STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 02/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(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 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews it was determined that the facility failed to protect 1 of 1 resident's (#1) from staff mistreatment. Findings included: Resident #1 was admitted to the facility on 12/18/16 with a primary diagnosis of right humeral fracture, general debility, diabetes mellitus, and chronic lymphedema with non-healing wounds, hypertension, hyperlipidemia, renal cell carcinoma and osteoarthritis. Review of the Minimum Data Set Assessment (MDS) 12/24/16 revealed that Resident #1 had a	F 224	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of this deficiency. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1. Corrective Action: NA #1 was immediately suspended when	3/25/17

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

Electronically Signed | 03/20/2017

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F 224	Continued From page 1 brief interview of mental status score of 15, indicating that the resident was alert and oriented. The resident was coded as requiring extensive 2 person support for bed mobility, transfer and toilet use. Review of a statement signed by Resident #1 revealed, "NA #1 (Nursing assistant) threw me in this wheelchair and grabbed me from the bed like a sack of potatoes in the bed on Friday morning, which had to be December 23rd before breakfast. She grabbed me out of the bed and slung me in the wheelchair and I said, "God". It someway burned me or pinched me between my legs. This was the first time she acted this way as she usually mellows out during the day. She said she had 14 people she had to check on that morning after she had throwed me in the chair and then she threw me in the bathroom and I slid all over the commode seat. I had messed on the commode seat and I did not know that she had messed up my "Jon" until yesterday when I was in the shower and I did not had looked down at myself. It resembled a rattlesnake with a scar an inch to an inch and a half or so which was brown in the middle and the rest is black around it, She ran and got a gait belt after she did the damage to me and I said nothing to her about wearing a gait belt". Interview with Resident #1 on 3/1/17 at 3:58 PM revealed that the day on 12/24/16 NA #1 picked him up and threw him in his wheelchair to take him to the bathroom. Then she threw him on the toilet. The resident stated that she put her hands under his knees and her arm around his back and picked him up. He said that his penis was skinned and he had a hole in his bottom where she dropped him.	F 224	Administrator was notified of Resident #1 abuse allegations on 12/28/16. Following completion of 5 day investigation, NA #1 was terminated on 01/04/17. 2. Others with Potential to be Affected: All patients on current census on 03/08/17 were interviewed by Administrator and IDT (Interdisciplinary Team) member and asked if they had ever been abused at the facility that have not been reported or witnessed any type of abuse of another at the facility. All findings were "no". 3. Measures/ Systemic Changes: All current staff in-serviced by Administrator/ Senior Care Partner and/or Interim Director of Health Services on training of abuse policy including prevention, identification, notification and no retaliation. Staff currently on FMIA, Leave of Absence and/or vacation will be trained on their first scheduled day of work by Administrator/ Director of Health Services and/or Senior Care Partner. Education is ongoing part of new partner orientation conducted by the Administrator and/or the Director of Health Services. On March 13, 2017 the Administrator met with Resident Council to review abuse and reporting of abuse. The Administrator, Director of Nursing and/or Senior Care Partner will interview	

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F 224	Continued From page 2 Review of a typed statement signed by Resident #1's roommate stated, "All the staff normally pulls the privacy curtain to do anything, but on this particular time, she did not pull it, she left it open allowing me to see everything. She threw him in the wheelchair from the bed and snatching him up and used both of her arms to pick him up by the upper body and slammed him in the wheelchair." Interview with NA #1 on 2/25/17 at 4:23 PM via telephone revealed that after breakfast the resident's call light was on. She stated that she went in to tell the resident she would be there as soon as she could and turned off the call light. She said that she had one resident on the bedpan and one on the toilet. She offered the resident the bedpan and he declined. The NA stated that she went in to Resident #1's room pulled the covers back and pulled the wheelchair over because the resident couldn't do anything with his right side. She reported putting the bed in a low position and sliding him down. She grabbed him by his incontinent brief, put her arm on his back and used her knee to put him in the wheelchair. She stated that he might have sat down hard. She said that the resident was able to stand enough to pivot and get in the chair. She said he pulled up on the rails in the bathroom to sit on the toilet with his left hand and held onto the rail while she turned him and pulled his clothes down. NA #1 stated that she could not pick the resident up because she had a rod in her arm. She said that she braced the resident against her body to transfer him to the chair. NA#1 stated that she had not received training on how to transfer the resident. She stated that the resident had not been assessed prior to the	F 224	10 residents about abuse weekly x 4 weeks, then monthly x 2 month, and then quarterly thereafter. 4. Monitoring: The Administrator, Director of Nursing and/or Senior Care Partner will interview 10 residents about abuse weekly x 4 weeks, then monthly x 2 month, and then quarterly thereafter. The Administrator will track and trend the results and present the findings to the monthly Performance Improvement Committee until substantial compliance is maintained.	

