016. The Director of Nursing took statements over the phone from Nurse #1 and NA #1 and Resident #3 on 02/26/2016. On 02/27/2016 Resident #3 contacted the Police, who came into the Facility, and Resident #3 was transferred to the hospital for medical evaluation. Resident #3 received STD testing and prophylactic treatment with Truvada and Raltegravir for 30 days. Resident #3 received Psych services on 02/29/16 for ongoing emotional support. The Director of Nursing called the Administrator on 02/27/2016 at approximately 1:30 PM to inform him of Resident #3's allegation. A 24 hour report for Resident #3 was submitted by the Director of Nursing on 02/29/2016 and the 5 Day report was submitted by the Administrator on 03/4/2016. Nurse #1 was re-educated by the

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Director of Nursing on the Facility's Policy for Abuse Prohibition including the Elder Justice Act.

2. On 02/28/2016 Resident #4 called the Police to report an allegation of abuse. Resident #4 notified Nurse #2 of same allegation. Resident #4 alleged that NA #1 came into the bathroom and sexually abused her and was unable to remember the date or time. Nurse #2 then immediately notified the Director of Nursing on 02/28/16. NA #1 was previously suspended on 02/26/26 and continued to remain out of the facility. The Police came into the Facility and Resident #4 declined to go to the hospital for medical evaluation and STD testing. Resident #4 received Psych Services on 03/9/16 and 03/23/16 for ongoing emotional support. A 24 Hour Report was submitted on 02/29/2016, by the Director Nursing for Resident #4's allegation of abuse. The 5 Day Report was submitted for Resident #4 on 03/04/2016 by the Administrator. Nurse #1 was re-educated on 03/22/2016 by the Director of Nursing on the Facility's Policy for Abuse Prohibition including the Elder Justice Act. Nurse # 2's last day worked in facility was February 28, 2016.

Current Residents have the potential to be affected by the same alleged deficient. By 03/03/2016 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to verify no other unreported allegations of abuse occurred. On 03/23/16 the Social Services Director completed an audit of families and responsible parties for those resident unable to participate in the prior interviews to verify no other unreported allegations of abuse occurred. On 03/03/2016 the Administrator, Social Services

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Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to verify no other unreported allegations of abuse occurred No new allegations were identified as a result of these interviews. These audits and interviews were completed on 03/23/16. The Facility's Abuse Prohibition Policy was reviewed the District Director of Operations, the District Director of Clinical Services, the Director of Nursing and the Administrator and all required components related to F226 were present.

3. Measures put in place to ensure the alleged deficient practice does not recur include:
The Director of Nursing was suspended by the Administrator on February 29, 2016 pending investigation related to delayed reporting of abuse allegation to the Administrator and timely completion of investigation. The Administrator provided the Director of Nursing with disciplinary action as a final warning and was placed on a Performance Improvement Plan that included reporting allegations of abuse/neglect to the appropriate parties in a timely manner and initiate the investigation immediately upon returning to work on 03/08/2016.

The Director of Nursing was terminated on 03/24/16 and replaced with an Interim Director of Nursing who was immediately re-educated by the District Director of Clinical Services regarding Abuse Prohibition to include timely completion of 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect.

On 03/23/16 all facility staff, the Nursing

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Department including Resident Care Specialists (CNAs), Business Office Staff, Housekeeping, Dietary and Therapy were re-educated by the Director of Nursing, Unit Manager, and Area Staff Development Coordinator regarding:
*The definition of Abuse meaning the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Injuries of unknown origin may occur as a result of abuse.
*Immediately intervene to stop.
*A schedule has been developed by the Administrator, to begin 03/24/16, for the next 7 days to include daily supervision during all 3 shifts. All staff involved have reviewed and agreed to the schedule. The Administrator, Director of Nursing (DON), Unit Manager (UM), District Director of Clinical Services (DDCS) or District Director of Operations (DDO) will participate in this weekly schedule. A member of this leadership team will be available and rounding within the facility each day assessing the ongoing performance of the facility staff to ensure there is no tolerance for abuse.
*No tolerance for abuse.

No staff shall work prior to receiving this education. All new employees will be educated on the above prior to working in resident care area. This education will be completed by the Area Human Resource Officer or the Director of Nursing during orientation.

Immediate jeopardy was removed on 03/24/16 at 8:12 PM when interviews with nursing staff and administrative staff and non-nursing staff confirmed they had received in-service training and knew the different types of abuse and the appropriate boundaries to maintain when caring

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F 223	Continued From page 30 for residents in order to maintain a professional yet caring relationship with residents.	F 223		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		5/4/16

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F 225	Continued From page 31 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, and record reviews the facility failed to report allegations of abuse to the Administrator, report suspicion of a crime to law enforcement and complete and send the 24 hour report to the Health Care Personnel Registry (HCPR) as required. This affected 2 of 4 residents sampled for abuse (Residents #3 and #4). Immediate Jeopardy began on 02/26/16 when after Resident #3 alleged rape to Nurse #1, neither Nurse #1 nor the DON informed the Administrator of the abuse allegation or called the police. The DON did not fax the 24 hour initial report to the HCPR until 02/29/16. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, neither Nurse #1 nor Nurse #2 called the police and neither nurse nor the Director of Nursing (DON) called the Administrator. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to informing the Administrator of allegations of abuse, informing law enforcement of the suspicion of a crime and making reports to the HCPR within 24 hours of an allegation of	F 225	F225 Actions taken for the identified residents On 2/26/16 the Director of Nursing removed NA #1 from the resident care assignment and was suspended pending investigation. NA #1 was terminated on 3/15/16. Resident #3 and Resident #4 were educated on 3/24/16 on the definition of neglect/abuse and who to report allegations to. Action taken for residents with the potential to be affected. On 2/29/16, the Social Worker conducted interviews with all interviewable residents to ensure no other allegations of abuse. None were noted. 100% audit of staff was conducted on 2/29/16 through 3/3/16 by the Administrator, Social Worker, District Director of Operations and the District Director of Care Managements and revealed no new allegations of abuse. Area Staff Development Coordinator, DON, and Unit Managers educated staff by 3/23/16 on reporting allegations of abuse to Administrator, reporting suspicion of a crime to law enforcement and completing and sending the 24 hour reporting to Health Care Registry. Residents were educated by 3/24/16 by the Interdisciplinary Team on definition of	

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F 225	Continued From page 32 abuse. The findings included: 1. Resident #3 was admitted to the facility on 12/11/14. Her diagnoses included chronic obstructive pulmonary disease, anxiety disorder, fibromyalgia, manic episode without psychotic symptoms, and major depressive disorder single episode. The annual Minimum Data Set (MDS) dated 12/11/15 coded her with having intact cognition, as understanding others and being understood with clear speech and no communication problems. She was coded as having no behaviors, no signs of delirium, feeling tired 2-6 days over the previous 2 weeks, and requiring supervision of one person physical assistance for most activities of daily living skills. Nursing notes dated 02/26/16 at 7:20 PM, written by Nurse #1, revealed Resident #3 asked to speak to this nurse privately. During this conversation, Resident #3 told Nurse #1 that Nurse Aide (NA) #1 "stuck it in" her and her genital area hurt. The nurse noted she asked Resident #3 if she wanted the police called or to be sent out (for evaluation) and the resident stated she only wanted the nurse to call the DON or the Administrator. Nurse #1 wrote that she immediately instructed NA #1 not to go back into Resident #3's room and then went to her office and called the DON. The note stated the DON instructed Nurse #1 to make sure NA #1 did not go back into the room and to have NA #1 call the DON immediately which she did. Review of an incident report dated 02/26/16	F 225	abuse and who to report allegations to. System in place to ensure the alleged deficient practice does not recur. On 2/29/16 the District Director of Clinical Services re-educated the Director of Nursing on the facility's Abuse and Neglect Policy to include timeliness of reporting of 24 hour and 5 Day Report to NC Division of Health Service Regulation, notification of residents physician and families with change of condition and/or allegation of abuse and the Elder Justice Act. The Director of Nursing was suspended on 2/29/16 pending investigation and was given disciplinary action as a final warning and was placed on a Performance Improvement Plan upon returning to work on 3/8/16. On 2/29/16 the District Director of Operations re-educated the Administrator on the facility's Abuse and Neglect Policy, the Elder Justice Act, reporting guidelines for the 24 hour and 5 Day report to the NC Division of Health Service Regulation, and his responsibilities in investigation as the abuse coordinator. On 2/29/16, the District Director of Clinical Services instructed the Administrator and the Director of Nursing to immediately notify her of any new incidents or allegations to ensure facility's Abuse and Neglect policy was followed. The District Director of Clinical Services is holding a weekly call thru 5/27/16 with facility to discuss all incidents and allegations to ensure facility is following policy. By 3/23/16 all staff in facility were	

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F 225	Continued From page 33 revealed at 7:20 PM Resident #3 "made allegations of being sexually assaulted by NA #1. Initially she indicated that she said no (to pain/hurt) and she was just scared. Then she complained of vaginal pain & said he penetrated her." This incident report was completed by Nurse #1. Interview with Nurse #1 on 03/21/16 at 2:35 PM revealed that when she spoke to Resident #3 on 02/26/16, Resident #3 began crying and pointed to her genital area stating it hurt. She stated NA #1 stuck it in her, which Nurse #1 stated referred to his penis. Nurse #1 told NA #1 to not return to Resident #3's room and called the DON from her office. The DON told Nurse #1 she would take care of the issue and instructed the nurse to have NA #1 call her. After talking to the DON, Nurse #1 instructed NA #1 to call the DON and said she did not talk to the DON again that evening. Nurse #1 stated she was not given instructions other than making sure NA #1 did not go back into Resident #3's room. Nurse #1 stated she assigned Resident #3 and her roommate to another nurse aide and did not see NA #1 again. She stated she did not think NA #1 was on the hall but could not guarantee it. She saw him at the end of the shift when he left the facility with his girlfriend NA #2. Nurse #1 stated DON said she would take care of everything and so she did not call the police or address it again during her shift. Nurse #1 stated that she understood her responsibility was to call her supervisor (DON) regarding abuse and the DON was to give instructions and handle the situation. Nurse #1 stated she did not call the police or send her to the hospital because Resident #3 was crying and very upset and adamant she call the DON or Administrator. Neither the DON nor the	F 225	educated by Director of Nursing, Unit Manager, District Director of Clinical Services and/or Area Staff Development Nurse on the facility's Abuse and Neglect policy and Elder Justice Act. No staff will be allowed to work until education has been completed. Nurse #1 was re-educated on 3/22/16 by Director of Nursing on facility's abuse and neglect policy, Elder Justice Act notification of families and physicians for all change of conditions or allegations and to perform head to toe assessment on any resident who alleges physical abuse. Administrator/DON will audit any allegations of abuse to ensure that allegations have been reported to Administrator, if there is a suspicion of a crime that it has been reported to Law Enforcement and that the 24-hour report has been completed and sent to the Health Care Registry. This audit will be conducted 5 times a week for 4 weeks and then 3 times a week for 2 months. The results of the audits will be reported at the monthly QAPI meeting. Quality Assurance measures in place to ensure the practices are sustained: The Administrator and Director of Nursing will began monitoring the management of allegations by reviewing all allegations with the Division Director of Clinical Services. This practice is completed anytime there is an allegation to ensure adherence to the Facility Policy on Abuse Prohibition. A weekly focus call is conducted to further review events	

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BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	516 WALL STREET WAYNESVILLE, NC 28786

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F 225	Continued From page 34 Administrator came to the facility. Upon follow up interview on 03/22/16 at 3:59 PM, Nurse #1 stated she asked the DON if she should call anyone else when she spoke to her on 02/26/16 and the DON stated no. She stated she assumed the DON would take the lead in handling the allegation and investigation. Nurse #1 further stated she did not reassign the rest of NA #1's residents because she was not aware of what the DON told NA #1 and she did not talk to the DON after the initial phone call. The DON gave no instructions to call the police or the Administrator so Nurse #1 just held and comforted Resident #3. Nurse #1 kept saying she thought the DON was handling the situation. Nursing notes dated 02/27/16 at 1:30 PM written by Nurse #2 revealed Resident #3 stated a nurse aide (not identified in the note) helped her to the bathroom, pushed her against the wall and put his penis in her vagina. She stated that she then moved away and the nurse aide kissed her forcefully. The police were called and Resident #3 was sent to the hospital for a rape kit and exam. Review of the hospital records revealed Resident #3 was seen in the emergency room on 02/27/16 at 3:13 PM for reported sexual assault and assault by bodily force. Laboratory tests were drawn and post exposure prophylaxis were ordered. A phone interview was conducted with Nurse #2 on 03/21/16 at 3:21 PM. Nurse #2 stated she arrived for work on 02/27/16 and Resident #3 asked who her nurse aide was for the day, around 10:00 AM. When told NA #1 was	F 225	occurring throughout the week, for 6 months, to ensure completion of investigations and reporting as required. The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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scheduled, Resident #3 started crying. Nurse #2 stated she was unaware of the allegations Resident #3 made to Nurse #1 the previous day. When asked what was wrong, Nurse #2 stated Resident #3 told her that 2 days prior, NA #1 asked if she needed to go to the bathroom and she walked independently to the bathroom. Resident #3 stated he followed her into the bathroom, closed the door, locked the door, pushed her against the wall, over the toilet where she grabbed the grab bar and he put his penis between her legs, moved around a bit and then actually penetrated her. Nurse #2 stated Resident #3 told her NA #1 had kissed her about 15 times previously and recently bought her perfume. Nurse #2 called the DON about the allegation. The DON stated she would handle it. Then Nurse #2 told the DON that Resident #3 was told to call the police (Nurse #2 stated she told Resident #3 to call the police). Nurse #2 stated the DON told her they needed to keep everyone out of the issue and when Nurse #2 told the DON that she was not ok with that, the DON agreed for the police to be called. Once the police arrived, the officer and Nurse #2 agreed it was appropriate to send Resident #3 to the hospital. Nurse #2 stated neither the DON or the Administrator came to the facility over the weekend.

During an interview with Resident #3 on 03/21/16 at 9:53 AM, Resident #3 stated that she was "raped" by NA #1. She stated she was lying in bed when NA #1 suggested she go to the bathroom before her roommate returned from a smoke break. NA #1 followed Resident #3 into the bathroom, locked the door, and placed the tip of his penis in her vagina. Resident #3 stated she returned to bed and did not tell anyone until the next day when she told a nurse. Resident #3

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cried during this interview.

Review of the Health Care Personnel Registry (HCPR) 24 hour report revealed it was completed by the DON who signed it on 02/27/16. The report noted there was a reasonable suspicion of a crime for resident abuse as Resident #3 alleged NA #1 put his penis in her vagina. The report noted the police were called and she was taken to the emergency room. This form was noted to be faxed to the HCPR on 02/29/16 at 9:43 AM.

