STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 05/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 5/16/17 through 5/23/17. Immediate jeopardy was identified at CFR 483.12 at tag F 223 at a scope and severity (J) CFR 483.12 at tag F 226 at a scope and severity (J) CFR 483.70 at tag F 490 at a scope and severity (J) The tags F 223 and F 226 constituted Substandard Quality of Care. Immediate jeopardy began on 5/11/17 and was removed on 5/18/17. An extended survey was conducted. On 5/23/17, additional information was obtained from the facility and the CA for F 223 and F 490 was amended.	F 000		
F 223 SS=J	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 223		6/26/17

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

Electronically Signed | 06/14/2017

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F 223	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, resident and physician interview, the facility failed to protect 2 (Residents # 2 & # 7) of 2 sampled residents from abuse. Resident #2, who was cognitively impaired, was witnessed by residents and staff being sexually abused by Resident #1, who was cognitively intact. Resident #7, who was cognitively intact, was verbally abused by Nurse #2. Immediate jeopardy began on 5/11/17 for Resident #2 when he was sexually abused by Resident #1. It was witnessed by NA #1 and NA #1 did not remove Resident # 2 from the situation. Immediate jeopardy was removed on 5/18/17 when an acceptable credible allegation was provided. 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) for example #2, Resident #7 and to ensure all staff members are in-serviced and interventions put in place are effective. Findings included: 1. Resident #2 was admitted to the facility on 4/14/17 with multiple diagnoses including Intellectual Disability, hydrocephalus status post ventriculo peritoneal (VP) shunt and Poly substance abuse. He was assessed as Preadmission Screening Resident Review (PASRR) level II. Resident #2 was discharged to an assisted living facility on 5/12/17. Resident #2's admission Minimum Data Set (MDS) assessment dated 4/20/17 indicated that	F 223	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. 1. 5/11/17 Resident #1 and Resident #2 were immediately separated and Resident #1 was placed on One on One Supervision. Resident #1 and Resident #2 were interviewed separately by Social Services Director on 5/11/17 immediately following the event and both residents indicated the incident that occurred had been consensual. Police were notified immediately by the Charge Nurse and came to the facility at 8:30pm 5/11/17 to interview Resident #1 and Resident #2. Resident #1 and Resident #2 reported that a consensual kiss occurred and denied other physical contact. Police determined and communicated to Administrator that no crime had been committed. Resident #2 was assessed by the Charge Nurse on 5/11/17 following the event, according to Charge Nurse Assessment was within normal limits but was not documented in medical record. The Physician of Resident #1 and Resident #2 was notified by the Administrator. Resident #2 was placed on 15 minute checks by the charge nurse with emotional support provided by the Social Services Director until discharge	

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F 223	Continued From page 2 he had impaired cognition. The Care Area Assessment (CAA) indicated "triggered for cognition related to Brief Interview for mental status (BIMS) score of 08/15. Diagnoses includes Mental Retardation (MR), anxiety disorder, encephalopathy, and epilepsy. Able to verbalize needs. Had prior placement in group home setting but cannot return. Currently receiving skilled therapy. Displays behaviors which are not of new onset. Has support from family." Resident #2's care plan dated 4/26/17 was reviewed. One of the care plan problems was "(name of Resident #2) has impaired cognitive function and impaired thought processes related to MR, Anxiety disorder, cognitive impairment, polysubstance abuse and epilepsy." The goal was Resident #2 "will be able to communicate basic needs on a daily basis and have minimal risk of injury related to cognitive impairment through the review date." The approaches included to identify self at each interaction, face resident when speaking and make eye contact, reduce any distractions and to try to provide consistent care givers as much as possible in order to decrease confusion. List of abuse investigations since the last survey (March 2017 to present time) was requested from the Administrator. The Administrator provided folders containing written statements from residents and staff. There were 2 incidents were staff and residents were alleging abuse. One of the two incidents was for Resident #2. The staff and residents alleged that Resident #2 was sexually abused by Resident #1. Resident #1 was admitted to the facility on	F 223	5/12/17. Social Services Director completed a Health Questionnaire and BIMS (Cognitive Assessment) on Resident #2 on 5/12/17 prior to discharge to ALF. Resident #2 with BIM of 8 with no change from prior assessment. Resident #1 is responsible his own Responsible Party. Resident #1 was provided education by the Social Services Director and Administrator on safe sex, with the understanding that privacy would be offered upon request for friends/visitors. Resident #1 was transported to Emergency Room for Psych and Medical evaluation on the night of 5/11/17 were he was diagnosed with a Urinary Tract Infection and discharged at 10:23am from Emergency Room with a friend 5/12/17. Resident #1 returned to the facility from leave of absence on 5/16/17 and was immediately placed on One on One Supervision until Interdisciplinary team established a re-evaluation. Resident #1 no longer resides in facility as of 6/12/17. Resident #7 was interviewed by Administrator and denies any abuse by staff or any other resident in any capacity. Resident #7 BIM is 15 with no change from last assessment. Abuse and abuse reporting education provided to Resident #7 by Administrator and Social Services Director. Nurse #2 no longer employed at this facility. 2. Audit completed 5/18/17 by Social Services Director, Social Services Assistant, Activities Director and Nurse Managers of current residents with BIMS score of 8-15, this audit included one on	

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F 223	Continued From page 3 12/22/16. His diagnosis included a disease that could spread by sexual contact. His quarterly MDS assessment dated 5/5/17 indicated that he had intact cognition. Resident #1's nurse's notes were reviewed. The notes dated 5/11/17 at 9:07 PM revealed "at approximately 7:15 PM this nurse was called to the resident's smoking area because Resident #1 was touching Resident #2 inappropriately. When I got to the smoking area I noted Resident #1 trying to put his hand back into Resident #2's pants. I stated to Resident #1 that he needed to stop what he was doing right now. Resident #1 then replied "I can jerk him off he likes it." I told him he can't do that in the open for all to see. Considering other residents and family members were outside looking. After I started talking to Resident #2 and make sure his penis was in his underwear and not hanging out I realized he may not understand what was going on. At that time Resident #1 says "He's a grower not a shower." I told Resident #1 that Resident #2 may not understand and he said " I'm going to suck his d--- in his room tonight I'm getting me some d--- honey." I tried to redirect the conversation by asking Resident #1 what was he doing and he had a boyfriend he stated "We mad at each other he won't f--- me." An aide brought Resident #2 back into the building and took him to the social worker. A nursing Assistant asked Resident #1 what was he doing and he stated "Molesting this little boy." Resident #1 then came inside and said at the nurses station out loud "it's nothing you all can do I'm going to get me some of that d--- and my old man upset." We immediately began 1 on 1 care for Resident #1 to monitor his behavior. At 7:20 PM, the administrator and Director of Nursing (DON) were contacted. At 7:30 PM, I	F 223	one interviews by questioning each resident to determine any other residents who have been approached in an inappropriate manner by any other resident/staff or made to feel uncomfortable. Responsible Party or Guardians of residents with BIM below 8 were contacted regarding abuse and abuse reporting by Social Services Director. Audits were completed on 5/18/17 with no new allegations at this time. All staff to include agency, interviewed by Administrator and Staff Development Coordinator on 5/18/17 regarding abuse an abuse reporting. No negative outcomes identified at this time. 3. 5/17/17 -5/18/17 In-services provided to nursing and non nursing staff by Administrator and Staff Development Coordinator on Abuse Prohibition to include Elder Justice Act, what to do if a resident displays aggressive behaviors, and actions to be taken if abuse was observed and or suspected, reporting and resident assessment. Staff Development Coordinator provided in-service to all nursing and non-nursing weekend and part-time staff via phone. Nursing and non nursing staff not permitted to work until in service completed. Facility to monitor and review all new grievances in morning meeting to ensure proper follow up and to identify any possible alleged abuse. Compliance rounds completed daily. Administrator and Social Services Director to provide in-services on sexuality and intimate relationships in long term care settings. To be completed by 6/29/17.	

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F 223	Continued From page 4 called on call physician and he returned the call at 7:45 PM. (Name of physician) ordered for Resident #1 to be sent to the emergency room (ER) to have a psych evaluation. The responsible party (RP) of Resident #1 was contacted and made aware of the new order and expressed that she understood. At 8:00 PM, contacted county Police department and at 8:15 PM (name of Officer) came to the building to do the police report. I explained to him what happened. I also showed him the area the incident happened in as well. At 8:30 PM, we both interviewed Resident #2 and we asked what happened and if he gave Resident #1 permission to touch him on his penis. Resident #2 said that Resident #1 had touched his penis and he told him to stop 3x (times) and Resident #1 did not. That he was not like that (meaning gay) like Resident #1. Resident #1 kept doing it and Resident #2 said that Resident #1 had kissed him 2x before in the mouth. Resident #2 also said he didn't want Resident #1 around him anymore. He wanted the police to tell Resident #1 this as well and that next time he'll testify against him. But right now he didn't want Resident #1 to go to jail. At 8:45 PM we interviewed Resident #1 who said that Resident #2 wanted to be touched and liked it. But he had learned his lesson this time. (Name of Officer) explained to Resident #1 the consequences of his actions and he acknowledged the fact that he understood what the officer was stating to him. At 9:00 PM, nonemergency transport picked up Resident #1 and transported him to the emergency room (ER) for the psych evaluation. Called and gave report to ER at 9:15 PM. Resident #1 left in stable condition." Tried to interview Nurse #1, author of the nurse's	F 223	Administrator/Staff Development Coordinator will continue to provide education to staff to include all new hires and any new agency. Administrator, Social Worker, or Staff Development Coordinator will provide education on Abuse Prohibition to include Elder Justice Act to all new hires during orientation. This will be completed by date of compliance. All new admission packets will include the facilities Abuse Prohibition Policy and Facility Grievance Policy to be discussed during admission process. 4. Audit tools will be used by Social Services Director to interview 10 Family/ Resident weekly x 6 weeks, then 5 Family/Residents weekly x 6 weeks to determine if there are any new alleged allegations. Audit tools will be used by Administrator, Director of Nursing, Unit Managers and Therapy Manager to interview 10 staff members weekly x 6 weeks, and then 5 staff members weekly x 6 weeks to determine if there are any new alleged allegations. The Administrator or Director of nursing will report any new allegations of abuse to state and the proper authorities. Results will be brought to QAPI monthly x 3 to assure compliance.	