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incident, but a therapy staff person had helped her transfer the resident once. NA #1 said that she might have been frustrated when transferring the resident because he kept screaming and hollering. She stated that she took the resident to the toilet again that same day and he had no complaints of pain.

The written statement completed by NA #1 stated, "Resident #1 had his light on and told me he had to go to the bathroom. I told him it would be a few minutes because I someone else across the hall on the toilet and I also had another resident on bedpan. He said he couldn't wait he needed to get up and go now. I offered him the bedpan, he refused it, he said he didn't want the bedpan, he said he needed to sit on the toilet. I let the nurse know what was going on but nothing was done. So I got the other people off the toilet went over to assist him getting the out of the bed. I turned his legs around so they were on the side of the bed then sit him up. He had no strength to help me so I picked him up and put him in his wheel chair and into the bathroom and put him on the toilet. He was unable to assist me so I had to hold him up with one hand and knee in order to get his brief off and sit him on the toilet. Later when I went back to get him off he told me I was rough with him and I told him I was sorry but I didn't mean to be as aggressive but I had to do what I could by myself because no one was available to help me. I also explained to him that I was the only one down on that end and I can only help one person at a time, but I did acknowledge his light to let him know I would be there as soon as I can. He continued to holler and say, "You need to get me to the bathroom right now. I can't wait."

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Review of a statement written by Nurse #3 who was on duty on 12/24/16 revealed that she noticed NA#1 walking past her in the hallway mumbling, looking upset and frustrated. She stated that she went into Resident #1's room and his roommate told her that NA#1 dropped Resident #1 in his wheelchair. Nurse #3 wrote that the NA #1 told her that when she was lifting Resident #1 "he was yelling and rushing her and she had to hurry up to put him back in the chair. NA#1 never asked for help that time."

During interview with the facility social worker via telephone on 2/28/17 at 4:25 PM she stated that Resident #1 and his family came down to talk to her on Christmas day. He reported that NA #1 was rough with him and manhandled him. He stated that he did not want NA #1 back in his room. The NA stated that she was concerned about the roughness and spoke with the nurse on duty and left a message for the administrator.

Interview via telephone with the former Director of Nurses (DON) revealed that she interviewed Resident #1 and his roommate on 12/26/16. Resident #1 said that everything was alright. His roommate said he heard him yelling but thought that was because he was going to the bathroom. He stated he did not see anything or see NA #1 hurt him. Later in the week the resident said she skinned his bottom. The DON stated that she was present during the skin assessment and his bottom was red instead of skinned due to wounds on his bottom. She stated the resident needed 2 people to transfer. The DON said that NA #1 could not have picked Resident #1 up the way he said because she (NA#1) had pins in her arm and had some limitations. The DON said that the resident changed his story when he and his

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roommate were in the room together stating we were in service together (referring to military service) and we're sticking together.

Interview with Nurse #2 (treatment nurse) on 2/25/17 at 4:56 PM revealed that she conducted a complete skin assessment for Resident #1 on 12/28/17. She stated that she was already treating multiple wounds and using zinc oxide to his entire perineum. His penis was raw, pink, had discoloration and some breakdown to the groin area. Nurse #2 said that the resident's bottom and groin area looked a little redder but it did not look scraped nor did he have a skin tear. She described the area as macerated and stated he had incontinence dermatitis to his penis and scrotum.

Interview with the administrator at 3:35 PM on 2/25/17 revealed that NA #1 was terminated because she was careless with care and could have done something different. She said the resident could require the assistance of 1 or 2 people because he used a sliding board. She stated he was a 2 person assist if he was not using a sliding board. She reported that NA #1 did not use a gait belt.