Interview with the DON on 03/21/16 at 12:03 PM revealed NA #1 was suspended at 8:04 PM on 02/26/16 but he had no ride home so he stayed in the residents' television room until 11:00 PM. She presented his time clock report for 02/17/16 which showed he clocked out for supper at 8:04 PM, clocked back in at 8:32 PM and out again at 11:06 PM.

Notes taken by the DON, presented by the Administrator, revealed:
*on 02/26/16 at 8:00 PM, Nurse #1 called her and told her NA #1 had raped Resident #3. The DON spoke to Resident #3 on the phone, she was crying and upset, and told the DON NA #1 bent her over the toilet and put his penis in her. DON told her she would call the police and Resident #3 stated no.
*on 02/26/16 at 8:20 PM, the DON spoke to NA #1 on the phone and told him he was suspended due to a pending investigation of an allegation of sexual assault which he denied. When told to leave the facility, NA #1 stated he did not have a ride and needed to wait for his friend so the DON told him to go to the television room and wait and do not enter any resident room.
*on 02/26/16 at 8:30 PM, the DON wrote she

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called Resident #3 again and she still did not want the police called and asked if the DON would take care of it.
*(still noted as 02/26/16) at 2:45 PM, the DON called the Administrator to inform him Resident #3 wanted the police called because she was raped by NA #1 on 02/25/16. Per this note, Resident #3 called the police.
*(still noted as 02/26/16) at 2:50 PM the Detective came to the facility and took Resident #3's statement. She had emergency medical services (EMS) coming to the facility to transport the resident to the hospital for evaluation and rape test. DON noted she agreed Resident #3 needed to go.

Follow up interview with the DON on 03/22/16 at 9:26 AM revealed she told Nurse #1 to call the police when she was informed of the allegation of rape on 02/26/16 but Resident #3 did not want the police called. She spoke to NA #1 on the phone on 02/26/16 and told him he was suspended and told to wait in the television room when informed he did not have a ride home. She did not recall telling him to clock out and did not instruct anyone to make sure he was supervised as he waited for his ride. She stated she did not come into the facility at all during the weekend. On Saturday (2/27/16) Nurse #2 called her to report Resident #3 called the police and they were on their way. The DON spoke to the Detective on the phone who informed the DON they were going to transport Resident #3 to the hospital for a rape kit. The DON called the Administrator on 02/27/16. The DON stated she started the HCPR 24 hour report after being informed of the resident going to the hospital, but had trouble getting the fax to go through until she arrived at the facility Monday morning. The DON

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stated she had no reason for not calling the police, stated she handled the situation wrong and on Monday 02/29/16 she was told she should have called NA #1 a cab and she was suspended for 5 days and did not have anything more to do with the investigation.

The DON stated on 03/22/16 at 3:36 PM that she tried to fax the 24 hour report to HCPR from her home fax/scan machine but couldn't get it to go through, so when she came to work on Monday 02/29/16 she faxed the report to HCPR then called and verified they had received the report. The DON stated she didn't have a reason for not coming into the facility over the weekend to fax the report. She then stated she thought the 24 hour report was 24 hours of business days not hours.

The Administrator was interviewed on 03/22/16 at 2:57 PM. The Administrator stated he was informed by the DON in the afternoon (02/27/16) that Resident #3 accused NA #1 of sexually assaulting her, that the DON suspended NA #1, the police came to the facility and arranged for a forensic examination. At the time of the call, Resident #1 was at the hospital and he was told she was ok and cooperating with the police. The Administrator stated he did not come to the facility as the police were involved and the DON stated she had completed the HCPR 24 hour report. The Administrator stated he was not aware Resident #3 made the initial allegation on Friday night (02/26/16) and the actual abuse occurred on Thursday (02/25/16) until he arrived at work Monday 02/29/16. The Administrator further stated that he should have been called on 02/26/16 and the interviews started immediately but that everyone was interviewed, NA #1 was not

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in the facility, and the police had been called (he suspected by Resident #3). He stated he found out on 02/29/16 that the DON did not come into the facility over the weekend. He stated the DON should have called the police and made sure NA #1 left the facility. They since talked about calling a cab to remove the alleged perpetrator. He stated he was unaware if the physician or family were notified and unaware if a physical assessment had been done prior to the hospital visit. In addition, the Administrator stated that NA #1's second language was English and he did not understand he was suspended until the next day. NA #1 was just told to sit in the television room on 02/26/16. He gave no reason why he did not come to the facility when he was alerted to the abuse allegations. The Administrator stated NA #1 was terminated on 03/15/16 for "the pattern of allegations made against him" as there was no definitive hard core proof of guilt.

Review of the investigative notes taken by the Administrator revealed he did not begin interviewing staff, including NA #1, or Resident #3, until 03/03/16 and completed interviews on 03/04/16. The HCPR 5 day investigation report faxed 03/04/16 at 8:54 PM marked that the allegation was unsubstantiated at this time and there was an ongoing police investigation.

Interview with the Detective on 03/22/16 at 10:21 AM revealed this was an ongoing investigation, NA #1 had secured legal counsel and the police were hoping to arrange for an interview with NA #1 this week. The Detective was unable to say who initiated the report to the police. The Detective stated it could be months before the results of the rape kit collected at the hospital would be available. The Detective stated she

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preferred the surveyors not interview NA #1 prior to her being able to interview him.

2. Resident #4 was admitted to the facility on 03/24/15. Her diagnoses included cerebral infarct without residual deficits, acute respiratory failure, chronic obstructive pulmonary disease, and anxiety disorder.

The quarterly Minimum Data Set (MDS) dated 11/18/15 coded her with intact cognition, being understood and understanding, having no communication problems, no behaviors and no signs of delirium. She was coded as requiring supervision of one staff for most activities of daily living skills.

The annual MDS dated 02/12/16 coded her with intact cognition, having no behaviors, no communication problems, no signs of delirium, and requiring set up or limited assistance with ADL.

A phone interview with Nurse #2 was conducted on 03/21/16 at 3:43 PM. Nurse #2 stated on 02/28/16 she was asked by Resident #8 to talk with Resident #4. Nurse #2 stated Resident #4 felt comfortable talking since Resident #3 had come forward with allegations of abuse. Resident #4 stated NA #1 had been kissing her while she slept. It occurred multiple times. Then the resident stated about 2-3 weeks ago, NA #1 was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported he had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 called the DON who told her that Resident #4 just heard about the incident with Resdient #3 and "got on

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the band wagon." The DON told Nurse #2 she and the Administrator would be in on Monday to talk to her. Nurse #2 then stated after talking to the Director of Nursing via phone, Nurse #2 told Resident #4 to call the police. Resident #4 stated she used Resident #8's phone to call the police.

There were no nursing notes written by Nurse #2 about the allegations made by Resident #4.

Nursing notes dated 02/28/16 at 11:00 AM, written by Nurse #1 revealed she received a call from Nurse #2 who reported that Resident #4 had made an allegation that Nurse Aide (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 this had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then 3 to 4 days later she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom, NA #1 returned and as she turned to get into the wheelchair, he put his hand on her back where she was over the chair, her pants had not been pulled up yet, he pulled his pants down but could not get his penis in her vagina so he ejaculated between her inner thighs.

Inteview with Nurse #1 on 03/21/16 at 2:38 PM revealed she received a call from Nurse #2 on 02/28/16 at 11:00 AM who stated Resident #4 claimed she was assaulted by NA #1. Nurse #2 stated she told Nurse #2 to complete an incident report and concern form. Nurse #1 stated she went to the facility and got a statement from Resident #4 and then the police arrived. Nurse #1 stated she never spoke to the DON on 02/28/16 and the DON did not come to the

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facility. She assumed the DON was handling the situation.

There was no incident report or concern form completed related to Resident #4's allegation of sexual assault.

An interview with Resident #4 was conducted on 03/21/16 at 10:19 AM. Resident #4 stated she was assaulted by NA #1 3 times. The first time she was sound asleep and woke to his tongue being in her mouth. Crying, she referred to this incident as a "violation" that took place a month ago. The second time, she was in the bathroom, had gotten up, pulled her pants up, he grabbed hold of her, pulled her to him and started gyrating against her. The third time she was in the bathroom, had not pulled her pants up yet and he came into the bathroom pushed her forward and bent her over and ran his hands between her legs and tried to put his penis inside her. She stated his penis was too floppy to penetrate her so he finished by putting his penis between her thighs and ejaculated. He then brought her wash cloths with soap and water and instructed her to clean up.

Follow up interview with Resident #4 on 03/23/16 at 8:24 AM revealed she did not tell anyone for fear and that it happened often. She stated she finally felt comfortable when she told Resident #8 about what NA #1 did to her and Resident #8 told her either Resident #4 had to tell someone about it or he would tell someone about NA #1.

Review of the Health Care Personnel Registry (HCPR) 24 hour report signed and faxed by the DON on 02/29/16 at 12:24 PM marked there was no reasonable suspicion of a crime.

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The DON was interviewed on 03/21/16 at 12:03 PM who stated NA #1 had been suspended on 02/26/16 for a previous allegation of sexual assault made by Resident #3.

Follow up interview with the DON on 03/22/16 at 9:45 AM revealed on Sunday (02/28/16), Nurse #2 called her and informed her that Resident #4 had called the police because NA #1 "got her also." The DON stated she talked to Resident #4 via phone who stated it happened a long time ago. When asked why she waited to report it, Resident #4 stated she just didn't want to. The DON stated the resident asked her if she (Resident #4) should not have called the police but the DON said she told the resident it was ok to call the police. Resident #4 refused to go to the hospital. The DON did not come to the facility and stated the police had already been called, NA #1 had been suspended and the resident did not want to go to the hospital. The DON stated she talked with the Administrator via phone on 02/28/16. She stated neither she nor the Administrator came in on Sunday.

The Administrator provided notes written by the DON relating to what she did once she received the allegation about Resident #4:
*on 02/28/16 at about 11:00 AM, the DON received a phone call from Nurse #2 who informed her that Resident #4 was accusing NA #1 of raping her too. This occurred a long time ago and that the resident called the police. Per the notes, the DON spoke to Resident #4 on the phone and was told NA #1 ejaculated between her legs while she was in the bathroom. Resident #4 told her about another time waking up with NA #1's tongue in her mouth. The DON told

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Resident #4 it was ok that she called the police and that the resident would probably go to the hospital. Resident #4 declined to go to the hospital. The DON called and texted the Administrator. When he returned her call, the Administrator instructed the DON to call the District Director of Operations. She noted the District Director of Operation told her to call the corporate attorney, who she spoke with twice. The DON then called other corporate staff and the physician per these notes.

Another interview with the DON on 03/22/16 at 3:46 PM revealed she was suspended on Monday 02/29/16 and had no more involvement in the investigation. She further stated she felt the resident was safe since NA #1 was already suspended.

The Administrator was interviewed on 03/22/16 at 2:57 PM. The Administrator stated the DON was suspended on Monday 02/29/16 for not following the policy for allegations of abuse. He stated he found out on 02/29/16 that the DON did not come into the facility over the weekend. He stated his understanding was the resident had called the police before he was informed of the allegation. The Administrator stated the District Director of Operations came at his request to conduct interviews. He gave no reason why he did not come to the facility when he was alerted to the abuse allegations. The Administrator stated NA #1 was terminated on 03/15/16 for "the pattern of allegations made against him" as there was no definitive hard core proof of guilt.

Review of the investigative notes taken by the Administrator revealed he did not begin interviewing staff, including NA #1, until 03/03/16

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and completed interviews on 03/04/16. Resident #3 refused to be interviewed explaining her family secured an attorney.

The HCPR 5 day investigation report faxed 03/04/16 at 8:58 PM marked that there was no reasonable suspicion of a crime related to resident abuse and the allegation was unsubstantiated at this time and there was an ongoing police investigation.

Interview with the Detective on 03/22/16 at 10:21 AM revealed Resident #4 called the police herself. The Detective stated this was an ongoing investigation, NA #1 had secured legal counsel and the police were hoping to arrange for an interview with NA #1 this week. The Detective stated she preferred the surveyors not interview NA #1 prior to her being able to interview him.

On 03/22/16 at 4:46 PM, the Administrator and the DON were informed of Immediate Jeopardy. The Administration provided an acceptable credible allegation of compliance on 03/24/16 at 6:32 PM.

Brian Center Waynesville respectfully submits the following allegation of compliance for F 225.

1. Nurse #1 notified the Director of Nursing (DON) of an allegation of abuse related to Resident #3 on 02/26/16. On 02/26/16, immediately following the notification from Nurse #1 the Director of Nursing removed Nursing Assistant (NA) #1 from the Resident Care Areas, but NA #1 was allowed to stay in the facility while unsupervised in a non resident care area until his shift concluded. The accused NA did not return to the facility and was terminated on 03/15/16.

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(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
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The Director of Nursing took statements over the phone from Nurse # 1 and NA #1 and Resident #3 on 02/26/16. On 02/27/16 Resident #3 contacted the Police, who came into the Facility, and Resident #3 was transferred to the hospital for medical evaluation. The Director of Nursing called the Administrator on 02/27/16 at approximately 1:30 PM to inform him of Resident #3 ' s allegation. On 02/28/16 Resident #4 called the Police to report an allegation of abuse against NA #1. Resident #4 then notified Nurse #2 of same allegation. Nurse #2 then immediately notified the Director of Nursing on 02/28/16. NA #1 was previously suspended on 02/26/16 and continued to remain out of the facility. The Police came into the Facility on 02/28/16 and Resident #4 declined to go to the hospital for medical evaluation. A 24 Hour Report was submitted on 02/29/16, by the Director Nursing for Resident #3's allegation of abuse and Resident #4's allegation of abuse. The 5 Day Report was submitted for Resident #3 and Resident #4 on 03/4/16 by the Administrator. Nurse #1 was re-educated on 03/22/16 by the Director of Nursing on the Prohibition including the Elder Justice Act to include calling the police for a reasonable suspicion of a crime. Nurse #2's last day worked in facility was 02/28/16 due to her being a no call no show on 02/29/16 and has never returned to facility.

2. Current Residents have the potential to be affected by the same alleged deficient. By 030/3/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to verify no other unreported allegations of abuse occurred. On 03/23/16 the Social Services Director completed an audit of families and responsible parties for

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those resident unable to participate in the prior interviews to verify no other unreported allegations of abuse occurred. On 03/03/16 the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. No new allegations were identified as a result of these interviews. These audits and interviews were completed on 03/23/16.

3. Measures put in place to ensure the alleged deficient practice does not recur include:
On 02/29/2016 the District Director of Clinical Services re-educated the Director of Nursing on the following:
* Prohibition to include timely completion of 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect.

The Director of Nursing was suspended by the Administrator on 02/29/16 pending investigation related to delayed reporting of abuse allegation to the Administrator and timely completion of investigation. The Administrator provided the Director of Nursing with disciplinary action as a final warning and was placed on a Performance Improvement Plan that included leading by example, maintain professionalism and report allegations of abuse/neglect to the appropriate parties in a timely manner, take each allegation in a serious nature and initiate the investigation immediately with follow through with interviewing witnesses and involved persons upon returning to work on 3/8/16.