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notes dated 5/11/17 but not available.

Review of the EMS report dated 5/11/17 revealed that a non- emergency transport was dispatched to (the name of facility). The nurse at the facility stated that they had caught Resident #1 performing sexual acts on another resident (Resident #2) and he was transported to the ER for psychiatric evaluation. The report further stated that Resident #1 was able to walk from stretcher to the wheelchair without assistance.

Review of the ER notes dated 5/11/17 revealed that Resident #1 presented in ER via EMS from the (name of facility) for psychiatric evaluation. Resident #1 stated that he "was caught masturbating another patient (Resident #2) that was mentally disabled." Resident #1 also stated that "well, he (Resident #2) told me he liked it until we got caught." The notes revealed that Resident #1 denied "suicidal ideation/homicidal ideation or hallucinations. Denies any previous charges/convictions for sexual assault." Resident #1 was diagnosed with Urinary Tract Infection (UTI) and was discharged back to facility with a prescription for antibiotic.

Review of the Police report dated 5/11/17 revealed "Nurse reported that some of the staff had observed a male patient (Resident #1) at the facility masturbating another male patient (Resident #2). Nurse stated that the person (Resident #2) being masturbated did not have the mental capacity to consent to such activity." The report further indicated that the Police and the Nurse interviewed the alleged victim (Resident #2). He stated that the offender (Resident #1) kissed him on the mouth and masturbated him. He indicated that he told the offender (Resident

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#1) to stop on 3 different occasions but he did not until staff interrupted the incident. The report revealed that "while interviewing the victim (Resident #2), he appeared to be cognitively aware of everything that happened and appeared to use normal reasoning skills. The victim (Resident #2) told me and the Nurse that he did not want to pursue charges at this time however he did want me to speak to the offender (Resident #1) and make him aware that if anything like this ever occur again he would pursue charges." The report also revealed that the Police had spoken with the offender (Resident #1) who denied that the victim (Resident #2) ever told him to stop.

The written statement from the SW dated 5/11/17 was reviewed. The statement was an interview with Resident #1. The statement indicated that when the SW questioned Resident #1 what happened, he stated that he had asked Resident #2 if he could touch his d--- and he said he could. Resident #1 also indicated that he asked Resident #2 if he was in his right mind and he said he was. Resident #1 then stated that he asked him if he could feel it, and he said he could. SW asked him if he touched Resident #2 and he said "yes." SW also revealed that Resident #1 smelled alcohol and had a styro foam cup with him. The cup was empty but smelled of beer. When asked if he was drinking and he replied "yes." When he was leaving the office Resident #1 stated that the facility could not stop him from smoking, drinking or doing anything he wanted.

The written statement from the SW dated 5/11/17 was reviewed. The statement was an interview with Resident #2. The statement indicated that

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Resident #2 stated that he was not a gay but he thought that Resident #1 was. He indicated that Resident #1 had told him that he wanted to do him in his b--- h--- and then he kissed him. Resident #2 stated that Resident #1 wanted him as a boyfriend because he was little. He denied Resident #1 touching him.
The written statement from the SW dated 5/11/17 was reviewed. The statement was an interview with Resident #8. Resident #8 stated that he was in the smoking area when he saw Resident #1's taking his hands out of top of Resident #2's waistband.

The written statement from the SW dated 5/12/17 was reviewed. This statement was from an interview with Resident #11. Resident #11 reported to the SW that Resident #1 and the guy (Resident #2) were out in the smoking area. The resident stated that Resident #1 got in the guy's pants and he said that he was making it hard then they kissed on the mouth.

Resident #11 was not available for interview.

The written statement from NA #1 dated 5/12/17 was reviewed. The statement revealed that she was in the smoking area when she saw the hands of Resident #1 down in Resident #2's pants. NA #1 indicated that she told them this was not the appropriate area because there were other people out there. She told Resident #1 to stop but he would not stop. She went to get the nurse.

The written statement from the SW dated 5/12/17 was reviewed. This statement was an interview with Resident #9. Resident #9 informed the SW that they were all smoking in the smoking area. It just happened that she looked and saw Resident

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#1's hands down the boy's pants (Resident #2). She yelled at him asking him what he was doing and he replied "was playing with the guy's d-----." Then Resident #1 yelled saying "you b---- mind your own business." NA #1 was there and she went to get the nurse. While the NA was gone, Resident #1 lifted Resident #2's shirt up and was playing with his chest. He asked him for a kiss and the boy gave him a pop kiss on the lips.

The written statement from the SW dated 5/12/17 was reviewed. This statement was an interview with Resident #10. Resident #10 stated that they were all smoking in the smoking area when Resident #9 yelled at Resident #1 asking him what the h-- he was doing. Resident #10 turned and saw Resident #1 playing with the guy. Resident #1 stated that he was about to play with the guy's d---. Resident #10 asked Resident #1 if he was serious, it was very disrespect with woman out there. Resident #1 replied "b----- mind your own business."

Resident #1's doctor's progress notes dated 5/15/17 was reviewed. The progress notes revealed that the Nurse Practitioner had seen Resident #1 following an alleged sexual assault. The notes indicated that Resident #1 was reported to have sexually assaulted another resident (Resident #1). The other resident (Resident #2) was a male who was intellectually challenged.

A brief tour of the facility was conducted on 5/16/17 at 11:40 AM. Resident #1, who was cognitively intact, was observed in his room. Patient Care Assistant (PCA) #1 was observed outside of Resident #1's room. At 11:45 AM, PCA #1 was interviewed. She stated that Resident #1

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was on 1:1 monitoring because he had grabbed a resident's private area (Resident #2).

On 5/16/17 at 1:55 PM, the Social Worker (SW) was interviewed. She stated that she was at the facility when the incident happened. The staff members informed her that Resident #1 had inappropriately touched Resident #2. She interviewed both residents and had written statements. She also called the Administrator. The SW added that when she interviewed Resident #1, he was holding a cup that was empty. The cup smelled of beer.

On 5/16/17 at 2:00 PM, the Administrator was interviewed. She stated that she received a call from the facility on 5/11/17 at 7:21 PM informing her of the situation regarding Resident #1 and Resident #2. The Nurse assigned to Resident #1 was no longer employed at the facility. The Police was called and staff and residents were interviewed. The Administrator stated that after the interview with Resident #2 who denied being inappropriately touched by Resident #1 and after talking to the Police, the kissing between Resident #1 and #2 was consensual, so she didn't implement the abuse policy. The Administrator had provided a copy of the timeline of the incident and the written statements from the staff.

The timeline included:
1. 7:21 PM, received a call from facility nurse that there was a situation in which Resident #1 had inappropriately touched Resident #2
2. Resident #2 was removed from smoke area and placed on 15 minute checks to ensure there was no emotional distress displayed.
3. Resident #1 was brought inside the facility

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and placed on 1:1 monitoring.
4. Resident #2 interviewed by the SW at this time.
5. Resident #1 interviewed by SW
6. Follow up interviews with staff and residents present at the time of incident.
7. Physician notified and Police called. New orders obtained to send Resident #1 out for psychiatric evaluation.
8. Resident #1's RP notified at 7:30 PM. Resident #2's guardian notified by Administrator via telephone. Message left to please return call.
9. 8:30 PM, Police into facility and spoke to both residents at different times. Then spoke to Administrator stating that no crime has been committed here and that Resident #2 was very alert and coherent and could explain everything that happened, but didn't want Resident #1 around him anymore. No arrest where made at this time.
10. Resident #1 out of facility via EMS for evaluation.
11. Resident #1 returned to facility 5/12/17 at 10:23 AM from ER with significant other. Resident sat outside in the car and significant other brought paperwork in from the hospital and signed Resident #1 out on leave of absence (LOA).

On 5/16/17 at 2:05 PM, Resident #8, who has intact cognition, was interviewed. He stated that he was in the smoking area the evening of 5/11/17 smoking. Several other residents including Resident #9 and #10 were there smoking. He heard Resident #9 screaming, he turned around and saw Resident #1 pulling his hands out of Resident #2's pants. Resident #2 was a young guy who was mentally challenged

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and he acted as if nothing had happened.

A telephone interview was conducted on 5/16/17 at 2:40 PM with Resident #2. He stated that Resident #1 had kissed him on his lips 2-3 times in the past. He indicated that he reported it to the nurse (didn't know name) and the Administrator. He added that he didn't like him kissing him and told him to stop. Resident #2 was unable to remember the incident on 5/11/17 in the smoking area.

On 5/16/17 at 3:44 PM, Nursing Aide (NA) #1 was interviewed. She indicated that she had known Resident #2 and he was alert but confused at times. She also stated that she had known Resident #1. His cognition was intact and he was able to walk but preferred to use a wheelchair. NA #1 reported that she was outside smoking with other residents including Resident #1, #8, #9 and #10 the evening of 5/11/17. Resident #2 came and sat beside Resident #1. Few minutes later, she observed Resident #1 put his hands inside the pants of Resident #2. Resident #2 didn't say a word. She didn't hear Resident #1 asking permission from Resident #2 if he could touch him. She told Resident #1 that this was a wrong place for him to do it and he responded "you b---- if you didn't like it turn your head away." She then went to get the nurse.