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The Director of Nursing was terminated on 03/24/16 and replaced with an Interim Director of Nursing who was immediately re-educated by the District Director of Clinical Services regarding Abuse Prohibition to include timely completion of 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect.

On 02/29/16 the District Director of Operations re-educated the Administrator on Abuse Prohibition, the Elder Justice Act, reporting guidelines for the 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, and his responsibilities to coordinate an effective investigation by ensuring timely interviews and assessments, reviewing results and findings, and determining interventions according to opportunities identified during the investigation.

The Administrator was terminated on 03/24/16 and replaced with an Interim Administrator who was immediately re-educated by the District Director of Operations regarding Abuse prohibition, the Elder Justice Act, reporting guidelines for the 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, and her responsibilities to coordinate an effective investigation by ensuring timely interviews and assessments, reviewing results and findings, and determining interventions according to opportunities identified during the investigation.

On 03/23/16 all facility staff including housekeeping, dietary, and therapy were re-educated by the Director of Nursing, Unit Manager, and Area Staff Development Coordinator on Abuse Prohibition, the Elder

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F 225	Continued From page 49 Justice Act to include reporting allegations immediately to the abuse coordinator and calling the police for a reasonable suspicion of a crime. No staff will be allowed to work before receiving this re-education. All new employees will be educated on the facility's Policy for Abuse Prohibition, the Elder Justice Act and their responsibility of calling the police for a reasonable suspicion of a crime. This education will be completed by the Area Human Resource Officer or the Director of Nurse during orientation. On 02/29/16 the Administrator and Director of Nursing implemented a new system to monitor the management of allegations by reviewing all events with the Division Director of Clinical Services daily to ensure adherence to the Abuse Prohibition and Elder Justice Act and conduct a weekly focus call to further review events occurring throughout the week to ensure completion of investigations and reporting as required. Immediate jeopardy was removed on 03/24/16 at 8:12 PM when interviews with nursing staff, administrative staff, non-nursing staff, confirmed they had received in-service training and knew the different types of abuse, the need to report allegations of abuse to the Administrator, the need to compete a 24 hour and 5 day HCPR report within required time frames, and the need to call the police to report suspicion of a crime.	F 225		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		5/4/16

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F 226	Continued From page 50 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 resident interviews, staff interviews, and record reviews the faclity failed to implement their abuse policy in the areas of identification, protection, reporting and responding. The facility failed to supervise the alleged perpetrator until he left the facility, call law enforcement to report suspicion of a crime, failed to immediately assess the residents for injuries, failed to immediately notify the Administrator, and failed to file the 24 hour report to the Health Care Personnel Registry as required. This affected 2 of 4 residents sampled for abuse (Residents #3 and #4). Immediate Jeopardy began on 02/26/16 when Resident #3 told Nurse #1 she had been raped by Nurse Aide (NA) #1 and the Director of Nursing (DON) allowed the perpetrator to remain in the building without supervision for 3 additional hours. Neither Nurse #1 nor the DON informed the Administrator of the abuse allegation, called the police, or sought medical attention for Resident #3. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, neither Nurse #1 nor Nurse #2 called the police or medically assessed Resident #4, and neither nurse or the Director of Nursing (DON) called the Administrator. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out	F 226	F 226 Actions taken for the identified residents: On 2/26/16 the Director of Nursing removed NA#1 from the Resident Care Assignment and suspended pending the investigation. NA #1 did not return to the facility and was terminated on 3/15/16. Resident #3 was transferred to hospital for medical evaluation. Resident #3 received Psych services on 2/29/16 for ongoing emotional support. Nurse #1 was re-educated by the Director of Nursing on the facility's policy for Abuse Prohibition to include removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately and to file a 24-hour report with the Health Care Personnel Registry within 24 hours. Resident #4 declined to go to the hospital for medical evaluation. Resident #4 received Psych Services on 3/9/16 and 3/23/16 for ongoing emotional support. The DON was educated on 2/29/16.	

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F 226	Continued From page 51 of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused and following the abuse policy. The findings included: The facility's Abuse and Neglect Prohibition policy with a revision date of June 2013 included: *The facility administrator is the Abuse Prevention Coordinator. *Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. *Facility supervisors will immediately correct and intervene in reported situations of abuse. *Any employee alleged to be involved in an instance of abuse will be suspended immediately. *The facility will protect residents from harm during the investigation. *The facility will report all allegations of abuse to the state agency in accordance with the state regulation. *In accordance with the Elder Justice Act, the facility will report to law enforcement agencies any reasonable suspicion of a crime against any individual who is a resident of the facility. 1. Resident #3 was admitted to the facility on 12/11/14. Her diagnoses included chronic obstructive pulmonary disease, anxiety disorder, fibromyalgia, manic episode without psychotic symptoms, and major depressive disorder single episode. The annual Minimum Data Set (MDS) dated	F 226	Education on Facility's Prohibition Policy to include: removing alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately, and to file a 24- hour report with the Health Care Personnel Registry within 24 hours. Actions taken for those residents with the potential to be affected: By 3/3/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to determine if any other unreported allegations of abuse occurred. On 3/23/16 the Social Services Director completed an audit of families and responsible parties for those residents unable to participate in the prior interviews to determine if any other unreported allegations of abuse occurred. On 3/3/16 the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to determine if any other unreported allegations of abuse occurred. No new allegations were identified as a result of these interviews. These audits and interviews were completed on 3/23/16. The Residents will be educated by 4/29/16 on Facility's Prohibition Policy to include the definition of abuse and who to report it to.	

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F 226	Continued From page 52 12/11/15 coded her with having intact cognition, scoring a 15 out of 15 on the Brief Interview for Mental Status, which measures long and short term memory and temporal orientation. She was coded as understanding others and being understood with clear speech and no communication problems. She was coded as having no behaviors, no signs of delirium, feeling tired 2-6 days over the previous 2 weeks, and requiring supervision of one person physical assistance for most activities of daily living skills including bed mobility, transfers, walking, toileting and hygiene. She was coded as always being continent of bowel and bladder. Nursing notes dated 02/26/16 at 7:20 PM, written by Nurse #1, revealed Resident #3 asked to speak to this nurse privately. During this conversation, Resident #3 told Nurse #1 that Nurse Aide (NA) #1 "stuck it in" her and her genital area hurt. The nurse noted she asked Resident #3 if she wanted the police called or to be sent out (for evaluation) and the resident stated she only wanted the nurse to call the DON or the Administrator. Nurse #1 wrote that she immediately instructed NA #1 not to go back into Resident #3's room and then went to her office and called the DON. The note stated the DON instructed Nurse #1 to make sure NA #1 did not go back into the room and to have NA #1 call the DON immediately which she did. Review of an incident report dated 02/26/16 revealed at 7:20 PM Resident #3 "made allegations of being sexually assaulted by NA #1. Initially she indicated that she said no (to pain/hurt) and she was just scared. Then she complained of vaginal pain & said he penetrated her." This incident report was completed by	F 226	Current employees were educated on 3/24/16 on Facility's Prohibition Policy to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately and to file a 24- hour report with the Health Care Personnel Registry within 24 hours. Staff will be educated during orientation and annual inservice on Facility's Prohibition Policy to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately, and to file a 24- hour report with the Health Care Personnel Registry within 24 hours. System in place to ensure the alleged deficient practice does not recur: On 2/29/16 the District Director of Clinical Services educated the Director of Nursing on the following: The facility's Policy for Abuse Prohibition to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately and to file a 24- hour report with the Health Care Personnel Registry within 24 hours.	

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F 226	Continued From page 53 Nurse #1. Interview with Nurse #1 on 03/21/16 at 2:35 PM revealed that when she spoke to Resident #3 on 02/26/16, Resident #3 began crying and pointed to her genital area stating it hurt. She stated NA #1 stuck it in her, which Nurse #1 stated referred to his penis. Nurse #1 told NA #1 to not return to Resident #3's room and called the DON from her office. The DON told Nurse #1 she would take care of the issue and instructed the nurse to have NA #1 call her. After talking to the DON, Nurse #1 instructed NA #1 to call the DON and said she did not talk to the DON again that evening. Nurse #1 stated she was not given instructions other than making sure NA #1 did not go back into Resident #3's room. Nurse #1 stated she assigned Resident #3 and her roommate to another nurse aide and did not see NA #1 again. She stated she did not think NA #1 was on the hall but could not guarantee it. She saw him at the end of the shift when he left the facility with his girlfriend NA #2. Nurse #1 stated DON said she would take care of everything and so she did not call the police or address it again during her shift. Nurse #1 stated that she understood her responsibility was to call her supervisor (DON) regarding abuse and the DON was to give instructions and handle the situation. Nurse #1 stated she did not call the police or send her to the hospital because Resident #3 was crying and very upset and adamant she call the DON or Administrator. Neither the DON nor the Administrator came to the facility. Upon follow up interview on 03/22/16 at 3:59 PM, Nurse #1 stated she asked the DON if she should call anyone else when she spoke to her on 02/26/16 and the DON stated no. She stated she	F 226	The Director of Nursing was terminated on 3/24/16 and replaced with an Interim Director of Nursing who was immediately re-educated by the District Director of Clinical Services regarding Abuse Prohibition to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately and to file a 24-hour report with the Health Care Personnel Registry within 24 hours. The Administrator was terminated on 3/24/16 and replaced with an Interim Administrator who was immediately re-educated by the District Director of Operations regarding Abuse Prohibition, to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, and to file a 24- hour report with the Health Care Personnel Registry within 24 hours. On 3/23/16 all facility staff were re-educated by the Director of Nursing, Unit Manager, and Area Staff Development Coordinator regarding the facility's Policy for Abuse Prohibition to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately and to file a 24- hour report with the Health Care Personnel Registry	

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F 226	Continued From page 54 assumed the DON would take the lead in handling the allegation and investigation. Nurse #1 further stated she did not reassign the rest of NA #1's residents because she was not aware of what the DON told NA #1 and she did not talk to the DON after the initial phone call. The DON gave no instructions for a physical assessment of Resident #3, to call the police or the Administrator so Nurse #1 just held and comforted Resident #3. Nurse #1 kept saying she thought the DON was handling the situation. Nursing notes dated 02/27/16 at 1:30 PM written by Nurse #2 revealed Resident #3 stated a nurse aide (not identified in the note) helped her to the bathroom, pushed her against the wall and put his penis in her vagina. She stated that she then moved away and the nurse aide kissed her forcefully. The police were called and Resident #3 was sent to the hospital for a rape kit and exam. Review of the hospital records revealed Resident #3 was seen in the emergency room on 02/27/16 at 3:13 PM for reported sexual assault and assault by bodily force. Laboratory tests were drawn and post exposure prophylaxis were ordered. A phone interview was conducted with Nurse #2 on 03/21/16 at 3:21 PM. Nurse #2 stated she arrived for work on 02/27/16 and Resident #3 asked who her nurse aide was for the day, around 10:00 AM. When told NA #1 was scheduled, Resident #3 started crying. Nurse #2 stated she was unaware of the allegations Resident #3 made to Nurse #1 the previous day. When asked what was wrong, Nurse #2 stated Resident #3 told her that 2 days prior, NA #1	F 226	within 24 hours. All new employees will be educated on the facility's Policy for Abuse Prohibition to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately and to file a 24- hour report with the Health Care Personnel Registry within 24 hours. This education will be completed by the Area Human Resource Officer or the Director of Nursing during orientation. By 4/29/16 all residents and /or families were educated by the Social Worker, Area Staff Development Nurse and Unit Manager on the definition of abuse, their right to be free from abuse, and to report abuse immediately to the Administrator, Director of Nursing or the Charge Nurse. All new residents and/or Responsible Party will be education by Social Worker within 72 hours of admission on the facility's Abuse Prohibition Policy to include: the definition of abuse, their right to be free from abuse, and to report abuse immediately to the Administrator, Director of Nursing or the Charge Nurse. The Administrator and Director of Nursing will audit all allegations of abuse to include: removing the alleged person from resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident	

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F 226	Continued From page 55 asked if she needed to go to the bathroom and she walked independently to the bathroom. Resident #3 stated he followed her into the bathroom, closed the door, locked the door, pushed her against the wall, over the toilet where she grabbed the grab bar and he put his penis between her legs, moved around a bit and then actually penetrated her. Nurse #2 stated Resident #3 told her NA #1 had kissed her about 15 times previously and recently bought her perfume. Nurse #2 called the DON about the allegation. The DON stated she would handle it. Then Nurse #2 told the DON that Resident #3 was told to call the police (Nurse #2 stated she told Resident #3 to call the police). Nurse #2 stated the DON told her they needed to keep everyone out of the issue and when Nurse #2 told the DON that she was not ok with that, the DON agreed for the police to be called. Once the police arrived, the officer and Nurse #2 agreed it was appropriate to send Resident #3 to the hospital. Nurse #2 stated neither the DON or the Administrator came to the facility over the weekend. During an interview with Resident #3 on 03/21/16 at 9:53 AM, Resident #3 stated that she was "raped" by NA #1. She stated she was lying in bed when NA #1 suggested she go to the bathroom before her roommate returned from a smoke break. NA #1 followed Resident #3 into the bathroom, locked the door, and placed the tip of his penis in her vagina. Resident #3 stated she returned to bed and did not tell anyone until the next day when she told a nurse. Resident #3 cried during this interview. Follow up interview with Resident #3 on 03/23/16 at 9:15 AM, revealed in the past, NA #1 had kissed her and touched her breast. She stated	F 226	for injuries, to notify the Administrator immediately, and to file a 24- hour report with the Health Care Personnel Registry within 24 hours, to ensure ongoing compliance and audit results will be reported monthly to QAPI for review. A weekly focus call is conducted thru 5/27/16 to further review events occurring throughout the week to ensure completion of investigations and reporting as required. Quality Measures in place to ensure the practice is sustained: The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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F 226	Continued From page 56	F 226		

she liked his friendliness and so never reported the incidents. She stated NA #1 bought her perfume which she really liked. She stated she did not report the sexual assault because she was afraid he would not buy her more perfume which she really liked. Crying, Resident #3 stated she had to make a decision about getting perfume and being raped and she decided she did not want to be raped again so she reported it.

Review of the Health Care Personnel Registry (HCPR) 24 hour report revealed it was completed by the DON who signed it on 02/27/16. The report noted there was a reasonable suspicion of a crime for resident abuse as Resident #3 alleged NA #1 put his penis in her vagina. The report noted the police were called and she was taken to the emergency room. This form was noted to be faxed to the HCPR on 02/29/16 at 9:43 AM.

Interview with the DON on 03/21/16 at 12:03 PM revealed NA #1 was suspended at 8:04 PM on 02/26/16 but he had no ride home so he stayed in the residents' television room until 11:00 PM. She presented his time clock report for 02/17/16 which showed he clocked out for supper at 8:04 PM, clocked back in at 8:32 PM and out again at 11:06 PM.

Notes taken by the DON, presented by the Administrator, revealed:
*on 02/26/16 at 8:00 PM, Nurse #1 called her and told her NA #1 had raped Resident #3. The DON spoke to Resident #3 on the phone, she was crying and upset, and told the DON NA #1 bent her over the toilet and put his penis in her. DON told her she would call the police and Resident #3 stated no.
*on 02/26/16 at 8:20 PM, the DON spoke to NA

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#1 on the phone and told him he was suspended due to a pending investigation of an allegation of sexual assault which he denied. When told to leave the facility, NA #1 stated he did not have a ride and needed to wait for his friend so the DON told him to go to the television room and wait and do not enter any resident room.
*on 02/26/16 at 8:30 PM, the DON wrote she called Resident #3 again and she still did not want the police called and asked if the DON would take care of it.
*(still noted as 02/26/16) at 2:45 PM, the DON called the Administrator to inform him Resident #3 wanted the police called because she was raped by NA #1 on 02/25/16. Per this note, Resident #3 called the police.
*(still noted as 02/26/16) at 2:50 PM the Detective came to the facility and took Resident #3's statement. She had emergency medical services (EMS) coming to the facility to transport the resident to the hospital for evaluation and rape test. DON noted she agreed Resident #3 needed to go.

Follow up interview with the DON on 03/22/16 at 9:26 AM revealed she told Nurse #1 to call the police when she was informed of the allegation of rape on 02/26/16 but Resident #3 did not want the police called. She spoke to NA #1 on the phone on 02/26/16 and told him he was suspended and told to wait in the television room when informed he did not have a ride home. She did not recall telling him to clock out and did not instruct anyone to make sure he was supervised as he waited for his ride. She stated she did not come into the facility at all during the weekend. On Saturday (2/27/16) Nurse #2 called her to report Resident #3 called the police and they were on their way. The DON spoke to the

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Detective on the phone who informed the DON they were going to transport Resident #3 to the hospital for a rape kit. The DON called the Administrator on 02/27/16. The DON stated she started the HCPR 24 hour report after being informed of the resident going to the hospital, but had trouble getting the fax to go through until she arrived at the facility Monday morning. The DON stated she had no reason for not calling the police, stated she handled the situation wrong and on Monday 02/29/16 she was suspended for 5 days and did not have anything more to do with the investigation.

The Administrator was interviewed on 03/22/16 at 2:57 PM. The Administrator stated he was informed by the DON in the afternoon (02/27/16) that Resident #3 accused NA #1 of sexually assaulting her, that the DON suspended NA #1, the police came to the facility and arranged for a forensic examination. At the time of the call, Resident #1 was at the hospital and he was told she was ok and cooperating with the police. The Administrator stated he did not come to the facility as the police were involved and the DON stated she had completed the HCPR 24 hour report. The Administrator stated he was not aware Resident #3 made the initial allegation on Friday night (02/26/16) and the actual abuse occurred on Thursday (02/25/16) until he arrived at work Monday 02/29/16. The Administrator further stated that he should have been called 02/26/16 and the interviews started immediately but that everyone was interviewed, NA #1 was not in the facility, and the police had been called(he suspected by Resident #3). He stated he found out on 02/29/16 that the DON did not come into the facility over the weekend. He stated the DON should have called the police. He stated he was

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unaware if the physician or family were notified and unaware if a physical assessment had been done prior to the hospital visit. In addition, the Administrator stated that NA #1's second language was English and he did not understand he was suspend until the next day. NA #1 was just told to sit in the television room on 02/26/16. The Administrator stated the DON should have called a cab to remove NA #1 from the premises. He gave no reason why he did not come to the facility when he was alerted to the abuse allegations. The Administrator stated NA #1 was terminated on 03/15/16 for "the pattern of allegations made against him" as there was no definitive hard core proof of guilt.

Review of the investigative notes taken by the Administrator revealed he did not begin interviewing staff, including NA #1, or Resident #3, until 03/03/16 and completed interviews on 03/04/16. The HCPR 5 day investigation report faxed 03/04/16 at 8:54 PM marked that the allegation was unsubstantiated at this time and there was an ongoing police investigation.

Interview with the Detective on 03/22/16 at 10:21 AM revealed this was an ongoing investigation, NA #1 had secured legal counsel and the police were hoping to arrange for an interview with NA #1 this week. The Detective stated it could be months before the results of the rape kit collected at the hospital would be available. The Detective stated she preferred the surveyors not interview NA #1 prior to her being able to interview him.

NA #1 was not interviewed.

2. Resident #4 was admitted to the facility on 03/24/15. Her diagnoses included cerebral infarct

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without residual deficits, acute respiratory failure, chronic obstructive pulmonary disease, and anxiety disorder.

The quarterly Minimum Data Set (MDS) dated 11/18/15 coded her with intact cognition and being understood and understanding with no communication issues. She was coded as requiring supervision of one staff for most activities of daily living skills (ADL) including bed mobility, toileting and hygiene, and being continent of bowel and bladder. She was coded as feeling bad about herself 2-6 days over the last 2 weeks, having no behaviors and no signs of delirium.

The annual MDS dated 02/12/16 coded her with intact cognition, having no behaviors, no communication problems, no signs of delirium, feeling bad about herself 2- 6 days over the last 2 weeks, and requiring set up or limited assistance with ADLs.

A phone interview with Nurse #2 was conducted on 03/21/16 at 3:43 PM. Nurse #2 stated on 02/28/16 she was asked by Resident #8 to talk with Resident #4. Nurse #2 stated Resident #4 felt comfortable talking since Resident #3 had come forward with allegations of abuse. Resident #4 stated NA #1 had been kissing her while she slept. It occurred multiple times. Then the resident stated about 2-3 weeks ago, NA #1 was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported he had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 then stated after talking to the Director of Nursing via phone, Nurse #2 told Resident #4 call the police.

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Nurse #2 stated that because the incident happened a couple of weeks prior to the report, there was no need to send her to the hospital as evidence would be gone. Nurse #2 called the physican who agreed not to send her to the hospital for an exam.

There were no nursing notes written by Nurse #2 about the allegations made by Resident #4.

Nursing notes dated 02/28/16 at 11:00 AM, written by Nurse #1 revealed she received a call from Nurse #2 who reported that Resident #4 had made an allegation that Nurse Aide (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 this had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then 3 to 4 days later she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom, NA #1 returned and as she turned to get into the wheelchair, he put his hand on her back where she was over the chair, her pants had not been pulled up yet, he pulled his pants down but could not get his penis in her vagina so he ejaculated between her inner thighs.

Inteview with Nurse #1 on 03/21/16 at 2:38 PM revealed she received a call from Nurse #2 on 02/28/16 at 11:00 AM who stated Resident #4 claimed she was assaulted by NA #1. Nurse #2 stated she told Nurse #2 to complete an incident report and concern form. Nurse #1 stated she went to the facility and got a statement from Resident #4 and then the police arrived. Nurse #1 stated she never spoke to the DON on 02/28/16 and the DON did not come to the

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facility.

There was no incident report or concern form completed related to Resident #4's allegation of sexual assault.

An interview with Resident #4 was conducted on 03/21/16 at 10:19 AM. Resident #4 stated she was assaulted by NA #1 3 times. The first time she was sound asleep and woke to his tongue being in her mouth. Crying, she referred to this incident as a "violation" that took place a month ago. The second time, she was in the bathroom, had gotten up, pulled her pants up, he grabbed hold of her, pulled her to him and started gyrating against her. The third time she was in the bathroom, had not pulled her pants up yet and he came into the bathroom pushed her forward and bent her over and ran his hands between her legs and tried to put his penis inside her. She stated his penis was too floppy to penetrate her so he finished by putting his penis between her thighs and ejaculated. He then brought her wash cloths with soap and water and instructed her to clean up.

Follow up interview with Resident #4 on 03/23/16 at 8:24 AM revealed she did not tell anyone for fear and that it happened often. She stated she finally felt comfortable when she told Resident #8 about what NA #1 did to her and Resident #8 told her either Resident #4 had to tell someone about it or he would tell someone about NA #1.

Review of the Health Care Personnel Registry (HCPR) 24 hour report signed and faxed by the DON on 02/29/16 marked there was no reasonable suspicion of a crime. The allegation noted that the incident was a long time ago and

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described the allegation was that NA #1 came into the bathroom and ejaculated between Resident #4's legs. The allegation on this report also stated another time she was sleeping and he kissed her with his tongue in her mouth. She did not report these incidents to anyone until 02/28/16.

The DON was interviewed on 03/21/16 at 12:03 PM who stated NA #1 had been suspended on 02/26/16 for a previous allegation of sexual assault made by Resident #3.

Follow up interview with the DON on 03/22/16 at 9:45 AM revealed on Sunday (02/28/16), Nurse #2 called her and informed her that Resident #4 had called the police because NA #1 "got her also." The DON stated she talked to Resident #4 via phone who stated it happened a long time ago. When asked why she waited to report it, Resident #4 stated she just didn't want to. The DON stated the resident asked her if she (Resident #4) should not have called the police but the DON said she told the resident it was ok to call the police. Resident #4 refused to go to the hospital. The DON stated that if the resident who was her own responsible party wanted the family to be called the nurse should call the family. The DON did not come to the facility and stated the police had already been called, NA #1 had been suspended and the resident did not want to go to the hospital. The DON stated she talked with the Administrator via phone on 02/28/16. She stated neither she nor the Administrator came in on Sunday.

The Administrator provided notes written by the DON relating to what she did once she received the allegation about Resident #4:

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*on 02/28/16 at about 11:00 AM, the DON received a phone call from Nurse #2 who informed her that Resident #4 was accusing NA #1 of raping her too. This occurred a long time ago and that the resident called the police. Per the notes, the DON spoke to Resident #4 on the phone and was told NA #1 ejaculated between her legs while she was in the bathroom. Resident #4 told her about another time waking up with NA #1's tongue in her mouth. The DON told Resident #4 it was ok that she called the police and that the resident would probably go to the hospital. Resident #4 declined to go to the hospital. The DON called and texted the Administrator. When he returned her call, the Administrator instructed the DON to call the District Director of Operations. She noted the District Director of Operation told her to call the corporate attorney, who she spoke with twice. The DON then called other corporate staff and the physician per these notes.

Another interview with the DON on 03/22/16 at 3:46 PM revealed she was suspended on Monday 02/29/16 and had no more involvement in the investigation. She stated the nurse should have completed a body assessment but she had not looked at the record to see if an assessment was completed. She further stated she felt the resident was safe since NA #1 was already suspended.

The Administrator was interviewed on 03/22/16 at 2:57 PM. The Administrator stated the DON was suspended on Monday 02/29/16 for not following the policy for allegations of abuse. He stated he found out on 02/29/16 that the DON did not come into the facility over the weekend. He stated his understanding was the resident had called the

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police before he was informed of the allegation. He stated he was unaware if the physician or family were notified and unaware if a physical assessment had been done. The Administrator stated the District Director of Operations came at his request to conduct interviews. He gave no reason why he did not come to the facility when he was alerted to the abuse allegations. The Administrator stated NA #1 was terminated on 03/15/16 for "the pattern of allegations made against him" as there was no definitive hard core proof of guilt.

Review of the investigative notes taken by the Administrator revealed he did not begin interviewing staff, including NA #1, until 03/03/16 and completed interviews on 03/04/16. Resident #3 refused to be interviewed explaining her family secured an attorney.

The HCPR 5 day investigation report faxed 03/04/16 at 8:58 PM marked that there was no reasonable suspicion of a crime related to resident abuse and the allegation was unsubstantiated at this time and there was an ongoing police investigation.

Interview with the Detective on 03/22/16 at 10:21 AM revealed Resident #4 called the police herself. The Detective stated this was an ongoing investigation, NA #1 had secured legal counsel and the police were hoping to arrange for an interview with NA #1 this week. The Detective stated she preferred the surveyors not interview NA #1 prior to her being able to interview him.

NA #1 was not interviewed.

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On 03/22/16 at 4:46 PM, the Administrator and the DON were informed of Immediate Jeopardy. The Administration provided an acceptable credible allegation of compliance on 03/24/16 at 6:32 PM.

Brian Center Waynesville respectfully submits the following allegation of compliance for F 226.

1. Nurse #1 notified the DON of an allegation of abuse related to Resident #3 on 02/26/16. Resident #3 alleged that NA#1 raped her in the shower on Thursday 02/25/2016. On 02/26/16, immediately following the notification from Nurse #1 the Director of Nursing removed NA #1 from the Resident Care Areas. The accused did not return to the facility and was terminated on 03/15/2016. The Director of Nursing took statements over the phone from Nurse # 1 and NA #1 and Resident #3 on 02/26/16. On 02/27/16 Resident #3 contacted the Police, who came into the Facility, and Resident #3 was transferred to the hospital for medical evaluation. Resident #3 received STD testing and prophylactic treatment with Truvada and Raltegravir for 30 days. Resident #3 received Psych services on 02/29/16 for ongoing emotional support. The Director of Nursing called the Administrator on 02/27/16 at approximately 1:30 PM to inform him of Resident #3's allegation. A 24 hour report for Resident #3 was submitted by the Director of Nursing on 02/29/16 and the 5 Day report was submitted by the Administrator on 03/04/16. Nurse #1 was re-educated by the Director of Nursing on the Facility's Policy for Abuse Prohibition including the Elder Justice Act.

2. On 02/28/16 Resident #4 called the Police to

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report an allegation of abuse. Resident #4 then notified Nurse #2 of same allegation. Resident #4 alleged that NA #1 came into the bathroom and sexually abused her and was unable to remember the date or time. Nurse #2 then immediately notified the Director of Nursing on 02/28/16. NA#1 was previously suspended on 2/26/16 and continued to remain out of the facility. The Police came into the Facility and Resident #4 declined to go to the hospital for medical evaluation and STD testing. Resident #4 received Psych Services on 03/9/16 and 03/23/16 for ongoing emotional support. A 24 Hour Report was submitted on 02/29/16, by the Director Nursing for Resident #4's allegation of abuse. The 5 Day Report was submitted for Resident #4 on 03/04/16 by the Administrator. Nurse #1 was re-educated on 03/22/16 by the Director of Nursing on the Facility's Policy for Abuse Prohibition including the Elder Justice Act. Nurse # 2 last day worked in facility was 02/28/16.

3. Current Residents have the potential to be affected by the same alleged deficient. By 03/03/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to verify no other unreported allegations of abuse occurred. On 03/23/16 the Social Services Director completed an audit of families and responsible parties for those resident unable to participate in the prior interviews to verify no other unreported allegations of abuse occurred. On 03/03/16 the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. No new allegations were identified as a result of these

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interviews. These audits and interviews were completed on 03/23/16. The Facility's Abuse Prohibition Policy was reviewed the District Director of Operations, the District Director of Clinical Services, the Director of Nursing and the Administrator and all required components related to F 226 were present.

4. Measures put in place to ensure the alleged deficient practice does not recur include:
On 02/29/16 the District Director of Clinical Services re-educated the Director of Nursing on the following:
*The Facility's Policy for Abuse Prohibition to include timely completion of 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect.