On 5/16/17 at 4:25 PM, the smoking area was observed. Resident #1, #8, #9 and #10 were observed smoking in the smoking area. A staff member was also observed. There was no unusual behavior observed.

On 5/16/17 at 4:45 PM, Resident #9, who has intact cognition, was interviewed. She stated that

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she was outside in the smoking area smoking with other residents the evening of 5/11/17. She indicated that Resident #2 came in the door and sat beside Resident #1. Later on, she saw Resident #1 with his hands inside the pants of Resident #2. She yelled at Resident #1 saying "what the h-- are you doing to that boy?" Resident #1 replied "playing with his d----. You b----, mind your own business." The NA who was in the smoking area saw it and she went to get the nurse. Resident #9 indicated that Resident #2 was mentally challenged and he didn't know what Resident #1 was doing to him.

On 5/16/17 at 5:00 PM, Resident #10, who has intact cognition, was interviewed. He stated that he was outside in the smoking area smoking the evening of 5/11/17. He saw Resident #2 came in the door and later on he observed Resident #1's hands in Resident #2's pants. When he asked Resident #1, he responded "getting ready to play with his d-----." Resident #10 stated that he was so mad and wanted to hit him. He indicated that Resident #2 has a mind of a 5 year old.

On 5/16/17 at 5:10 PM, Resident #1 was interviewed. He stated that he remembered the incident with Resident #2 in the smoking area. He stated that he was "just playing with his d---." He added that it was not a big deal as Resident #2 was okay with it.

On 5/1617 at 8:39 PM, the Police called back and was interviewed. He stated that the only information he could share was "he handled the case the way the alleged victim wants it to be handled."

On 5/17/17 at 1:40 PM, the previous

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Administrator was interviewed. She stated that nobody had reported to her that Resident #2 had been kissed by Resident #1.

On 5/18/17 at 11:30 AM, the physician of Resident #1 and Resident #2 was interviewed. He stated that the facility had called and informed him about Resident #1 kissing Resident #2. He was also informed that the Police was contacted and there was no harm done to Resident #2. He indicated that he came to facility to assess Resident #2. He asked him about the kiss and he acknowledged that Resident #1 had kissed him. He didn't ask him about inappropriate touching because he was not informed by the facility that he was also inappropriately touched by Resident #1. The physician also shared that he went to the assisted living facility where Resident #2 was currently residing to interview him. He asked him again and he remembered about the kissing and he was embarrassed about the situation. He didn't asked him about the inappropriate touching because nobody had told him about it. The physician also indicated that Resident #2 had told him that he liked woman and not man. The physician stated that Resident #2 can make simple decision but not complex decision and he considered giving a consent for fondling was a complex decision to make.

A telephone interview on 5/23/17 at 10:15 AM was conducted with NA #1. NA #1 stated that when she observed Resident #1 touching Resident #2 inappropriately, she tried to remove Resident #2 away from Resident #1 but Resident #2 had refused. Then she tried to remove Resident #1 but he locked his wheelchair so she could not move it. So she left the smoking area to get the nurse.

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The administrator was notified of immediate jeopardy on 5/17/17 at 2:21 PM.

Credible Allegation:

1. On 5/11/17 at 7:21pm the Social Services Director notified the Administrator via phone of an event occurring in the smoking area where Resident #1 allegedly touched the penis of Resident #2. Resident #1 and Resident #2 were immediately separated by the Smoking Supervisor and Resident #1 was placed with one on one supervision. Resident #2 was placed on every 15 minute checks by the Charge Nurse with emotional support provided by the Services Director until discharge from the Facility on 5/12/17. Resident #1 and Resident #2 were interviewed separately by the Social Services Director on 5/11/17 immediately following the event and both indicated the event that occurred was consensual in nature when interviewed. The Police were notified immediately by the Charge Nurse and came to the facility at 8:30pm 5/11/17 to interview Resident #1 and Resident #2 During the course of this interview both parties reported a consensual kiss occurred and denied other physical contact. The Police determined and communicated to the Administrator that no crime was committed. Staff and Residents present when the event occurred were interviewed as part of the investigation, on 5/11/17 results of these interviews showed varying descriptions of the event that spanned from observations of a Resident #1 kissing Resident #2 to observations of Resident #1 touching the outside of Resident #2's pants and another that described Resident #1 placing his hands in the pants of Resident #2. The Physician of Resident #1 and Resident #2

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was notified by the Administrator on 5/11/17 at 7:30pm. The Administrator attempted to notify the Guardian for Resident #2 via phone message on 5/11/17 at 8:15pm, the message stated that the Administrator needed to discuss the event that occurred at the facility on 5/11/17. The Administrator attempted again to notify the Guardian for Resident #2 at 4:00pm on 5/12/17 prior to his discharge. On 5/18/17 at 1:00pm the Administrator and the Social Services Director made a third attempt to contact the Guardian for Resident #2 and left the same message as previous. Resident #1 is responsible for his own affairs. Resident #1 was transported to the Emergency Room for Psych and Medical evaluation, where he was diagnosed with a Urinary Tract Infection and discharged back to the Facility on 5/12/17 at 10:23am. Resident #1 sat outside in the car while He was signed out of the facility for a leave of absence by his friend on 5/12/17 and returned from the leave of absence on 5/16/17 and one on One Supervision was immediately restarted. One on One Supervision will be discontinued when the Interdisciplinary team agrees it is appropriate based on Psych and Medical evaluations to be completed by 5/23/17. Resident #2 was assessed by the Charge Nurse on 5/11/17 following the event, according to the Charge Nurse this assessment was within normal limits but was not documented in the medical record. The Social Services Director completed a Health Questionnaire and BIMS (Cognitive assessment) with score of 8 on 5/12/17. On 5/12/17 Resident #2 was discharged to an Assisted Living Facility as previously planned prior to this event.

2. Current residents have the potential to be affected by this alleged deficient practice. The Social Services Director, Social Services

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Assistant, Activities Director, and Nurse Managers conducted audits of current residents with a BIMS score of 8-15. This audit was completed on 5/18/17. This audit include one on one interviews by questioning each resident to determine any other residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable. For Residents who's BIMS score is below 8 the same audit and interview was conducted with their Responsible Party. No new allegations of abuse or residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable were identified as a result of these audits completed on 5/18/17.
On 5/18/17, the Administrator, Social Services Director, Director Clinical Services and Nurse Managers completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. No new allegations were identified as a result of the interviews conducted by 5/18/17. No facility staff shall return to work until interviews are completed. The Facility's Abuse Prohibition Policy was reviewed by the District Director of Clinical Services, the Director of Nursing and the Administrator and all required components related to F 223 were present.
1. Resident #2 received a planned discharge to an Assisted Living Facility on 5/12/17. Resident #1 remains on One on One Supervision in the Facility until the Interdisciplinary Team agrees to remove based on Psych services and Medical evaluations by 5/23/17. The Administrator and Director of Nursing were immediately re-educated by the District Director of Clinical Services regarding Abuse Prohibition to include the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect 5/17/17 On 5/18/17 facility staff, the Nursing

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F 223	Continued From page 17 Department, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration were re-educated by the Director of Nursing, Nurse Managers, and Staff Development Coordinator regarding; " The definition of Abuse: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Injuries of unknown origin may occur as a result of abuse. " Immediate intervention to stop " No tolerance for abuse Beginning 5/18/17 no Facility staff including Nursing, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration shall work prior to receiving this education. All new employees and any agency will be educated on the above prior to working in resident care area by the Administrator, Director of Nursing or Staff Development Coordinator. Facility Staff will be provided this education at least annually via the Administrator, Director of Nursing or Staff Development Coordinator. This education will be included in the facility's new hire orientation and newly hired Facility Staff will not be permitted to assume their floor responsibilities until they have completed this education	F 223		

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The credible allegation was verified on 5/18/17 at 5:00 PM as evidenced by staff interviews on abuse policy and procedures, different types of abuse, what to do if a resident displayed aggressive behaviors and actions to be taken if abuse was observed and/or suspected, reporting and resident assessments. Alert and oriented residents were also interviewed to assess if any other residents were affected.
Review of in-service records revealed 142 facility staff (licensed nursing staff, unlicensed nursing staff, administrative staff, activities, social worker) had been in-serviced by 5/18/17 and staff who did not have the in-service will be in-serviced prior to working on floor.
Review of list of alert and oriented residents and list of families who were interviewed to assess if any other residents were affected.

2. Resident #7 was admitted to the facility on 11/3/14 with multiple diagnoses including malignant neoplasm of bone and prostate.

Review of Resident #7's quarterly MDS assessment dated 4/27/17 indicated that his cognition was intact and he had no behavior.

Review of Resident #7's nurse's notes dated 3/28/17 revealed "resident was highly upset with his nurse because he had not had his Fentanyl (narcotic pain medication) patch changed yet. He was threatening his nurse's job because she had to prioritize her care for woman who had fallen. When I asked him to calm down, he shouted at me "F-you." I asked him why is he swearing at me and he repeated "F-you faggot" and wanted me to swing at him. I told him I wasn't that stupid. He then said he has a friend coming to visit and

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he "would take care of me."

The author of the nurse's notes dated 3/28/17 was Nurse #2 and he was not available for interview.

Review of Nurse #2's personnel records revealed that he was terminated on 4/5/17 due to no call no show.

List of abuse investigations since the last survey (March 2017 to present time) was requested from the Administrator. The Administrator provided folders containing written statements from residents and staff. There were 2 incidents were staff and residents were alleging abuse. One of the two incidents was for Resident #7.