The Director of Nursing was suspended by the Administrator on 02/29/16 pending investigation related to delayed reporting of abuse allegation to the Administrator and timely completion of investigation. The Administrator provided the Director of Nursing with disciplinary action as a final warning and was placed on a Performance Improvement Plan that included reporting allegations of abuse/neglect to the appropriate parties in a timely manner and initiate the investigation immediately upon returning to work on 03/08/2016.

The Director of Nursing was terminated on 03/24/16 and replaced with an Interim Director of Nursing who was immediately re-educated by the District Director of Clinical Services regarding Abuse Prohibition to include timely completion of 24 Hour and 5 Day Reports to the NC Health

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Care Personnel Registry ,the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect.

On 02/29/16 the District Director of Operations re-educated the Administrator on the Facility's Policy for Abuse Prohibition , the Elder Justice Act, reporting guidelines for the 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, and his responsibilities to coordinate an effective investigation by ensuring timely interviews and assessments, reviewing results and findings, and determining interventions according to opportunities identified during the investigation.

The Administrator was terminated on 03/24/16 and replaced with an Interim Administrator who was immediately re-educated by the District Director of Operations regarding Abuse prohibition, the Elder Justice Act, reporting guidelines for the 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, and her responsibilities to coordinate an effective investigation by ensuring timely interviews and assessments, reviewing results and findings, and determining interventions according to opportunities identified during the investigation.

On 03/23/16 All facility staff, the Nursing Department including Resident Care Specialists (CNAs), Business Office Staff, Housekeeping, Dietary and Therapy were re-educated by the Director of Nursing, Unit Manager, and Area Staff Development Coordinator regarding the definition of Abuse meaning the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. Injuries of unknown origin may occur as

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a result of abuse. Education also included Abuse Prohibition and the Elder Justice Act. Education included maintaining a professional relationship with residents and families and the Resident's Right to live in the facility free from abuse and neglect. The facility will not tolerate abuse and will follow the policy for Abuse Prohibition to investigate all allegations of abuse or neglect thoroughly.

The Facility performs background checks and drug screens, reviews license and certifications and obtains references on all new employees by Area Human Resource Officer and or the Director of Nursing prior to orientation.

All new employees will be educated on the facility's Policy for Abuse Prohibition, the Elder Justice Act and their responsibility of calling the police for a reasonable suspicion of a crime. This education will be completed by the Area Human Resource Officer or the Director of Nurse during orientation.

On 02/29/16 the Administrator and Director of Nursing implemented a new system to monitor the management of allegations by reviewing all events with the Division Director of Clinical Services daily to ensure adherence to the Facility Policy on Abuse Prohibition and conduct a weekly focus call to further review events occurring throughout the week to ensure completion of investigations and reporting as required.

On 03/24/16 all residents and or families have been educated by the Social Worker, Area Staff Development Nurse and Unit Manager on the definition of abuse, their right to be free from

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F 226	Continued From page 71 abuse, and to report abuse immediately to the Administrator, Director of Nursing or the Charge Nurse. Immediate jeopardy was removed on 03/24/16 at 8:12 PM when interviews with residents revealed they were aware and felt comfortable reporting abuse incidents immediately. Nursing staff, administrative staff, non-nursing staff, and residents confirmed they had received in-service training and knew the different types of abuse, the need to report allegations of abuse to the Administrator and/or DON, the need to compete a 24 hour and 5 day HCPR report within required time frames, the need to call the police to report suspicion of a crime, the need to evaluate the resident and obtain appropriate medical interventions for the affected residents.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to obtain physician's orders for wound care treatment for Resident #1 and failed to obtain laboratory tests that were ordered for Resident #7. This deficient practice affected 2 of 5 sampled residents reviewed (Residents #1 and #7). The findings included: 1. Resident #1 was admitted to the facility on	F 281	F 281: Actions taken for the identified residents: Resident #1 was discharged from facility on 3/11/2016 and Resident #7 was discharged from facility on 3/25/2016 Actions taken for residents that have the potential to be affected: The Director of Nursing and Unit Manager	5/4/16

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F 281	Continued From page 72 02/10/16 with diagnoses including cellulitis, diabetes mellitus type 2 with circulatory complications, cerebrovascular accident and peripheral vascular disease. An admission Minimum Data Set (MDS) dated 02/17/16 indicated Resident #1 was cognitively impaired for daily decision making. The MDS indicated Resident #1 required extensive assistance with all activities of daily living. The MDS also indicated Resident #1 had a diabetic foot ulcer and surgical wound for which she received surgical wound care and application of dressings to feet. A care plan dated 02/17/16 addressed Resident #1's cellulitis, skin impairment and surgical wounds. Interventions included treatments as ordered by physician and assess skin weekly. Review of the nurses notes revealed entries dated 03/05/16, 03/08/16 and 03/11/16 of dressing changes to foot and sacral wounds. Review of an undated treatment record revealed the following entry: "Right foot incision and sutures - Cleanse wound with cleanser daily. Cover with Mepilex silver grey foam dressing, cut to fit then cover with 4 X 4 gauze. Wrap with Kerlix. Must be done DAILY." Documentation on the treatment record indicated the treatment was done days 1 through 11. Further review of Resident #1's medical record revealed no physician's orders for surgical wound care or treatments for the diabetic foot ulcer or excoriated sacrum. An interview with Nurse #4 on 03/24/16 at 11:00 AM about physician's orders for treatments	F 281	completed an audit 4/14/16 of residents with wounds to ensure treatment orders are in place. The MD was notified and orders were received on the residents being identified as not having wound treatment orders. On 4/15/16, the Director of Nursing/Unit Managers completed an audit of physician orders for labs to ensure all labs were obtained as ordered. The MD was notified for residents identified as being affected and orders were received to re-obtain labs or the labs were discontinued. No adverse outcome was noted to the residents identified as having been affected. System in place to ensure the alleged deficient practice does not recur include: The Director of Nursing and Unit Managers will educate licensed nurses by 4/20/16 regarding obtaining physician orders for treatments and following physicians orders related to the lab process. Once the order is received, the nurse is to log the lab into the lab book, and fill out the lab requisition. The Unit Managers/Nurses are to track, per the lab book, when the lab results are obtained to ensure follow through has been completed with the MD. Unit Managers will audit residents with wounds to ensure appropriate MD orders in place and lab orders to ensure labs obtained as ordered. These audits will be performed 5 times per week for 4 weeks and the 3 times a week for 2 months to ensure compliance. Results will be	

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F 281	Continued From page 73 revealed there should be a physician's order for any dressings or treatments applied to resident. When asked about the treatment orders for Resident #1 not being on the closed medical record, he stated the facility had a problem with a lot of missing documentation. When asked about the undated treatment record, Nurse #4 stated he thought it was the record for March 2016 because of the dates the treatments were initialed as done. An interview with the Director of Nursing on 03/24/16 at 12:00 PM about Resident #1 not having physician's orders for surgical wound care or treatments for the foot and sacral wounds revealed her expectation was for nurses to obtain a physician's order for any treatment or dressing change provided for the resident. 2. Resident #7 was admitted to the facility on 02/08/16 with diagnoses including diabetes mellitus type 1, coronary artery disease, hyperlipidemia and chronic obstructive pulmonary disease and end stage renal disease. Review of Resident #1's physician's orders revealed the following: a) an order dated 02/11/16 read: "Clarification standing Lab orders: hemoglobin (Hgb) A1c, lipid panel, aspartate aminotransferase (AST), alanine aminotransferase (ALT) every 3 months in February, May, August and November per admission orders." AST and ALT are enzymes found primarily in the heart and liver. Elevated blood levels often indicate heart or liver damage. b) an order was received on 02/12/16 for hemoglobin and hematocrit in morning (02/13/16).	F 281	reported to the monthly QAPI meeting for review. Quality Measures in place to ensure the practice is sustained: The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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Review of Resident #1's medical record revealed no results on the chart for the Hgb A1c, lipid panel, AST or ALT that were ordered on 02/11/16. There were also no results on the chart for the hemoglobin and hematocrit that were ordered on 02/12/16.

An interview on 03/24/16 with Nurse #4 about the process used for transcribing orders for lab tests revealed the nurse who received the order was responsible for completing a lab requisition, listing it in the lab book for the date the lab was to be drawn and putting a note on the calendar for the wing of the facility where the resident resided. Nurse #4 was asked who was responsible for following up to ensure that labs were obtained as ordered. He stated the Unit Coordinator (UC) was responsible for following up on lab orders but she quit about a week ago. Nurse #4 looked at Resident #1's medical record and stated the former UC transcribed the order for labs that was written on 02/11/16.

An interview on 03/24/16 at 1:00 PM with the Director of Nursing (DON) about the process for transcribing orders for labs revealed the nurse was responsible for writing the order on the lab book and should fill out a lab requisition. When asked about her expectation for obtaining lab tests that were ordered for a resident, the DON stated the labs should be obtained on the date the physician ordered for them to be obtained. The DON stated the former Unit Coordinator was not following up on labs the way she should have but she was unaware there was a problem until after the Unit Coordinator quit.

An interview on 03/24/16 at 2:04 PM with the Administrator revealed he expected lab tests

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F 281	Continued From page 75 ordered by the physician to be done. An interview on 03/24/16 at 4:34 PM with the Medical Records Director revealed she did not have any unfiled lab results for Resident #1 and she had called the facility's lab provider and verified they had not obtained the Hgb A1c, lipid panel, AST or ALT that were ordered on 02/11/16 and also had not obtained the hemoglobin and hematocrit that were ordered on 02/12/16.	F 281		
F 323 SS=G	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 record review and staff interviews, the facility failed to evaluate and analyze the circumstances and/or trends of falls and modify interventions to reduce the risk of falls and/or injuries. This affected 1 of 3 residents sampled for falls who fell multiple times resulting in a fractured shoulder (Resident #9). The findings included: Resident #9 was admitted to the facility on 07/12/13. Her diagnoses included delusional disorders, dementia, osteoporosis, benign neoplasm of meninges and anxiety disorder.	F 323	F323 Actions taken for the identified resident: Resident #9 is no longer a resident at the facility. Actions taken for those residents with the potential to be affected: The Director of Nursing and Unit Managers will evaluate and analyze all residents who had falls for a root cause and analysis in the last 30 days. Director	5/4/16

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F 323	Continued From page 76 A plan of care was originally developed on 07/10/15 which identified the problem that Resident #9 was at risk for falls related to mental status and the use of sedatives/hypnotics. The goal was for Resident #9 to "have a reduction in potential for falls and injury." This generic plan of care had check marks by the following pre-printed interventions: *Falling Star Program *Encourage resident to ask for assist *Ensure that resident has proper footwear as indicated and accepted *Interdisciplinary referral to physical therapy, occupational therapy, restorative nursing and social services *orient resident to room/environment *place call light within reach *offer/assist to toilet frequently and as accepted *observe for potential medication causes. The Care Area Assessment (CAA) dated 07/16/15 relating to falls stated Resident #9 was a long term resident with advanced dementia. She was described as ambulating around the facility independently, having an unsteady gait at times, needing to be reminded to walk close to the handrails for support. The last fall per this CAA occurred on 06/23/15 during which she was not injured. An interview with the Director of Nursing (DON) was conducted on 03/24/16 at 12:18 PM to review Resident #9's falls. She explained that after each fall the Interdisciplinary Team (IDT) committee met and discussed the falls and circumstances known to determine if care plan interventions needed to be added or changed. The DON stated the falling star program listed on	F 323	of Nursing and Unit Managers will review all recommendations to ensure that interventions were implemented to reduce the risk of falls and/or injury. The audit will be completed by 5/1/16. Systems in place to ensure the alleged deficient practice does not recur: Director of Nursing/Unit Managers educated nurses by 4/20/16, regarding determining the root cause of the fall and implementing interventions to prevent the fall from reoccurring. Audits will be performed 5 times per week for 4 weeks and then 3 times a week for 2 months to ensure compliance and results will be reported to the monthly QAPI for review. Quality measures in place to ensure the practice is sustained: The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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Resident #9's care plan just identified the resident as a fall risk and indicated to staff that they should keep an eye on her.

Resident #9 had recurring falls as follows:

On 12/25/15 at 7:35 PM, an incident report noted Resident #9 was found on the floor by the side of the bed. She sustained a skin tear to her left hand between her thumb and index finger. The Situation, Background, Assessment, Recommendation (SBAR)/progress note dated 12/15/15 stated she was continually more confused and agitated and needed more assistance with activity of daily living skills. The SBAR stated she had small emesis. The (IDT) post fall review for the unwitnessed fall on 12/25/15 stated that staff were instructed to increase visual checks due to resident's severe dementia and that the resident would not leave the bedroom door open. The intervention recommendations included a check for care plan revision and for "other" with a note for staff education. The care plan noted 12/25/15 to increase visual checks.

The DON stated during interview on 03/24/16 at 12:18 PM that the intervention to check more often was that staff would check more frequently and try to keep her door open. She stated there was no set time or frequency to check on her and she could not describe what "frequently" meant. She further stated that if staff noticed her walking and she appeared tired, they would encourage to sit and rest. She stated the unit manager would pass the information to the staff from the IDT meeting and update the care plan to check on her more frequently.

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On 12/30/15 at 7:25 PM, an incident report noted Resident #9 was found on the floor vomiting beside the bed. The SBAR/progress note contained no additional note other than nursing thought the problem may be dizziness from vomiting. The IDT post fall review of this unwitnessed fall stated staff were instructed to attempt to leave the bedroom door open and increase visual checks. The intervention recommendations included a check for care plan revision and for "other" with a note for staff education. The care plan noted 12/30/15 to continue approach and encourage the resident to leave the door open and continue to increase visual checks.

The DON stated during interview on 03/24/16 at 12:18 PM that staff were instructed to try to keep the bedroom door open to increase visual checks since both Resident #9 and the roommate often closed the door.

The quarterly Minimum Data Set dated 01/01/16 coded her as being severely cognitively impaired, having wandering behaviors, being unsteady but able to stabilize herself, requiring supervision for most activities of daily living skills, including ambulation, being occasionally incontinent of bladder and having 1 fall with a non-major injury since the previous assessment. She received antidepressant and antianxiety medications daily. There were no new care plan interventions relative to falls at this review.

Resident #9 continued to fall as follows:

On 01/02/16 at 2:00 PM, an incident report noted Resident #9 was found lying in another resident's room. She complained about right elbow, right

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hip and nasal pain. A bruise on the right elbow was noted on the form. The SBAR/progress note stated she complained of nausea post fall and the nurse thought the problem may be confusion and agitation. Physician orders were obtained on 01/02/16 for Xrays of the right hip, right pelvis, right elbow and nasal bones. Results dated 01/02/16 revealed elbow, hip and pelvis were negative and the resident was uncooperative for Xrays of the nasal bones. The IDT post fall review for this unwitnessed fall stated staff were to continue visual checks. The intervention recommendations included a check for care plan revision and for "other" with a note for staff education. The care plan was only updated with the date of the fall.