Review of the statement written on 3/28/17 by Nurse #3 revealed "at approximately 4:30 PM I was in a room giving a resident medications when a Certified Medication Aide (CMA) came into the room with a look of fear on her face and said "I need you now." I went out in the hall and I could hear 2 people arguing and cursing very loudly. When I got over to station 3, Nurse #2 and Resident #7 were in verbal altercation. I tried to stop the verbal altercation and Resident #7 became very angry calling Nurse #2 a faggot and cursing him. Resident #7 jumped at Nurse #2 and 2 Resident Care Assistants (RCA) grabbed him and another RCA was trying to get Nurse #2. This is when Nurse #2 began shouting to Resident #7 "hit me M-F---!!" over and over. I was unable to stop this from happening and the RCA and the Activity Assistant were able to get Resident #7 to his room. This yelling and cursing between Nurse #2 and Resident #7 lasted probably 5 minutes while I was there."

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Review of the statement written on 3/29/17 by CMA revealed "around 5:30 PM on 3/28/17 I heard a loud altercation coming from around the corner on station 3 between Resident #7 and Nurse #2. Both were cursing and arguing with one another. Resident #7 was threatening Nurse #2. Nurse #2 was telling Resident #7 "go ahead and hit me, come on, f-me, f-you." I got Nurse #3 to see if she could help the confrontation. Like I said it was so sudden and off guard there was a lot of shouting and cursing between both individuals."

A telephone interview with the previous Administrator was conducted on 5/17/17 at 1:40 PM. She indicated that she remembered the incident with Resident #7 and Nurse #2. She acknowledged that she had read the written statements from the staff members. She revealed that she had interviewed Resident #7 and Nurse #2 and they both denied verbal abuse and so she did not proceed to follow the abuse policy. She also indicated that she did not document her interview with Resident #7 and Nurse #2.

An interview with the current Administrator was conducted on 5/17/17 at 1:45 PM. The current Administrator read the 3 written statements from the staff members and stated that this was a verbal abuse.

5/17/17 at 2:05 PM, Resident # 7 was interviewed. He remembered the incident with Nurse # 2. He was very mad at him (Nurse #2). He went to the nurse's station to ask his nurse for his pain medication as it was already late. His nurse was explaining as to why his medication

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was late and Nurse #2 stepped in. He was so mad and acknowledged that he did scream at his nurse. Then Nurse #2 started screaming at him back. He was also so mad to him (Nurse #2) for stepping in, he was not his nurse. Resident #7 did not remember what Nurse #2 had told him because he was very mad at him.

An interview with the Activity Assistant (AA) was conducted on 5/17/17 at 2:13 PM. The AA stated that she was at the nurse's station and she heard Resident #7 asking for his medication. The nurse assigned to Resident #7, responded to him "it's only 2 hours late and you are not going to die." Resident #7 went back to his room and asked for a concern form. She went to get a concern form for Resident #7. When she came back she observed Nurse #2 screaming and cursing saying F---, M-F-words several times to Resident #7. The AA indicated that the Director of Nursing (DON) was informed and she requested to write a statement. She stated that the response from the nurse to the resident was inappropriate.

An interview with Nurse #3 was conducted on 5/18/17 at 8:00 AM. She stated that she was on the medication cart on the other station passing medications. She could hear the screaming and cussing on station 3. A staff member (CMA) came and told her to come now. When she arrived at station 3, Resident #7 and Nurse #2 were arguing and cursing very loudly. She tried to stop the verbal altercation. Staff members tried to stop both of them, when Nurse #2 began shouting to Resident #7 "hit me, hit me m-f-"over and over again. The verbal altercation lasted for 5 minutes while she was there.

An interview with CMA was conducted on 5/18/17

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F 223	Continued From page 22 at 9:04 AM. The CMA indicated that she was on another station working and she could hear a loud altercation from station 3. She went to station 3 and observed Resident #7 and Nurse #2 cursing at each other. Resident #7 was threatening Nurse #2. Nurse #2 responded to Resident #7 "hit me, come on, f-me, f-you." She went to get Nurse #3.	F 223		
F 226 SS=J	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse,	F 226		6/26/17

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F 226	Continued From page 23 neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, resident and physician interview, it was determined that the facility failed to operationalize abuse policies and procedures in the areas of identification (immediately assessing if other residents could have been affected) and reporting (notifying the state agency and adult protective services) for 2 (Resident #2 & #7) of 2 sampled residents reviewed for abuse. Immediate jeopardy began on 5/11/17 for Resident #2 when other residents were not assessed for potential abuse and the allegation of abuse was not reported to the state agency and adult protective services after Resident #2 was sexually abused by Resident #1. Immediate jeopardy was removed on 5/18/17. An acceptable credible allegation was provided on 5/23/17. The facility remains out 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) for example #2, Resident #7 and to ensure all staff are in-serviced on abuse and the monitoring systems put into place are effective. Findings included: The facility's abuse policy and procedure dated January 2017 was reviewed. The policy under Identification read in part "The facility Quality Assurance and Performance Improvement	F 226	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. 1. On 5/11/17 at 7:21pm the Social Services Director notified the Administrator via phone of an event occurring in the smoking area where Resident #1 allegedly touched the penis of Resident #2. Resident #1 and Resident #2 were immediately separated by the Smoking Supervisor and Resident #1 was placed with one on one supervision. Resident #2 was placed on every 15 minute checks by the Charge Nurse with emotional support provided by the Services Director until discharge from the Facility on 5/12/17. Resident #1 and Resident #2 were interviewed separately by the Social Services Director on 5/11/17 immediately following the event and both indicated the event that occurred was consensual in nature when interviewed. The Police were notified immediately by the Charge Nurse and came to the facility at 8:30pm 5/11/17 to interview Resident #1 and Resident #2 During the course of	

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(QAPI) Committee will review available data to identify patterns and trends that may indicate the presence of abuse, neglect, injuries of unknown origin or misappropriate of resident property. The facility supervisory staff will integrate into the supervisory process monitoring staff members and residents for behavior indicative of high stress levels that may lead to abuse/neglect or may escalate a continuum of aggression."
The policy under Reporting and Response read in part "The facility will report all allegation and substantiated occurrences of abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation of property to the administrator, State Survey Agency, Law Enforcement officials and adult protective services (where state law provides for jurisdiction in long term care facilities) in accordance with State Law through established procedures."

Findings included:

1. Resident #2 was admitted to the facility on 4/14/17 with multiple diagnoses including Intellectual Disability, hydrocephalus status post ventriculo peritoneal (VP) shunt and Poly substance abuse. He was assessed as Preadmission Screening Resident Review (PASRR) level II. Resident #2 was discharged to an assisted living facility on 5/12/17.

Resident #2's admission Minimum Data Set (MDS) assessment dated 4/20/17 indicated that he had impaired cognition. The Care Area Assessment (CAA) indicated "triggered for cognition related to Brief Interview for mental status (BIMS) score of 08/15. Diagnoses includes Mental Retardation (MR), anxiety disorder, encephalopathy, and epilepsy. Able to

this interview both parties reported a consensual kiss occurred and denied other physical contact. The Police determined and communicated to the Administrator that no crime was committed. Staff and Residents present when the event occurred were interviewed as part of the investigation, on 5/11/17 results of these interviews showed varying descriptions of the event that spanned from observations of a Resident #1 kissing Resident #2 to observations of Resident #1 touching the outside of Resident #2□s pants and another that described Resident #1 placing his hands in the pants of Resident #2. The Physician of Resident #1 and Resident #2 was notified by the Administrator on 5/11/17 at 7:30pm. The Administrator attempted to notify the Guardian for Resident #2 via phone message on 5/11/17 at 8:15pm, the message stated that the Administrator needed to discuss and event that occurred at the facility on 5/11/17. The Administrator attempted again to notify the Guardian for Resident #2 at 4:00pm on 5/12/17 prior to his discharge. On 5/18/17 at 1:00pm the Administrator and the Social Services Director made a third attempt to contact the Guardian for Resident #2 and left the same message as previous. Resident #1 is responsible for his own affairs. Resident #1 was transported to the Emergency Room for Psych and Medical evaluation, where he was diagnosed with a Urinary Tract Infection and discharged back to the Facility on 5/12/17 at 10:23am. Resident #1 sat outside in the

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F 226	Continued From page 25 verbalize needs. Had prior placement in group home setting but cannot return. Currently receiving skilled therapy. Displays behaviors which are not of new onset. Has support from family." Resident #2's care plan dated 4/26/17 was reviewed. One of the care plan problems was "(name of Resident #2) has impaired cognitive function and impaired thought processes related to MR, Anxiety disorder, cognitive impairment, polysubstance abuse and epilepsy." The goal was Resident #2 "will be able to communicate basic needs on a daily basis and have minimal risk of injury related to cognitive impairment through the review date." The approaches included to identify self at each interaction, face resident when speaking and make eye contact, reduce any distractions and to try to provide consistent care givers as much as possible in order to decrease confusion. List of abuse investigations since the last survey (March 2017 to present time) was requested from the Administrator. The Administrator provided folders containing written statements from residents and staff. There were 2 incidents were staff and residents were alleging abuse. One of the two incidents was for Resident #2. The staff and residents alleged that Resident #2 was sexually abused by Resident #1. Resident #1 was admitted to the facility on 12/22/16. His diagnosis included a disease that could spread by sexual contact. His quarterly MDS assessment dated 5/5/17 indicated that he had intact cognition. Resident #1's nurse's notes were reviewed. The	F 226	car while He was signed out of the facility for a leave of absence by his friend on 5/12/17 and returned from the leave of absence on 5/16/17 and One on One Supervision was immediately restarted. One on One Supervision will be discontinued when the Interdisciplinary team agrees it is appropriate based on Psych and Medical evaluations to be completed by 5/23/17. Resident #2 was assessed by the Charge Nurse on 5/11/17 following the event, according to the Charge Nurse this assessment was within normal limits but was not documented in the medical record. The Social Services Director completed a Health Questionnaire and BIMS (Cognitive assessment) with score of 8 on 5/12/17. On 5/12/17 Resident #2 was discharged to and Assisted Living Facility as previously planned prior to this event. 2. Current residents have the potential to be affected by this alleged deficient practice. The Social Services Director, Social Services Assistant, Activities Director, and Nurse Managers conducted audits of current residents with a BIMS score of 8-15. This audit was completed on5/18/17. This audit includes one on one interviews by questioning each resident to determine any other residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable. For Residents with BIMS score below 8 the same audit and interview was conducted with their Responsible Party. No new allegations of abuse or residents who	

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F 226	Continued From page 26 notes dated 5/11/17 at 9:07 PM revealed "at approximately 7:15 PM this nurse was called to the resident's smoking area because Resident #1 was touching Resident #2 inappropriately. When I got to the smoking area I noted Resident #1 trying to put his hand back into Resident #2's pants. I stated to Resident #1 that he needed to stop what he was doing right now. Resident #1 then replied "I can jerk him off he likes it." I told him he can't do that in the open for all to see. Considering other residents and family members were outside looking. After I started talking to Resident #2 and make sure his penis was in his underwear and not hanging out I realized he may not understand what was going on. At that time Resident #1 says "He's a grower not a shower." I told Resident #1 that Resident #2 may not understand and he said " I'm going to suck his d--- in his room tonight I'm getting me some d--- honey." I tried to redirect the conversation by asking Resident #1 what was he doing and he had a boyfriend he stated "We mad at each other he won't f--- me." An aide brought Resident #2 back into the building and took him to the social worker. A nursing Assistant asked Resident #1 what was he doing and he stated "Molesting this little boy." Resident #1 then came inside and said at the nurses station out loud "it's nothing you all can do I'm going to get me some of that d--- and my old man upset." We immediately began 1 on 1 care for Resident #1 to monitor his behavior. At 7:20 PM, the administrator and Director of Nursing (DON) were contacted. At 7:30 PM, I called on call physician and he returned the call at 7:45 PM. (Name of physician) ordered for Resident #1 to be sent to the emergency room (ER) to have a psych evaluation. The responsible party (RP) of Resident #1 was contacted and made aware of the new order and expressed that	F 226	have been approached in an inappropriate way by any other resident or made to feel uncomfortable were identified as a result of these audits completed on 5/18/17. On 5/18/17 the District Director of Clinical Services re-educated the Administrator and the Director of Nursing 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, investigations 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 as well as assessment of all other residents that might be affected. On 5/18/16 facility staff, the Nursing Department including Nursing Assistants, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration were re-educated by the Administrator and Staff Development Coordinator regarding; Abuse and Abuse Reporting. Beginning 5/18/17 no Facility staff including Nursing, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration shall not work prior to receiving this education. All new employees and any agency will be educated on the above prior to working in resident care area by the Administrator, Director of Nursing or Staff Development Coordinator. Facility Staff will be provided this education at least annually via the	

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F 226	Continued From page 27 she understood. At 8:00 PM, contacted county Police department and at 8:15 PM (name of Officer) came to the building to do the police report. I explained to him what happened. I also showed him the area the incident happened in as well. At 8:30 PM, we both interviewed Resident #2 and we asked what happened and if he gave Resident #1 permission to touch him on his penis. Resident #2 said that Resident #1 had touched his penis and he told him to stop 3x (times) and Resident #1 did not. That he was not like that (meaning gay) like Resident #1. Resident #1 kept doing it and Resident #2 said that Resident #1 had kissed him 2x before in the mouth. Resident #2 also said he didn't want Resident #1 around him anymore. He wanted the police to tell Resident #1 this as well and that next time he'll testify against him. But right now he didn't want Resident #1 to go to jail. At 8:45 PM we interviewed Resident #1 who said that Resident #2 wanted to be touched and liked it. But he had learned his lesson this time. (Name of Officer) explained to Resident #1 the consequences of his actions and he acknowledged the fact that he understood what the officer was stating to him. At 9:00 PM, nonemergency transport picked up Resident #1 and transported him to the emergency room (ER) for the psych evaluation. Called and gave report to ER at 9:15 PM. Resident #1 left in stable condition." Tried to interview Nurse #1, author of the nurse's notes dated 5/11/17 but not available. The written statement from the SW dated 5/11/17 was reviewed. The statement was an interview with Resident #1. The statement indicated that when the SW questioned Resident #1 what	F 226	Administrator, Director of Nursing or Staff Development Coordinator. This education will be included in the facility□s new hire orientation and newly hired Facility Staff will not be permitted to assume their floor responsibilities until they have completed this education. On 5/18/17 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 weekly to ensure adherence to the Facility Policy on Abuse Prohibition and conduct a weekly focus call, if needed, to further review events occurring throughout the week to ensure completion of investigations and reporting as required. 3. 5/17/17 -5/18/17 In-services provided to all nursing and non nursing staff by Administrator and Staff Development Coordinator on Abuse Prohibition to include Elder Justice Act, what to do if a resident displays aggressive behaviors, and actions to be taken if abuse was observed and or suspected, reporting and resident assessment. Facility to monitor and review all new grievances in morning meeting to ensure proper follow up and to identify any possible alleged abuse. Compliance rounds completed daily. Administrator and Social Services Director to provide in-services on sexuality and intimate relationships in long term care settings to all nursing and non nursing staff. To be completed by 6/29/17. Administrator, Social Worker, or Staff Development Coordinator will continue to	

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F 226	Continued From page 28 happened, he stated that he had asked Resident #2 if he could touch his d--- and he said he could. Resident #1 also indicated that he asked Resident #2 if he was in his right mind and he said he was. Resident #1 then stated that he asked him if he could feel it, and he said he could. SW asked him if he touched Resident #2 and he said "yes." The written statement from the SW dated 5/11/17 was reviewed. The statement was an interview with Resident #2. The statement indicated that Resident #2 stated that he was not a gay but he thought that Resident #1 was. He indicated that Resident #1 had told him that he wanted to do him in his b-h--- and then he kissed him. Resident #2 stated that Resident #1 wanted him as a boyfriend because he was little. He denied Resident #1 touching him. The written statement from the SW dated 5/11/17 was reviewed. The statement was an interview with Resident #8. Resident #8 stated that he was in the smoking area when he saw Resident #1's taking his hands out of top of Resident #2's waistband. The written statement from the SW dated 5/12/17 was reviewed. This statement was from an interview with Resident #11. Resident #11 reported to the SW that Resident #1 and the guy (Resident #2) were out in the smoking area. The resident stated that Resident #1 got in the guy's pants and he said that he was making it hard then they kissed on the mouth. Resident #11 was not available for interview. The written statement from NA #1 dated 5/12/17	F 226	provide education on Abuse Prohibition Reporting and the Elder Justice Act to include all new hires and any new agency staff during initial orientation prior to their assuming responsibilities on the floor. This will be completed by date of compliance. All new admission packets will include the facilities Abuse Prohibition Policy and Facility Grievance Policy to be discussed during admission process. Any new alleged allegations will be reported by the Administrator or Director of Nursing to the state and proper authorities. 4. Audit tools will be used by Social Services Director to interview 10 Family/ Resident weekly x 6 weeks, then 5 Family/Residents weekly x 6 weeks to determine if there are any new alleged allegations. Audit tools will be used by Administrator, Director of Nursing, Unit Managers and Therapy Manager to interview 10 staff members weekly x 6 weeks, and then 5 staff members weekly x 6 weeks to determine if there are any new alleged allegations. The Administrator or Director of nursing will report any new allegations of abuse to state and the proper authorities. Results will be brought to QAPI monthly x 3 to assure compliance.	

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was reviewed. The statement revealed that she was in the smoking area when she saw the hands of Resident #1 down in Resident #2's pants. NA #1 indicated that she told them this was not the appropriate area because there were other people out there. She told Resident #1 to stop but he would not stop. She went to get the nurse.

The written statement from the SW dated 5/12/17 was reviewed. This statement was an interview with Resident #9. Resident #9 informed the SW that they were all smoking in the smoking area. It just happened that she looked and saw Resident #1's hands down the boy's pants (Resident #2). She yelled at him asking him what he was doing and he replied "was playing with the guy's d----." Then Resident #1 yelled saying "you b----- mind your own business." NA #1 was there and she went to get the nurse. While the NA was gone, Resident #1 lifted Resident #2's shirt up and was playing with his chest. He asked him for a kiss and the boy gave him a pop kiss on the lips.

The written statement from the SW dated 5/12/17 was reviewed. This statement was an interview with Resident #10. Resident #10 stated that they were all smoking in the smoking area when Resident #9 yelled at Resident #1 asking him what he was doing. Resident #10 turned and saw Resident #1 playing with the guy. Resident #1 stated that he was about to play with the guy's d---. Resident #10 asked Resident #1 if he was serious, it was very disrespect with woman out there. Resident #1 replied "b----- mind your own business."

Resident #1's doctor's progress notes dated 5/15/17 was reviewed. The progress notes revealed that the Nurse Practitioner had seen

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Resident #1 following an alleged sexual assault. The notes indicated that Resident #1 was reported to have sexually assaulted another resident (Resident #1). The other resident (Resident #2) was a male who was intellectually challenged.