The DON stated during interview on 03/24/16 at 12:18 PM that she could not say how often staff were expected to visually check on Resident #9. The DON stated because she was ambulatory there was nothing staff could do to try to prevent her from falling. She further stated that during the IDT meetings, the team did not discuss any time frames for visually checking on Resident #9 and identified no trends involved with her falling as she fell at all different times.

On 01/18/16 at 10:00 AM a physician note indicated Resident #9 was seen for increased anxiety. Trazodone (an antidepressant medication) 25 milligrams (mg) was added as needed every 6 hours for anxiety.

On 01/31/16 at 9:00 PM, an incident report noted Resident #9 was found lying on the floor in the bathroom between the toilet and the wall. She stated her right elbow hurt but there was no obvious redness, bruising or edema. The

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SBAR/progress note stated the resident was falling more frequently and that physical therapy (PT) eval and treatment should be considered. The IDT post fall review for this unwitnessed fall stated staff were advised to remove socks before bed. Also the resident has had frequent falls and physician was aware and a request for a PT eval was made. The intervention recommendations included a check for care plan revision and for "other" with a note for staff education. The care plan noted 01/02/16 continue approach, increase visual checks. The care plan was updated with a request for physician to eval for PT for frequent falls on 01/31/16. There was nothing added to the care plan regarding socks.

The DON stated during interview on 03/24/16 at 12:18 PM that she could not recall what the significance of having staff remove her socks at night entailed, as there was nothing related to socks in the incident report. The DON stated Resident #9 normally wore shoes and socks when up and dressed. The DON stated they analyzed and talked in IDT committee about what staff could do to keep the resident safe.

On 02/04/16 Resident #9 was seen by the nurse practitioner (NP) due to an increase in falls. The physician note stated there was no clear reason for her frequent falls. The NP's plan was to hold Procardia (a hypertension medication)due to low blood pressure, have PT/occupational therapy (OT) evaluate, and obtain a CT scan to evaluate a brain mass which had not been checked since 2009.

PT began working with the resident on 02/09/16 for therapeutic exercises, neuromuscular re-education, and gait training.

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On 03/02/16 at 3:00 AM, an incident report revealed Resident #9 was found on the floor in her room. She hit her head on the floor and sustained 2 small bumps on the back of her head. Neurochecks were initiated. The IDT post fall review for this unwitnessed fall stated the resident was severely cognitively impaired. Her short term memory was absent. The resident could not remember to ask for assistance or ring the call light. Resident #9 was on frequent visual checks and staff was attempting to leave the door open by repeatedly reminding her to not close her door. The intervention recommendations included a check for care plan revision.

The DON stated during interview on 03/24/16 at 12:18 PM that the facility was unable to prevent her from falling as she was ambulatory.

On 03/02/16 at 7:10 PM, an incident report revealed Resident #9 was found sitting beside her bed and denied falling stating she was just resting. The SBAR/progress note for 03/02/16 noted the resident fell twice this date and was treated with ice to her head. The IDT post fall review for this unwitnessed fall stated the resident has had frequent falls due to severe dementia and has been placed on visual checks. She was noted as non-compliant with any instruction. The care plan was updated on 03/03/16 noting she had a fall in her room and sustained 2 hematomas to her head. The only other thing noted was to continue the goal through the next review.

The DON stated during interview on 03/24/16 at 12:18 PM that the intervention was for staff to keep an eye on Resident #9. She stated there

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was nothing the staff could do to stop her from falling. She further stated Resident #9 did get more confused in the afternoons due to "sundowning."

The resident was seen by the nurse practitioner (NP) on 03/03/16 for followup. Her blood pressures were noted essentially normal. The NP noted tremors were noted at rest which were "worse than previous", she had very poor safety awareness, she was unaware of her surroundings and her falls were generally unwitnessed. An EKG noted supraventricular bradycardia. The NP discontinued medications of Metoprolol (a hypertension medication) and requested a cardiology consult. On 03/24/16 at 10:01 AM the Medical Records Clerk stated Resident #9 died prior to the cardiology appointment.

On 03/12/16 at 1:15 PM, an incident report noted Resident #9 fell on the floor and was found with a swollen abnormal left upper arm. The IDT note indicated she was found lying in the hall and it was an unwitnessed fall. A physician's order was obtained for an X-ray of the left shoulder, left humerus, and left wrist. Mobile X-ray results revealed Resident #9 sustained an acute fracture of the surgical neck and greater tuberosity. There was medial displacement of the distal fragment and medial apex angulation. The physican ordered Resident #9 to be sent to the hospital for treatment of the fracture. Resident #9 returned to the facility with a sling. The care plan was not changed.

During interview on 03/24/16 at 12:18 PM, the DON stated there was no written plan to increase supervision for Resident #9 and the DON was unable to say how often staff were expected to

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visually check on the resident.

Per physician notes on 03/13/16, Resident #9 developed a temperature, was lethargic, not eating, diaphoretic and clammy. Treatment for laboratory testing and IV fluids were ordered on 03/13/16. Resident #9 died in the facility on 03/16/16.

On 03/24/16 at 10:25 PM Nurse #4 was interviewed. Nurse #4 stated Resident #9's dementia progressively declined. He described poor short term memory. He stated the resident's ambulation became very shaky before she fractured her shoulder. When asked what interventions were in place to reduce her falls, Nurse #4 stated staff were to check on her frequently. After she fractured her shoulder, Nurse #4 stated she became very lethargic and basically did not ambulate anymore.

On 03/24/16 at 2:06 PM the Administrator stated Resident #9 ambulated independently, was confused and staff were expected to keep their eye on her. He was unable to explain what was meant by frequent visual checks.

Nurse #3 was interviewed on 03/24/16 at 7:14 PM. Nurse #3 stated she thought Resident #9 had a bed alarm and the bed was kept in the lowest position. She stated Resident #9 was up all hours day and night and wandered all around the facility.

Nurse Aide (NA) #5 stated during interview on 03/24/16 at 7:22 PM that she worked second shift. She stated Resident #9 was unsteady and she would walk her back to her room. NA #5 stated she could not recall an alarm being used

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F 323	Continued From page 84 and could not recall any directions regarding checking on her frequently. NA #6, who worked 7:00 PM to 7:00 AM, stated during interview on 03/24/16 at 7:28 PM that Resident #9 was progressively becoming more unsteady over the last 3 months. She stated she could not recall receiving any instruction related to visual checks and that she did not recall an alarm used for her. During interview with NA #7, who worked 7:00 PM to 7:00 AM, NA #7 described Resident #9 as very confused. She stated the resident was fairly steady up until the last month and a half and she started falling. She did not recall any alarm in place. She further stated staff keep their eye on her but nothing different than they did for any other resident.	F 323		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record reviews, and police interviews, the administration failed to impose expectations related to immediately removing an alleged perpetrator from resident care areas, failed to impose expectations related to immediately calling law enforcement when a crime is	F 490	F490 Actions taken for the identified residents: NA #1 was removed from the resident care assignment and was suspended pending the facility investigation. NA #1 did not return to the facility and was	5/4/16

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F 490	Continued From page 85 suspected, failed to empower staff to make the call to law enforcement when a crime is suspected, and failed to impose expectations that the Administrator be informed immediately of an allegation of abuse, failed to impose expectations that the Health Care Personnel Registry (HCPR) be notified within 24 hours of an allegation of abuse by a staff member and failed to impose expectations that the physician and responsible parties of the residents involved were notified of allegations of abuse and health status. Immediate Jeopardy began on 02/25/16 when Resident #3 was sexually assaulted by Nurse Aide (NA) #1. Resident #3 told Nurse #1 she had been raped by NA #1 and the Director of Nursing (DON) allowed the perpetrator to remain in the building without supervision for 3 additional hours. Neither Nurse #1 nor the DON informed the Administrator of the abuse allegation, called the police, called the responsible party, or called the physician. In addition, the 24 hour initial report was not faxed to the HCPR within the required 24 hours. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, and neither Nurse #1, Nurse #2, or the DON called the police, the administrator immediately, the responsible party, or called the physician. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused,	F 490	terminated on 3/15/16. Nurse # 1 was educated on 3/22/16 by the Director of Nursing on the Facility□s Policy for Abuse Prohibition including the Elder Justice Act, and the policy for notification of Physicians and Responsible Parties when a resident has a change of condition, incident, or allegation of abuse/neglect. Nurse #2 no longer is employed by our facility. Resident #3 and Resident #4 were educated on who to report abuse to and the definition of abuse on 3/24/16 by the Interdisclipnary Team. The facility staff, including Administrator and Director of Nursing, were educated on the facility'□s abuse prohibition policy including who to report to, to contact law enforcement if a suspicion of a crime, immediately remove the alleged person from the resident care areas, the Administrator must be contacted immediately of the allegation of abuse, the physician must be notified, the responsible party must be notified and the Health Care Personnel Registry must be notified within 24 hours. Actions Taken for those residents with the potential to be affected: On 3/3/16, Social Service Director completed interviews with residents who were alert, oriented and able to answer questions to determine any other	

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F 490	Continued From page 86 notifying the physician and responsible parties and following the facility's abuse policy and procedure. The findings included: Cross refer to F 157: Based on resident interviews, responsible party interviews, staff interviews, physican interviews and record reviews, the facility failed to inform the responsible parties and the physician when 2 of 4 sampled residents alleged sexual abuse by a staff member (Residents #3 and #4). Cross refer to F 223: Based on resident interviews, record review and staff interviews, the facility failed to maintain 2 of 4 sampled residents' right to be free of sexual abuse (Residents #3 and #4). Cross refer to F 225: Based on resident interviews, staff interviews, and record reviews the facility failed to report allegations of abuse to the Administrator, report suspicion of a crime to law enforcement and complete and send the 24 hour report to the Health Care Personnel Registry (HCPR) as required. This affected 2 of 4 residents sampled for abuse (Residents #3 and #4). Cross refer to F 226: Based on resident interviews, staff interviews, and record reviews the faclity failed to implement their abuse policy in the areas of identification, protection, reporting and responding. The facility failed to supervise the alleged perpetrator until he left the facility, call law enforcement to report suspicion of a crime, failed to immediately assess the residents for injuries, failed to immediately notify the	F 490	unreported allegations of abuse occurred. On 3/24/16, Social Services Director completed an audit of families and responsible parties for those residents unable to participate in the prior interviews to determine any other unreported allegations of abuse occurred. On 3/3/16, the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with facility staff to determine any other unreported allegations of abuse occurred. No new allegations were identified as a result of these interviews. Interviews were completed on 3/23/16. All facility residents will be educated on the definition of abuse and who to report to by the Interdisclipnary Team to be completed by 4/29/16. All facility staff, including Administrator and Director of Nursing were educated on the facility'□s Abuse Prohibition Policy to include removing the alleged person from the resident care areas, to report to the law enforcement officials, to notify the Administrator immediately, to notify the physician, to notify the responsible party and to report to the Health Care Personnel Registry within 24 hours. Systems in place to ensure the alleged deficient practice do not recur: On 2/29/16, District Director of Clinical	

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F 490	Continued From page 87 Administrator, and failed to file the 24 hour report to the Health Care Personnel Registry as required. This affected 2 of 4 residents sampled for abuse (Residents #3 and #4). On 03/22/16 at 4:46 PM, the Administrator and the DON were informed of Immediate Jeopardy. The Administration provided an acceptable credible allegation of compliance on 03/24/16 at 6:32 PM. Brian Center Waynesville respectfully submits the following allegation of compliance for F 490. 1. Nurse #1 notified the DON of an allegation of abuse related to Resident #3 on 02/26/16. On 02/26/16, immediately following the notification from Nurse #1 the Director of Nursing removed CNA #1 from the Resident Care Areas. The accused did not return to the facility and was terminated on 03/15/16. The Director of Nursing took statements over the phone from Nurse # 1 and CNA #1 and Resident #3 on 02/26/16. On 02/27/16 Resident #3 contacted the Police, who came into the Facility, and Resident #3 was transferred to the hospital for medical evaluation. The Director of Nursing called the Administrator on 02/27/16 at approximately 1:30 PM to inform him of Resident #3's allegation. On 02/28/16 Resident # 4 called the Police to report an allegation of abuse. Resident #4 then notified Nurse #2 of same allegation. Nurse #2 then immediately notified the Director of Nursing on 02/28/16. CAN#1 was previously suspended on 02/26/16 and continued to remain out of the facility. The Police came into the Facility and Resident #4 declined to go to the hospital for medical evaluation. A 24 Hour Report was submitted on 02/29/16, by the Director Nursing	F 490	Services educated the Director of Nursing on the following: -The Facility'□s Policy for Abuse Prohibition to include timely completion of 24 hour and 5 day reports to the NC Health Care Personnel Registry within 24 hours, the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect. To remove the allege person from resident care areas and to report to law enforcement officials. - The Facility Policy for Notification of Physicians and Responsible parties when a resident has a Change of Condition, and incident or accident occurs or when an allegation of abuse or neglect occurs. New employees will be educated on the facility□s Abuse Prohibition Policy to include removing the alleged person from the resident care areas, to report to the law enforcement officials, to notify the Administrator immediately, to notify the physician, to notify the responsible party and to report to the Health Care Personnel Registry within 24 hours. Administrator/DON will audit any allegations of abuse to ensure that allegations have been reported to Administrator if there is a suspicion of a crime that it has been reported to Law Enforcement, the 24-hour report has been completed and sent to the Health Care Registry and the physician and Responsible Party have been notified. This audit will be conducted 5 times a week for 4 weeks and then 3 times a	

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F 490	Continued From page 88 for Resident #3's allegation of abuse and Resident #4's allegation of abuse. The 5 Day Report was submitted for Resident #3 and Resident #4 on 03/04/16 by the Administrator. Nurse #1 was re-educated on 03/22/16 by the Director of Nursing on the Facility's Policy for Abuse Prohibition including the Elder Justice Act, and the policy for notification of Physicians and Responsible Parties when Residents have a change of condition, incident or allegation of abuse or neglect. Nurse # 2 last day worked in facility was 02/28/16. On 02/29/16 the Director of Nursing notified the Physician of Resident #3 regarding the allegation of abuse received on 02/26/16. Resident #3 is responsible for her own affairs and she notified her family on 02/29/16. On 02/29/16 the Director of Nursing notified the Physician of Resident #4 regarding the allegation of abuse received on 02/28/16. Resident #4 is responsible for her own affairs and she notified her Responsible Party on 02/28/16. 2. Current Residents have the potential to be affected by the same alleged deficient. By 03/03/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to verify no other unreported allegations of abuse occurred. On 03/03/2016 the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to verify no other unreported allegations of abuse occurred No new allegations were identified as a result of these interviews. These audits and interviews were completed on 03/23/16. By 03/03/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to verify no other unreported	F 490	week for 2 months. The results of the audits will be reported at the monthly QAPI meeting. Quality Assurance measures in place to ensure the practices are sustained: The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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allegations of abuse occurred. On 03/23/16 the Social Services Director completed an audit of families and responsible parties for those resident unable to participate in the prior interviews to verify no other unreported allegations of abuse occurred. On 03/03/16 the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. On 03/23/16 the Administrator completed an audit of all previously reported allegations of abuse or neglect received during the last 6 months to validate Physician and Responsible Party notification was completed. No further Physician notifications were required as a result of these interviews as no new allegations were identified. These audits and interviews were completed on 03/23/16.