A brief tour of the facility was conducted on 5/16/17 at 11:40 AM. Resident #1, who was cognitively intact, was observed in his room. Patient Care Assistant (PCA) #1 was observed outside of Resident #1's room. At 11:45 AM, PCA #1 was interviewed. She stated that Resident #1 was on 1:1 monitoring because he had grabbed a resident's private area (Resident #2).

On 5/16/17 at 1:55 PM, the Social Worker (SW) was interviewed. She stated that she was at the facility when the incident happened. The staff members informed her that Resident #1 had inappropriately touched Resident #2. She interviewed both residents and had written statements. She also called the Administrator.

On 5/16/17 at 2:00 PM, the Administrator was interviewed. She stated that she received a call from the facility on 5/11/17 at 7:21 PM informing her of the situation regarding Resident #1 and Resident #2. The Nurse assigned to Resident #1 was no longer employed at the facility. The Police was called and staff and residents were interviewed. The Administrator stated that after the interview with Resident #2 who denied being inappropriately touched by Resident #1 and after talking to the Police, the kissing between Resident #1 and #2 was consensual, so she didn't implement the facility's abuse policy. The Administrator had provided a copy of the timeline of the 5/11/17 incident and the written statements

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from the staff. The timeline did not indicate that assessment of other residents was completed to identify other residents who might be affected by the abuse nor the allegation of abuse was reported to the state agency and adult protective services.

The timeline included:
1. 7:21 PM, received a call from facility nurse that there was a situation in which Resident #1 had inappropriately touched Resident #2
2. Resident #2 was removed from smoke area and placed on 15 minute checks to ensure there was no emotional distress displayed.
3. Resident #1 was brought inside the facility and placed on 1:1 monitoring.
4. Resident #2 interviewed by the SW at this time.
5. Resident #1 interviewed by SW
6. Follow up interviews with staff and residents present at the time of incident.
7. Physician notified and Police called. New orders obtained to send Resident #1 out for psychiatric evaluation.
8. Resident #1's RP notified at 7:30 PM. Resident #2's guardian notified by Administrator via telephone. Message left to please return call.
9. 8:30 PM, Police into facility and spoke to both residents at different times. Then spoke to Administrator stating that no crime has been committed here and that Resident #2 was very alert and coherent and could explain everything that happened, but didn't want Resident #1 around him anymore. No arrest where made at this time.
10. Resident #1 out of facility via EMS for evaluation.
11. Resident #1 returned to facility 5/12/17 at 10:23 AM from ER with significant other.

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Resident sat outside in the car and significant other brought paperwork in from the hospital and signed Resident #1 out on leave of absence (LOA).

On 5/16/17 at 2:05 PM, Resident #8, who has intact cognition, was interviewed. He stated that he was in the smoking area the evening of 5/11/17 smoking. Several other residents including Resident #9 and #10 were there smoking. He heard Resident #9 screaming, he turned around and saw Resident #1 pulling his hands out of Resident #2's pants. Resident #2 was a young guy who was mentally challenged and he acted as if nothing had happened.

A telephone interview was conducted on 5/16/17 at 2:40 PM with Resident #2. He stated that Resident #1 had kissed him on his lips 2-3 times in the past. He indicated that he reported it to the nurse (didn't know name) and the Administrator. He added that he didn't like him kissing him and told him to stop. Resident #2 was unable to remember the incident on 5/11/17 in the smoking area.

On 5/16/17 at 3:44 PM, Nursing Aide (NA) #1 was interviewed. She indicated that she had known Resident #2 and he was alert but confused at times. She also stated that she had known Resident #1. His cognition was intact and he was able to walk but preferred to use a wheelchair. NA #1 reported that she was outside smoking with other residents including Resident #1, #8, #9 and #10 the evening of 5/11/17. Resident #2 came and sat beside Resident #1. Few minutes later, she observed Resident #1 put his hands inside the pants of Resident #2.

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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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On 5/16/17 at 4:25 PM, the smoking area was observed. Resident #1, #8, #9 and #10 were observed smoking in the smoking area. A staff member was also observed. There was no unusual behavior observed.

On 5/16/17 at 4:45 PM, Resident #9, who has intact cognition, was interviewed. She stated that she was outside in the smoking area smoking with other residents the evening of 5/11/17. She indicated that Resident #2 came in the door and sat beside Resident #1. Later on, she saw Resident #1 with his hands inside the pants of Resident #2. She yelled at Resident #1 saying "what the h-- are you doing to that boy?" Resident #1 replied "playing with his d----. You b----, mind your own business." The NA who was in the smoking area saw it and she went to get the nurse. Resident #9 indicated that Resident #2 was mentally challenged and he didn't know what Resident #1 was doing to him.

On 5/16/17 at 5:00 PM, Resident #10, who has intact cognition, was interviewed. He stated that he was outside in the smoking area smoking the evening of 5/11/17. He saw Resident #2 came in the door and later on he observed Resident #1's hands in Resident #2's pants. When he asked Resident #1, he responded "getting ready to play with his d----." Resident #10 stated that he was so mad and wanted to hit him. He indicated that Resident #2 has a mind of a 5 year old.

On 5/16/17 at 5:10 PM, Resident #1 was interviewed. He stated that he remembered the incident with Resident #2 in the smoking area. He stated that he was "just playing with his d---." He added that it was not a big deal as Resident #2 was okay with it.

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F 226	Continued From page 34 On 5/17/17 at 1:40 PM, the previous Administrator was interviewed. She stated that nobody had reported to her that Resident #2 had been kissed by Resident #1. The administrator was notified of immediate jeopardy on 5/17/17 at 2:21 PM. Credible Allegation: 1. On 5/11/17 at 7:21pm the Social Services Director notified the Administrator via phone of an event occurring in the smoking area where Resident #1 allegedly touched the penis of Resident #2. Resident #1 and Resident #2 were immediately separated by the Smoking Supervisor and Resident #1 was placed with one on one supervision. Resident #2 was placed on every 15 minute checks by the Charge Nurse with emotional support provided by the Services Director until discharge from the Facility on 5/12/17. Resident #1 and Resident #2 were interviewed separately by the Social Services Director on 5/11/17 immediately following the event and both indicated the event that occurred was consensual in nature when interviewed. The Police were notified immediately by the Charge Nurse and came to the facility at 8:30pm 5/11/17 to interview Resident #1 and Resident #2 During the course of this interview both parties reported a consensual kiss occurred and denied other physical contact. The Police determined and communicated to the Administrator that no crime was committed. Staff and Residents present when the event occurred were interviewed as part of the investigation, on 5/11/17 results of these interviews showed varying descriptions of the event that spanned from observations of a	F 226		

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Resident #1 kissing Resident #2 to observations of Resident #1 touching the outside of Resident #2's pants and another that described Resident #1 placing his hands in the pants of Resident #2. The Physician of Resident #1 and Resident #2 was notified by the Administrator on 5/11/17 at 7:30pm. The Administrator attempted to notify the Guardian for Resident #2 via phone message on 5/11/17 at 8:15pm, the message stated that the Administrator needed to discuss the event that occurred at the facility on 5/11/17. The Administrator attempted again to notify the Guardian for Resident #2 at 4:00pm on 5/12/17 prior to his discharge. On 5/18/17 at 1:00pm the Administrator and the Social Services Director made a third attempt to contact the Guardian for Resident #2 and left the same message as previous. Resident #1 is responsible for his own affairs. Resident #1 was transported to the Emergency Room for Psych and Medical evaluation, where he was diagnosed with a Urinary Tract Infection and discharged back to the Facility on 5/12/17 at 10:23am. Resident #1 sat outside in the car while He was signed out of the facility for a leave of absence by his friend on 5/12/17 and returned from the leave of absence on 5/16/17 and one on One Supervision was immediately restarted. One on One Supervision will be discontinued when the Interdisciplinary team agrees it is appropriate based on Psych and Medical evaluations to be completed by 5/23/17. Resident #2 was assessed by the Charge Nurse on 5/11/17 following the event, according to the Charge Nurse this assessment was within normal limits but was not documented in the medical record. The Social Services Director completed a Health Questionnaire and BIMS (Cognitive assessment) with score of 8 on 5/12/17. On 5/12/17 Resident #2 was discharged to an

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assisted Living Facility as previously planned prior to this event.

On 5/23/17 the Administrator completed a 24 hour report outlining the events occurring on 5/11/17 and will complete a 5 day report with details of the investigation on 5/26/17.

On 5/23/17 the Administrator reported the events occurring on 5/11/17 to Adult Protective Services.

2. Current residents have the potential to be affected by this alleged deficient practice. The Social Services Director, Social Services Assistant, Activities Director, and Nurse Managers conducted audits of current residents with a BIMS score of 8-15. This audit was completed on 5/18/17. This audit include one on one interviews by questioning each resident to determine any other residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable. For Residents who's BIMS score is below 8 the same audit and interview was conducted with their Responsible Party. No new allegations of abuse or residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable were identified as a result of these audits completed on 5/18/17.

On 5/18/17, the Administrator, Social Services Director, Director Clinical Services and Nurse Managers completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. No new allegations were identified as a result of the interviews conducted by 5/18/17. No facility staff shall return to work until interviews are completed. The Facility's Abuse Prohibition Policy was reviewed by the

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District Director of Clinical Services, the Director of Nursing and the Administrator and all required components related to F 223 were present.

1. Resident #2 received a planned discharge to an Assisted Living Facility on 5/12/17. Resident #1 remains on One on One Supervision in the Facility until the Interdisciplinary Team agrees to remove based on Psych services and Medical evaluations by 5/23/17. The Administrator and Director of Nursing were immediately re-educated by the District Director of Clinical Services regarding Abuse Prohibition to include the Elder Justice Act and immediate notification to the Administrator of allegations of abuse or neglect 5/17/17. On 5/18/17 facility staff, the Nursing Department, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration were re-educated by the Director of Nursing, Nurse Managers, and Staff Development Coordinator regarding;

" The definition of Abuse:

Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Injuries of unknown origin may occur as a result of abuse.