3. Measures put in place to ensure the alleged deficient practice does not recur include:
On 2/29/16 the District Director of Clinical Services re-educated the Director of Nursing on the following:
*The Facility's Policy for Abuse Prohibition to include timely completion of 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect.
*The Facility Policy for Notification of Physicians and Responsible Parties when a Resident has a Change of Condition, an Incident or Accident occurs, or when an allegation of abuse or neglect occurs.

The Director of Nursing was suspended by the Administrator on 02/29/16 pending investigation

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related to delayed reporting of abuse allegation to the Administrator and timely completion of investigation. The Administrator provided the Director of Nursing with disciplinary action as a final warning and was placed on a Performance Improvement Plan that included leading by example, maintain professionalism and report allegations of abuse/neglect to the appropriate parties in a timely manner, take each allegation in a serious nature and initiate the investigation immediately with follow through with interviewing witnesses and involved persons upon returning to work on 03/08/16.

On 02/29/16 the District Director of Operations re-educated the Administrator on the Facility's Policy for Abuse Prohibition, the Elder Justice Act, reporting guidelines for the 24 Hour and 5 Day Reports to the NC Health Care Personnel Registry, and his responsibilities to coordinate an effective investigation by ensuring timely interviews and assessments, reviewing results and findings, and determining interventions according to opportunities identified during the investigation.

On 03/24/16 the Administrator was terminated and an Interim Administrator assigned by the District Director of Operations. The Interim Administrator was educated by the District Director of Clinical Services regarding the Facility's Policy for Abuse Prohibition to include the Elder Justice Act. Education also included maintaining a professional relationship with residents, families and the Resident's Right to live in the facility free from abuse and neglect. The facility will not tolerate abuse and will follow the policy for Abuse Prohibition to investigate all allegations of abuse or neglect thoroughly. As

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the Abuse Coordinator the Administrator is expected to ensure the implementation of Abuse prohibition throughout the facility and maintain an environment for Residents that is free from abuse and neglect.

On 03/23/16 Facility Staff including housekeeping, dietary, and therapy were re-educated by the Director of Nursing, Unit Manager, and Area Staff Development Coordinator on the Facility's Policy for Abuse Prohibition to include the Elder Justice Act. Education also included maintaining a professional relationship with residents and families and the Resident's Right to live in the facility free from abuse and neglect. The facility will not tolerate abuse and will follow the policy for Abuse Prohibition to investigate all allegations of abuse or neglect thoroughly.

Facility Staff shall not be allowed to work before receiving this re-education.

All new employees will be educated on Abuse Prohibition, the Elder Justice Act and their responsibility of calling the police for a reasonable suspicion of a crime. Education will also include maintaining a professional relationship with residents and families and the Resident's Right to live in the facility free from abuse and neglect. The facility will not tolerate abuse and will follow the policy for Abuse Prohibition to investigate all allegations of abuse or neglect thoroughly.

This education will be completed by the Area Human Resource Officer or the Director of Nurse during orientation.

On 02/29/16 the Administrator and Director of

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Nursing implemented a new system to monitor the management of allegations by reviewing all events with the Division Director of Clinical Services daily to ensure adherence to the Facility Policy on Abuse Prohibition and conduct a weekly focus call to further review events occurring throughout the week to ensure completion on investigations and reporting as required.

All Licensed nurses and CNAs were re-educated by the Area Staff Development Coordinator and the Director of Nursing on 03/23/16 regarding the facility's policy for Physician and Responsible Party Notification as it relates to:
*A Change in Resident Condition
*When and Incident or Accident occurs
*When an allegation of abuse or neglect occurs.

Licensed Nurses and CNAs shall not be allowed to work before receiving this re-education. All new employees will be educated by the Area Human Resource Officer or the Director of Nurse during orientation.

The Administrator and Director of Nursing will complete a root cause analysis by 04/01/16 regarding abuse within the facility. The Administrator and Director of Nursing will hold weekly staff meetings to review and re-educate Abuse Prohibition. During these meetings the leadership will reinforce the Resident's right to remain free from abuse and neglect.

A schedule has been developed by the Administrator, beginning 03/24/16, for the next 7 days to include daily supervision during all 3 shifts. All staff involved have reviewed and agreed to the schedule. The Admnistrator, Director of Nursing(DON), Unit Manager (UM),

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F 490	Continued From page 93 District Director of Clinical Services (DDCS) or District Director of Operations (DDO) will participate in this weekly schedule. A member of this leadership team will be available and rounding within the facility each day assessing the ongoing performance of the facility staff to ensure there is no tolerance for abuse. The Administrator and Director of Nursing will complete Performance Evaluations for current Licensed and Certified Nursing staff by April 30, 2016, then annually. Immediate jeopardy was removed on 03/24/16 at 8:12 PM when interviews with residents revealed they were aware and felt comfortable reporting abuse incidents immediately. Nursing staff, administrative staff, non-nursing staff, and residents confirmed they had received in-service training and knew the different types of abuse, the need to report allegations of abuse to the Administrator, the need to compete a 24 hour and 5 day HCPR report within required time frames, the need to call the police to report suspicion of a crime, the need to call the responsible party and the physican, and the need to evaluate the resident and obtain appropriate medical interventions for the affected residents.	F 490		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced	F 504		5/4/16

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	345411	A. BUILDING _____ B. WING _____	C 03/24/2016

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F 504	Continued From page 94 by: Based on record review and staff interview the facility failed to obtain a physician's order for a lab test for Resident #7. This deficient practice affected 1 of 5 sampled residents reviewed as part of the extended survey. (Resident #7). The findings included: Resident #7 was admitted to the facility on 02/08/16 with diagnoses including diabetes mellitus type 1, coronary artery disease, hyperlipidemia, chronic obstructive pulmonary disease and end stage renal disease. Further review of Resident #7's medical record revealed results for an albumin level drawn on 02/12/16. There was no order on Resident #7's medical record for an albumin level. An interview on 03/24/16 at 1:00 PM with the Director of Nursing (DON) about her expectation for obtaining physician's orders prior to performing lab tests revealed she expected nurses to have an order before completing a lab requisition form. The DON stated the facility had discovered a problem with missing documentation after the former Unit Coordinator (UC) quit about a week ago. The DON stated she thought perhaps that was an order that didn't get filed on the resident's chart by the former UC, who wasn't fulfilling all her assigned duties which included transcribing orders for labs and filing the orders in the resident's medical record. An interview on 03/24/16 at 2:04 PM with the Administrator revealed he thought the problem with the order for the Albumin level not being on the resident's medical record was because of the UC who quit within the past 2 weeks.	F 504	F 504 Actions taken for the identified resident: Resident #7 was discharged on 3/25/2016. Actions taken for those residents with the potential to be affected: The Director of Nursing, Unit Managers and Area Staff Development Coordinator completed a lab audit on 4/19/16 of the last 30 days of labs performed to ensure all labs have a corresponding physician order. Lab orders will be cross checked with Clinical Laboratory Services to ensure accuracy on 4/20/16. Measure implemented to ensure the alleged deficient practice does not recur: The Director of Nursing and Unit Managers will provide education for licensed nurses by 4/20/16 regarding correctly obtaining the physician orders prior to collecting labs. Unit managers will audit residents receiving labs 5 times weekly for 4 weeks then 3 times weekly for 2 months to ensure lab orders are in place, labs have been completed, physician notified and lab results placed in chart. Results of audits will be reviewed monthly during QAPI meeting. Quality Assurance measures in place: The Administrator and Director of Nursing	

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F 504	Continued From page 95 An interview on 03/23/16 at 3:49 PM with the Medical Records Director (MRD) revealed she didn't know why there wasn't an order for Albumin on Resident #7's chart and stated she didn't have any unfiled physician's orders in her office. A call was placed to the Medical Director on 03/24/16 at 4:52 PM and a message was left requesting a return phone call. Call was not returned.	F 504	will analyze the data obtained, and report patterns/trends to Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	
F 507 SS=E	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to file results of laboratory tests in the clinical records of Residents #2, #7 and #9). This deficient practice affected 3 of 5 sampled residents reviewed as part of the extended survey. (Residents #2, #7 and #9). The findings included: 1. Resident #2 was admitted to the facility on 03/01/16 with diagnoses including cellulitis, diabetes mellitus type 2, hypertension and chronic obstructive pulmonary disease. Review of Resident #2's medical record revealed an order dated 03/15/16 for urinalysis with	F 507	F507 Actions taken for the identified resident: Resident #2, Resident #7, and Resident #9 no longer reside in the facility. Actions taken for residents with the potential to be affected: The Director of Nursing and Unit Managers have performed a lab audit which was completed by 4/20/16, for the last 30 days to ensure all lab results have been filed in the residents medical record. Residents were identified as being	5/4/16

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F 507	Continued From page 96 culture. Further review of Resident #2's medical record revealed results of the urinalysis were on the record and contained 4 - 8 white blood cells and 3+ bacteria. A note on the lab by the Nurse Practitioner stated: "await C&S." There was no result for the urine culture on Resident #2's medical record. An interview on 03/23/16 at 2:00 PM with the Medical Records Director (MRD) revealed she didn't know why the result of the urine culture wasn't on Resident #2's chart. The MRD contacted the facility's lab provider and obtained a copy of the urine culture results which indicated the culture was positive for Escherichia coli (E. coli), a bacteria often found in urine cultures when a clean catch urine specimen was not obtained. An interview on 03/24/16 at 1:00 PM with the Director of Nursing (DON) about her expectation for lab results being on the resident's medical record revealed she expected results to be on the medical record within 24 hours of when they were obtained. The DON stated the former Unit Coordinator (UC) was responsible for following up on lab tests and making sure results were obtained and put on the resident's chart. The DON stated the UC quit about a week ago and that was when she discovered that the UC wasn't fulfilling all her assigned duties which included obtaining and filing lab results. An interview on 03/24/16 at 2:04 PM with the Administrator revealed he thought the problem with lab results not being on the resident's medical record was because of the UC who quit within the past 2 weeks. A call was placed to the Medical Director on	F 507	affected. Labs were obtained and filed in the medical record for affected residents by 4/20/16. System in place to ensure the alleged deficient practice does not recur: The Director of Nursing and Unit Managers provided education for licensed nurses on 4/20/16 regarding ensuring that once the MD has been notified of the results that they are to be filed to the resident medical record. Unit managers will audit residents whom have had labs drawn to ensure that the lab has been filed to the residents medical record 5 times a week x 4 weeks then 3 times a week x 2 months and results will be reported to the monthly QAPI meeting for review. Quality Measures in place to ensure the practice is sustained: The Director of Nursing will analyze the data obtained, and report patterns/trends to Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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F 507	Continued From page 97	F 507		

03/24/16 at 4:52 PM and a message was left requesting a return phone call. Call was not returned.

2. Resident #7 was admitted to the facility on 02/08/16 with diagnoses including diabetes mellitus type 1, coronary artery disease, hyperlipidemia, chronic obstructive pulmonary disease and end stage renal disease. Further review of Resident #7's medical record revealed an order dated 02/09/16 for a complete blood count (CBC), basic metabolic panel (BMP) and Magnesium (Mg) level. There was no result on Resident #7's medical record for the CBC, BMP or Mg level that was ordered on 02/09/16.

An interview on 03/24/16 at 1:00 PM with the Director of Nursing (DON) about her expectation for lab results being on the resident's medical record revealed she expected results to be on the medical record within 24 hours of when they were obtained. The DON stated the former Unit Coordinator (UC) was responsible for following up on lab tests and making sure results were obtained and put on the resident's chart. The DON stated the UC quit about a week ago and that was when she discovered that the UC wasn't fulfilling all her assigned duties which included obtaining and filing lab results.

An interview on 03/24/16 at 2:04 PM with the Administrator revealed he thought the problem with lab results not being on the resident's medical record was because of the UC who quit within the past 2 weeks.

An interview on 03/23/16 at 3:49 PM with the Medical Records Director (MRD) revealed she didn't know why the lab results weren't on

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Resident #7's chart. The MRD contacted the facility's lab provider and obtained a copy of the lab results which indicated resident had a hemoglobin of 8.6 (normal range: 12.0 - 16.5), hematocrit of 26.9 (normal range: 34.0 - 50.0), creatinine of 4.5 (normal range: 0.5 - 1.5).

A call was placed to the Medical Director on 03/24/16 at 4:52 PM and a message was left requesting a return phone call. Call was not returned.

3. Resident #9 was admitted to the facility on 07/12/13. Her diagnoses included delusional disorders, dementia, osteoporosis, benign neoplasm of meninges and anxiety disorder.

A physician's progress note dated 03/13/16 noted Resident #9 was seen for 100.8 degree Fahrenheit temperature. The note indicated that after given Tylenol, her temperature was coming down but she was lethargic, not eating, diaphoretic and clammy. She was also noted to have a left fractured humerus secondary to a fall. Resident #9 was described as lying in bed, sweaty and drooling, with coarse right lung fields. An intravenous (IV) of normal saline was ordered along with a urine with culture and sensitivity to be done immediately. A physician order was written for this urinalysis on 03/13/13.

Nursing notes dated 03/14/16 at 12:00 PM revealed the urinalysis was obtained via in and out catheterization and sent to the laboratory.

Physician notes dated 03/15/16 made no mention of the urinalysis or results. There were no narrative nursing notes after 03/14/16.

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F 507	Continued From page 99	F 507		

Review of the medical record revealed no urinalysis was in the medical record.

The Medical Records Director stated on 03/23/16 at 5:10 PM she would look for the urinalysis report.

The Medical Records Director had to obtain the urinalysis from the laboratory via fax on 03/24/16 at 10:24 AM. The results were negative.

Nurse #4 was interviewed regarding the process for obtaining laboratory testing. Nurse #4 stated that once there was a physician's order for a lab, the nurse filled out a lab requisition and marked the calendar. He further stated the unit manager, (no longer employed), was responsible for making sure labs were drawn. He further stated that papers disappear frequently in this facility and offered no explanation.

An interview on 03/24/16 at 1:00 PM with the Director of Nursing (DON) about her expectation for lab results being on the resident's medical record revealed she expected results to be on the medical record within 24 hours of when they were obtained. The DON stated the former Unit Coordinator (UC) was responsible for following up on lab tests and making sure results were obtained and put on the resident's chart. The DON stated the UC quit about a week ago and that was when she discovered that the UC wasn't fulfilling all her assigned duties which included obtaining and filing lab results.