" Immediate intervention to stop

" No tolerance for abuse

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F 226	Continued From page 38 Beginning 5/18/17 no Facility staff including Nursing, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration shall work prior to receiving this education. All new employees and any agency will be educated on the above prior to working in resident care area by the Administrator, Director of Nursing or Staff Development Coordinator. Facility Staff will be provided this education at least annually via the Administrator, Director of Nursing or Staff Development Coordinator. This education will be included in the facility's new hire orientation and newly hired Facility Staff will not be permitted to assume their floor responsibilities until they have completed this education. The credible allegation was verified on 5/18/17 at 5:00 PM as evidenced by staff interviews on abuse policy and procedures, different types of abuse, what to do if a resident displayed aggressive behaviors and actions to be taken if abuse was observed and/or suspected, reporting and resident assessments. Alert and oriented residents were also interviewed to assess if any other residents were affected. Review of in-service records revealed 142 facility staff (licensed nursing staff, unlicensed nursing staff, administrative staff, activities, social worker) had been in-serviced by 5/18/17 and staff who did not have the in-service will be in-serviced prior to working on floor. Review of list of alert and oriented residents and list of families who were interviewed to assess if any other residents were affected.	F 226		

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Review of the 24 hour report to the state agency and a letter that the APS was informed of the incident 5/11/17 with Resident #2 and interview with the Administrator was conducted.

2. Resident #7 was admitted to the facility on 11/3/14 with multiple diagnoses including malignant neoplasm of bone and prostate.

Review of Resident #7's quarterly MDS assessment dated 4/27/17 indicated that his cognition was intact and he had no behavior.

Review of Resident #7's nurse's notes dated 3/28/17 revealed "resident was highly upset with his nurse because he had not had his Fentanyl (narcotic pain medication) patch changed yet. He was threatening his nurse's job because she had to prioritize her care for woman who had fallen. When I asked him to calm down, he shouted at me "F-you." I asked him why is he swearing at me and he repeated "F-you faggot" and wanted me to swing at him. I told him I wasn't that stupid. He then said he has a friend coming to visit and he "would take care of me."

The author of the nurse's notes dated 3/28/17 was Nurse #2 and he was not available for interview.

Review of Nurse #2's personnel records revealed that he was terminated on 4/5/17 due to no call no show.

List of abuse investigations since the last survey (March 2017 to present time) was requested from the Administrator. The Administrator provided

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folders containing written statements from residents and staff. There were 2 incidents were staff and residents were alleging abuse. One of the two incidents was for Resident #7.

Review of the statement written on 3/28/17 by Nurse #3 revealed "at approximately 4:30 PM I was in a room giving a resident medications when a Certified Medication Aide (CMA) came into the room with a look of fear on her face and said "I need you now." I went out in the hall and I could hear 2 people arguing and cursing very loudly. When I got over to station 3, Nurse #2 and Resident #7 were in verbal altercation. I tried to stop the verbal altercation and Resident #7 became very angry calling Nurse #2 a faggot and cursing him. Resident #7 jumped at Nurse #2 and 2 Resident Care Assistants (RCA) grabbed him and another RCA was trying to get Nurse #2. This is when Nurse #2 began shouting to Resident #7 "hit me M-F---!!" over and over. I was unable to stop this from happening and the RCA and the Activity Assistant was able to get Resident #7 to his room. This yelling and cursing between Nurse #2 and Resident #7 lasted probably 5 minutes while I was there."

Review of the statement written on 3/29/17 by CMA revealed "around 5:30 PM on 3/28/17 I heard a loud altercation coming from around the corner on station 3 between Resident #7 and Nurse #2. Both were cursing and arguing with one another. Resident #7 was threatening Nurse #2. Nurse #2 was telling Resident #7 "go ahead and hit me, come on, f-me, f-you." I got Nurse #3 to see if she could help the confrontation. Like I said it was so sudden and off guard there was a lot of shouting and cursing between both individuals."

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A telephone interview with the previous Administrator was conducted on 5/17/17 at 1:40 PM. She indicated that she remembered the incident with Resident #7 and Nurse #2. She acknowledged that she had read the written statements from the staff members. She revealed that she had interviewed Resident #7 and Nurse #2 and they both denied verbal abuse and so she did not proceed to follow the facility's abuse policy. She also indicated that she did not document her interview with Resident #7 and Nurse #2.

An interview with the current Administrator was conducted on 5/17/17 at 1:45 PM. The current Administrator read the 3 written statements from the staff members and stated that this was a verbal abuse and the facility's abuse policy should have been implemented. She further indicated that she could not find any documentation to indicate that this allegation had been investigated nor reported to the state agency or adult protective services. She also stated that she could not find information to indicate that other residents were assessed to identify other residents who might have been verbally abused. The current Administrator indicated that she started as administrator of the facility on May 2017.

On 5/17/17 at 2:05 PM, Resident # 7 was interviewed. He remembered the incident with Nurse # 2. He was very mad at him (Nurse #2). He went to the nurse's station to ask his nurse for his pain medication as it was already late. His nurse was explaining as to why his medication was late and Nurse #2 stepped in. He was so mad and acknowledged that he did scream at his

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nurse. Then Nurse #2 started screaming at him back. He was also so mad to him (Nurse #2) for stepping in, he was not his nurse. Resident #7 did not remember what Nurse #2 had told him because he was very mad at him.

An interview with the Activity Assistant (AA) was conducted on 5/17/17 at 2:13 PM. The AA stated that she was at the nurse's station and heard Resident #7 asking for his medication. The Nurse assigned to Resident #7, responded to him "it's only 2 hours late and you are not going to die." Resident #7 went back to his room and asked for a concern form. She went to get a concern form for Resident #7. When she came back she observed Nurse #2 screaming and cursing saying F---, M-F-words several times to Resident #7. The AA indicated that the Director of Nursing (DON) was informed and she requested to write a statement. She stated that the response from the nurse to the resident was inappropriate.

An interview with Nurse #3 was conducted on 5/18/17 at 8:00 AM. She stated that she was on the medication cart on the other station passing medications. She could hear the screaming and cussing on station 3. A staff member (CMA) came and told her to come now. When she arrived at station 3, Resident #7 and Nurse #2 were arguing and cursing very loudly. She tried to stop the verbal altercation. Staff members tried to stop both of them, when Nurse #2 began shouting to Resident #7 "hit me, hit me m-f-"over and over again. The verbal altercation lasted for 5 minutes while she was there.

An interview with CMA was conducted on 5/18/17 at 9:04 AM. The CMA indicated that she was on

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F 226	Continued From page 43 another station working and she could hear a loud altercation from station 3. She went to station 3 and observed Resident #7 and Nurse #2 were cursing at each other. Resident #7 was threatening Nurse #2. Nurse #2 responded to Resident #7 "hit me, come on, f-me, f-you." She went to get Nurse #3.	F 226		
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. 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 record review, observation and staff, residents and physician interview, the administration failed to oversee and enforce the facility's abuse policy and procedures to ensure 2 of 2 sampled residents (Residents #2 and #7) were free from abuse. Resident #2 was sexually abused by Resident #1. Resident #7 was verbally abused by Nurse #2. Immediate jeopardy began on 5/11/17 for Resident #2 when he was sexually abused by Resident #1. Immediate jeopardy was removed on 5/18/17. An acceptable credible allegation was provided on 5/23/17. The facility remains out 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) for example #2, Resident #7 and to ensure all staff are in-serviced on abuse and the monitoring systems put into place are effective.	F 490	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. 1. On 5/11/17 at 7:21pm the Social Services Director notified the Administrator via phone of an event occurring in the smoking area where Resident #1 allegedly touched the penis of Resident #2. Resident #1 and Resident #2 were immediately separated by the Smoking Supervisor and Resident #1 was placed with one on one supervision. Resident #2 was placed on every 15 minute checks by the Charge	6/26/17

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F 490	Continued From page 44 The findings included: 1. Cross Refer to F223: Based on record review, observation and staff, resident and physician interview, the facility failed to protect 2 (Residents # 2 & # 7) of 2 sampled residents from abuse. Resident #2, who was cognitively impaired, was witnessed by residents and staff, being sexually abused by Resident #1, who was cognitively intact. Resident #7, who was cognitively intact, was verbally abused by Nurse #2. 2. Cross Refer to F226: Based on record review, observation and staff, resident and physician interview, it was determined that the facility failed to operationalize abuse policies and procedures in the areas of identification (immediately assessing if other residents could have been affected) and reporting (notifying the state and adult protective services) for 2 (Resident #2 & #7) of 2 sampled residents reviewed for abuse. The facility Administrator and Director of Nursing were informed of Immediate Jeopardy on 5/17/17 at 2:21 PM. The facility provided a credible allegation of compliance: 1. On 5/11/17 at 7:21pm the Social Services Director notified the Administrator via phone of an event occurring in the smoking area where Resident #1 allegedly touched the penis of Resident #2. Resident #1 and Resident #2 were immediately separated by the Smoking Supervisor and Resident #1 was placed with one on one supervision. Resident #2 was placed on	F 490	Nurse with emotional support provided by the Services Director until discharge from the Facility on 5/12/17. Resident #1 and Resident #2 were interviewed separately by the Social Services Director on 5/11/17 immediately following the event and both indicated the event that occurred was consensual in nature when interviewed. The Police were notified immediately by the Charge Nurse and came to the facility at 8:30pm 5/11/17 to interview Resident #1 and Resident #2 During the course of this interview both parties reported a consensual kiss occurred and denied other physical contact. The Police determined and communicated to the Administrator that no crime was committed. Staff and Residents present when the event occurred were interviewed as part of the investigation, on 5/11/17 results of these interviews showed varying descriptions of the event that spanned from observations of a Resident #1 kissing Resident #2 to observations of Resident #1 touching the outside of Resident #2□s pants and another that described Resident #1 placing his hands in the pants of Resident #2. The Physician of Resident #1 and Resident #2 was notified by the Administrator on 5/11/17 at 7:30pm . The Administrator attempted to notify the Guardian for Resident #2 via phone message on 5/11/17 at 8:15pm, the message stated that the Administrator needed to discuss and event that occurred at the facility on 5/11/17. The Administrator attempted again to notify the Guardian for Resident #2 at 4:00pm on 5/12/17 prior to his	