An interview on 03/24/16 at 2:04 PM with the Administrator revealed he thought the problem with lab results not being on the resident's

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F 507	Continued From page 100 medical record was because of the UC who quit within the past 2 weeks.	F 507		
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the physician of X-ray results for of 1 of 3 sampled residents (Resident #9). The findings included: Resident #9 was admitted to the facility on 07/12/13. Her diagnoses included delusional disorders, dementia, osteoporosis, benign neoplasm of meninges and anxiety disorder. On 01/02/16 at 2:00 PM, an incident report noted Resident #9 was found lying in another resident's room. She complained about right elbow, right hip and nasal pain. A bruise on the right elbow was noted on the form. Physician orders were obtained on 01/02/16 for X-rays of the right hip, right pelvis, right elbow and nasal bones. Another order dated 01/02/16 discontinued the nasal X-ray due to her being uncooperative. Review of the medical record revealed no results in the medical record of the X-rays to the pelvis or elbow. The Medical Records Director obtained the	F 511	F511 Actions taken for the identified resident: Resident #9 no longer resides at the facility. Actions taken for those residents with the potential to be affected: Area Staff Development Coordinator completed a record review by 4/15/16 for those residents that had received an x-ray in the last 30 days. Physicians were notified of results and radiology report placed in medical record. System in place to ensure the alleged deficient practice does not recur: The Director of Nursing and Unit Managers educated licensed nurses by 4/20/16 regarding notification to the physician when x-ray results are received at the facility. Unit Managers will audit those residents having received an x-ray to ensure physician was notified of the x-ray results. These audits will be	5/4/16

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F 511	Continued From page 101 X-rays from the mobile X-ray company via fax on 03/23/16 at 5:56 PM after she was unable to locate them in the facility. Both X-rays indicated the pelvis and elbow were negative for fractures. Interview with Nurse #4 on 03/24/16 revealed the process for obtaining X-rays was that once a physician ordered an X-ray, the nurse called for the X-ray to be done. The nurse who ordered the X-ray was responsible for making sure results were obtained. If the results were not obtained by the end of the shift, follow up would be done by the next shift via report. He could not recall if the physician was notified since the reports were not in the chart. He revealed that once he received the reports, he would stamp the report and note the date and who he spoke to about the results. He stated the physician came every Monday and the nurse practitioners were in Tuesdays and Thursdays. Review of the physician's visit notes revealed no notes related to the X-ray results and there were no nursing notes indicating the results were discussed with the physician. A call was placed to the physician on 03/24/16 at 4:52 PM and a message was left requesting a return phone call. Call was not returned.	F 511	performed 5 times per week for 4 weeks and then 3 times weekly for 2 months to ensure compliance. Results of these audits will be reported at QAPI monthly for review. Quality Measures in place to ensure the practice is sustained: The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced	F 513		5/4/16

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F 513	Continued From page 102 by: Based on record review and staff interviews, the facility failed to file X-ray results in the medical record of 1 of 3 sampled residents (Resident #9). The findings included: Resident #9 was admitted to the facility on 07/12/13. Her diagnoses included delusional disorders, dementia, osteoporosis, benign neoplasm of meninges and anxiety disorder. On 01/02/16 at 2:00 PM, an incident report noted Resident #9 was found lying in another resident's room. She complained about right elbow, right hip and nasal pain. A bruise on the right elbow was noted on the form. Physician orders were obtained on 01/02/16 for X-rays of the right hip, right pelvis, right elbow and nasal bones. Another order dated 01/02/16 discontinued the nasal X-ray due to her being uncooperative. Review of the medical record revealed no results in the medical record of the X-rays to the pelvis or elbow. The Medical Records Director obtained the X-rays from the mobile X-ray company via fax on 03/23/16 at 5:56 PM after she was unable to locate them in the facility. Both X-rays indicated the pelvis and elbow were negative for fractures. The Medical Records Director stated on 03/24/16 at 8:49 AM that it was the responsibility of the unit managers to follow up to ensure X-ray results were obtained. Interview with Nurse #4 on 03/24/16 revealed the process for obtaining X-rays was that once a	F 513	F 513 Actions taken for the identified resident: X-ray results were obtained and filed in Resident□s #9 Medical Record. Actions taken for residents with the potential to be affected: The Director of Nursing, Unit Managers and Area Staff Development Coordinator completed an audit of the last 30 days to ensure all x-rays ordered have been obtained and are filed in the Medical Record. This audit was completed on 4/15/16. System in place to ensure the alleged deficient practice does not recur: The Director of Nursing and Unit Managers have educated licensed nurses by 4/20/16, to ensure x-rays are obtained when ordered, and filed in the Medical Records after the physician has reviewed. Unit Managers will audit those residents having an x-ray to ensure x-ray results were received and filed in the medical record. These audits will be performed 5 times per week for 4 weeks and 3 times a week for 2 months to ensure compliance and results will be reported to the monthly QAPI for review. Quality Measures in place to ensure the practice is sustained:	

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F 513	Continued From page 103 physician ordered an X-ray, the nurse called for the X-ray to be done. The nurse who ordered the X-ray was responsible for making sure results were obtained. If the results were not obtained by the end of the shift, follow up would be done by the next shift via report. He was unable to recall any details as to why the X-rays were not in the medical record. He further stated that often papers were discovered missing from the medical records. Interview with the Director of Nursing (DON) on 03/24/16 at 1:07 PM revealed once the physician ordered an X-ray, the nurses filled out a requisition, keeping the yellow copy in the book. Nurses then called for the mobile Xray and once the X-ray results came, the yellow sheet would be removed, indicating it was done. The nurses were responsible for following up on obtaining X-ray results. The DON further stated the unit manger, no longer employed, was not doing her job. The DON stated she had conversations with her all the time about paperwork issues but no formal action was ever documented and the unit manager has since quit.	F 513	The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514		5/4/16

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F 514	Continued From page 104 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain accurate and complete medical documentation in the medical record for 1 of 9 sampled residents. Resident #9's medical record failed to include nursing monitoring and services provided for her related to falls, acute illness and death. The findings included: Resident #9 was admitted to the facility on 07/12/13. Her diagnoses included delusional disorders, dementia, osteoporosis, benign neoplasm of meninges and anxiety disorder. Nurse's notes dated 03/03/14 at 3:00 AM revealed Resident #9 attempted to get out of her wheelchair without assistance and fell in her room, hitting her head on the table. Ice was applied and the on call physician gave no new orders. According to the Interdisciplinary post fall review and incident report (not part of the medical record), this fall actually occurred on 03/02/16 at 3:00 AM. The medical record revealed a Situation, Background, Assessment, Recommendation (SBAR) note stating she fell a second time on 03/02/16. Interdisciplinary post fall review and incident report (not part of the medical record) revealed Resident #9 fell a second time on 03/02/16.	F 514	F514 Actions taken for the identified resident: Resident #9 no longer resides at the facility. Actions taken for those residents with the potential to be affected: Education will be provided by Director of Nursing/Unit Managers for licensed nurses by 4/20/16 regarding required nursing documentation as it relates to monitoring of acute illness of the resident and services provided for the resident with a fall. Unit Managers/Designee will review clinical records of all residents with falls to ensure physician and Responsible Party have been notified and interventions have been put in place. Systems in place to ensure the practice does not recur: Residents with an acute illness or who have had a fall are reviewed by nursing. Unit Managers will audit those residents who have had a fall and those residents with an acute illness to ensure nursing documentation is complete. These audits will be performed 5 times per week for 4 weeks and then 3 times a week for 2	

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	345411	A. BUILDING _____ B. WING _____	C 03/24/2016

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F 514	Continued From page 105 There were no nursing notes until the Nursing Weekly/Monthly summary dated 03/12/16 which indicated she fell this date and experienced shoulder pain. The Interdisciplinary post fall review indicated she was found lying in the hall and her left arm was swollen and painful. Although review of the physician telephone orders dated 03/12/16 indicated Resident #9 had a X-ray of her shoulder and was subsequently sent to the hospital for an evaluation of a fractured shoulder, the record did not include nursing notes related to the need to go to the hospital and/or any instructions following the hospital visit. The hospital report was faxed to the surveyors on 03/24/16 which indicated she needed to wear a sling. Physician progress notes dated 03/13/16 at 10:30 AM revealed Resident #9 had a temperature of 100.8 degrees Fahrenheit, was diaphoretic and clammy, lethargic and not eating. The physician note indicated intravenous fluids (IV) were started, Rocephin was administered and labs were ordered. A nursing note dated 03/14/16 at 12:00 PM noted Resident #9 had a decrease in responsiveness and she offered no response to the IV or lab procedures. Another physician progress note dated 03/15/16 at 10:00 AM revealed Resident #9 had a positive chest X-ray for right lower lobe infiltrate, still has a 100 degree Fahrenheit temperature, was getting 5 liters of oxygen per minute, her right hand with the IV was noted to be puffy and the left arm immobilized. The Nurse Practitioner	F 514	months to ensure compliance. Results of the audits will be reported at QAPI monthly meeting for review Quality Assurance measures implemented to ensure the practice is sustained: The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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F 514	Continued From page 106	F 514		

(NP) noted a long discussion with the out of town responsible party regarding her wish to keep Resident #9 in house until she arrived to make a firm decision about hospitalization. RP was noted as leaning toward comfort care.

There were no other progress notes either by the physician or the nurses after the physician note dated 03/15/16 at 10:00 AM. The next indication of Resident #9's condition or status was nurses's note, pre-typed to be completed at discharge. This form was dated 03/16/16 and noted Resident #9 was absent of vital signs on 03/16/16 at 8:10 PM and she was discharged to the funeral home. This note was signed by Nurse #3.

Interview with Nurse #3 on 03/23/16 at 5:06 PM revealed she was with Resident #9 when she took her last breath, holding her hand. She stated it was shortly after she came on duty, the family had left, and death was imminent and she did not want Resident #9 to die alone. She stated she did not write a nursing note, could give no reason, but stated she wrote the discharge note. She stated that the staff were providing comfort care only for Resident #9.

Interview with Nurse #4 on 03/24/16 at 10:25 AM revealed he charted on residents "by exception." She was on comfort measures so vital signs were not being taken and staff were waiting for the end. He stated he was sure the staff were in contact with the nurse practitioner. He further stated there probably could have been some notes regarding her condition and death.

The Director of Nursing was interviewed on 03/24/16 at 1:07 PM. When asked about her expectation of nursing notes related to Resident

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F 514	Continued From page 107 #9's illness and death, she stated the nurse did fill out the discharge note which indicated she died and was sent to the funeral home and confirmed there was no other note in the medical record.	F 514		
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance (QA and A) Committee failed to maintain implemented	F 520	F520 Actions taken for the alleged deficient practice:	5/4/16

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F 520	Continued From page 108 procedures and monitor the interventions that the committee put in place December 2015. This was for 5 deficiencies that were cited in December 2015 on a recertification survey. These deficiencies were re-cited on the current complaint survey. The deficiencies were in the areas of Services Meet Professional Standards, Supervision to Prevent Accidents, Labs Only Obtained with a Physician's Order, Lab Reports Filed in Chart and Quality Assessment and Assurance Program. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F281: Services Meet Professional Standards: Based on record review and staff interview the facility failed to obtain physician's orders for wound care treatment for Resident #1 and failed to obtain laboratory tests that were ordered for Resident #7. During the recertification survey of December 2015, the facility was cited for F281 for failure to obtain lab tests that were ordered by the physician. On the current survey the facility failed to obtain physician's orders for wound care treatment and failed to obtain laboratory tests that were ordered by the physician. F323: Supervision to Prevent Accidents: Based on record review and staff interviews, the facility failed to evaluate the circumstances and/or trends of falls in order to develop interventions to	F 520	Education has been provided for Administrator by District Director of Clinical on 4/15/16. Education included SAVA 's Quality Assurance and Performance Improvement Program and the expectations associated with that program. This process enables the identification of opportunities for improvement. Root causes are identified and corrective actions are determined, monitored and followed up on to ensure improvements are sustained. Actions taken for those residents with the potential to be affected: Quality Assurance monitoring of these areas will be completed as specified in the Plan of Correction related to the reciting of F281, F323, F504, and F514. Quality Assurance Committee has reviewed the meeting minutes for past three months to ensure any identified trends or action items have been completed as it relates to the previously cited tags. Systems in place to ensure the alleged deficient practice does not recur: Education was provided on 4/15/16 for the Quality Assurance and Performance Improvement Committee members regarding the responsibilities of the QAPI committee to ensure sustainability with identified areas of opportunity.	

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F 520	Continued From page 109 reduce the number of falls or injuries. During the recertification survey of December 2015, the facility was cited for F323 for failure to protect residents from potential environmental hazards by leaving the biohazard waste disposal units on 2 medication carts unlocked. On the current survey the facility failed to evaluate the circumstances or pattern of falls in a resident with recurring falls. F504: Labs only Obtained with a Physician's Order: Based on record review and staff interview the facility failed to obtain a physician's order prior to obtaining a lab test for one resident. During the recertification survey of December 2015, the facility was cited for F504 for failure to obtain a physician's order prior to obtaining a lab test for one resident. On the current survey the facility failed to obtain a physician's order prior to obtaining a lab test for one resident. F514: Lab Reports Filed in Chart: Based on record review and staff interview the facility failed to file results of laboratory tests in the clinical records of three residents. During the recertification survey of December 2015, the facility was cited for F514 for failure to obtain complete and accurate medication orders. On the current survey the facility failed to file the results of laboratory tests in the clinical records of three residents. F520 Quality Assessment and Assurance Program: Based on record review and staff interview the facility's Quality Assessment and Assurance (QA and A) Committee failed to	F 520	Quality Assurance Performance Improvement Committee meetings are being held weekly for 4 weeks and then monthly to discuss the deficient tags cited and plans of correction. The results of any audits will be discussed by committee members to ensure ongoing compliance. Quality Assurance measures in place: The Administrator sends the QAPI meeting minutes weekly for 4 weeks to the District Director of Operations and the District Director of Clinical for review and recommendations. The Administrator and Director of Nursing will analyze the data obtained, and report patterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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F 520	Continued From page 110	F 520		

maintain implemented procedures and monitor the interventions that the committee put in place in December 2015.

During the recertification survey of December 2015, the facility was cited for F520 for failure to maintain compliance at F253, F312 and F514 since the previous recertification survey of 02/27/15. On the current survey the facility had recurring noncompliance at F 281, F323, F504, F514 and F520.

An interview was held on 03/24/16 at 1:00 PM with the Director of Nursing (DON) about her expectation for obtaining orders for treatments including wound care and medicated ointments. The DON stated she expected staff to have an order for anything that was put on the resident. When asked about the resident with recurring falls and the lack of a change in interventions, the DON stated she didn't feel there was much they could do because the resident ambulated independently. When asked about her expectation for having a physician's order prior to obtaining laboratory tests, the DON stated no laboratory tests should be obtained without a physician's order.

An interview on 03/24/16 at 2:04 PM with the Administrator about the continued non-compliance at F281, F323, F504 and F514 revealed he thought the problem with lab results not being on the resident's medical record and some of the other issues was because of the Unit Coordinator who quit within the past 2 weeks. The Administrator stated they had continued to monitor all of the areas and could offer no further explanation.