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F 490	Continued From page 45 every 15 minute checks by the Charge Nurse with emotional support provided by the Services Director until discharge from the Facility on 5/12/17. Resident #1 and Resident #2 were interviewed separately by the Social Services Director on 5/11/17 immediately following the event and both indicated the event that occurred was consensual in nature when interviewed. The Police were notified immediately by the Charge Nurse and came to the facility at 8:30 pm 5/11/17 to interview Resident #1 and Resident #2 During the course of this interview both parties reported a consensual kiss occurred and denied other physical contact. The Police determined and communicated to the Administrator that no crime was committed. Staff and Residents present when the event occurred were interviewed as part of the investigation, on 5/11/17 results of these interviews showed varying descriptions of the event that spanned from observations of a Resident #1 kissing Resident #2 to observations of Resident #1 touching the outside of Resident #2's pants and another that described Resident #1 placing his hands in the pants of Resident #2. The Physician of Resident #1 and Resident #2 was notified by the Administrator on 5/11/17 at 7:30 pm. The Administrator attempted to notify the Guardian for Resident #2 via phone message on 5/11/17 at 8:15 pm, the message stated that the Administrator needed to discuss an event that occurred at the facility on 5/11/17. The Administrator attempted again to notify the Guardian for Resident #2 at 4:00 pm on 5/12/17 prior to his discharge. On 5/18/17 at 1:00 pm the Administrator and the Social Services Director made a third attempt to contact the Guardian for Resident #2 and left the same message as previous. Resident #1 is responsible for his own affairs. Resident #1 was transported to the	F 490	discharge. On 5/18/17 at 1:00pm the Administrator and the Social Services Director made a third attempt to contact the Guardian for Resident #2 and left the same message as previous. Resident #1 is responsible for his own affairs. Resident #1 was transported to the Emergency Room for Psych and Medical evaluation, where he was diagnosed with a Urinary Tract Infection and discharged back to the Facility on 5/12/17 at 10:23am. Resident #1 sat outside in the car while He was signed out of the facility for a leave of absence by his friend on 5/12/17 and returned from the leave of absence on 5/16/17 and One on One Supervision was immediately restarted. One on One Supervision will be discontinued when the Interdisciplinary team agrees it is appropriate based on Psych and Medical evaluations to be completed by 5/23/17. Resident #2 was assessed by the Charge Nurse on 5/11/17 following the event, according to the Charge Nurse this assessment was within normal limits but was not documented in the medical record. The Social Services Director completed a Health Questionnaire and BIMS (Cognitive assessment) with score of 8 on 5/12/17. On 5/12/17 Resident #2 was discharged to and Assisted Living Facility as previously planned prior to this event. 2. Current residents have the potential to be affected by this alleged deficient practice. The Social Services Director, Social Services Assistant, Activities Director, and Nurse Managers conducted	

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F 490	Continued From page 46 Emergency Room for Psych and Medical evaluation, where he was diagnosed with a Urinary Tract Infection and discharged back to the Facility on 5/12/17 at 10:23 am. Resident #1 sat outside in the car while he was signed out of the facility for a leave of absence by his friend on 5/12/17 and returned from the leave of absence on 5/16/17 and one on one supervision was immediately restarted. One on One Supervision will be discontinued when the Interdisciplinary team agrees it is appropriate based on Psych and Medical evaluations to be completed by 5/23/17. Resident #2 was assessed by the Charge Nurse on 5/11/17 following the event, according to the Charge Nurse this assessment was within normal limits but was not documented in the medical record. The Social Services Director completed a Health Questionnaire and BIMS (Cognitive assessment) with score of 8 on 5/12/17. On 5/12/17 Resident #2 was discharged to an Assisted Living Facility as previously planned prior to this event. On 5/23/17 the Administrator completed a 24 hour report outlining the events occurring on 5/11/17 and will complete a 5 day report with details of the investigation on 5/26/17. On 5/23/17 the Administrator reported the events occurring on 5/11/17 to Adult Protective Services. 1. Current residents have the potential to be affected by this alleged deficient practice. The Social Services Director, Social Services Assistant, Activities Director, and Nurse Managers conducted audits of current residents with a BIMS score of 8-15. This audit was completed on 5/18/17. This audit include one on one interviews by questioning each resident to	F 490	audits of current residents with a BIMS score of 8-15. This audit was completed on 5/18/17. This audit includes one on one interviews by questioning each resident to determine any other residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable. For Residents who□s BIMS score is below 8 the same audit and interview was conducted with their Responsible Party. No new allegations of abuse or residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable were identified as a result of these audits completed on 5/18/17. On 5/18/17, the Administrator and Staff Development Coordinator completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. No new allegations were identified as a result of the interviews conducted by 5/18/17. No facility staff shall return to work until interviews are completed. The Facility□s Abuse Prohibition Policy was reviewed by the District Director of Clinical Services, the Director of Nursing and the Administrator and all required components related to F 226 were present. On 5/18/17 the District Director of Clinical Services re-educated the Administrator and the Director of Nursing 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, and her	

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F 490	Continued From page 47 determine any other residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable. For Residents who's BIMS score is below 8 the same audit and interview was conducted with their Responsible Party. No new allegations of abuse or residents who have been approached in an inappropriate way by any other resident or made to feel uncomfortable were identified as a result of these audits completed on 5/18/17. 1. On 5/18/17, the Administrator, Social Services Director, District Director of Clinical Services and the Nurse Managers completed interviews with all facility staff to verify no other unreported allegations of abuse occurred. No new allegations were identified as a result of the interviews conducted by 5/18/17. No facility staff shall return to work until interviews are completed. The Facility's Abuse Prohibition Policy was reviewed by the District Director of Clinical Services, the Director of Nursing and the Administrator and all required components related to F 226 were present. 2. On 5/18/17 the District Director of Clinical Services re-educated the Administrator and the Director of Nursing 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, 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 as well as assessment of all other residents that might be affected. 3. On 5/18/16 facility staff, the Nursing Department including Nursing Assistants,	F 490	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 as well as assessment of all other residents that might be affected. On 5/18/16 facility staff, the Nursing Department including Nursing Assistants, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration were re-educated by Administrator and Staff Development Coordinator regarding Abuse and Abuse Reporting. Beginning 5/18/17 no Facility staff including Nursing and Nursing Assistants, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration shall work prior to receiving this education. All new employees and any agency will be educated on the above prior to working in resident care area. Facility Staff will be provided this education at least annually via the Administrator or Staff Development Coordinator. This education will be included in the facility□s new hire orientation and all newly hired Facility Staff will not be permitted to assume their floor responsibilities until they have completed this education. On 5/18/17 the Administrator and Director of Nursing implemented a new system to monitor the management of abuse allegations by reviewing all events with the Division Director of Clinical Services (DDCS) weekly to ensure adherence to	

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F 490	Continued From page 48 Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration were re-educated by the Director of Nursing, Nurse Managers, and Staff Development Coordinator regarding; 4. The definition of Abuse: 5. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Injuries of unknown origin may occur as a result of abuse. 6. Immediate intervention to stop 7. No tolerance for abuse 8. 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 9. The Facility Staff will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation of property to the Administrator, State Survey Agency, and law enforcement officials according to the required timeline as follows: If the events that caused the	F 490	the Facility Policy on Abuse Prohibition and conduct a weekly focus call to further review events occurring throughout the week to review completion of investigations and reporting as required. 3. 5/17/17 -5/18/17 In-services provided to all staff including nursing and non-nursing on Abuse Prohibition to include Elder Justice Act, what to do if a resident displays aggressive behaviors, and actions to be taken if abuse was observed and or suspected, reporting and resident assessment. Weekend and part-time nursing and non-nursing staff were in-serviced via phone by Staff Development Coordinator. Nursing and non-nursing staff unable to assume their floor responsibilities until they completed this education. This will be completed by date of compliance. All new admission packets will include the facilities Abuse Prohibition Policy and Facility Grievance Policy to be discussed during admission process. All new alleged allegations will be reported to the state and proper authorities by the Administrator or Director of Nursing. 4. Audit tools will be used by Social Worker to contact Family and interview Residents to determine if any new alleged allegations have been reported. 10 Family/Residents will be interviewed weekly x 6 weeks, then 5 Family/Residents weekly x 6 weeks. Audit tools will be used by Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers and Therapy	

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F 490	Continued From page 49 allegation involve abuse or result in serious bodily injury, a report is made not later than 2 hours after the management staff becomes aware of the allegation; or If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, a report is made not later than 24 hours after the management staff becomes aware of the allegation; 10. In accordance with the Elder Justice Act, the facility will report to law enforcement agencies and to the state agency any reasonable suspicion of a crime against any individual who is a resident of, or receives care from the facility 11. Beginning 5/18/17 no Facility staff including Nursing and Nursing Assistants, Therapy, Housekeeping, Dietary, Maintenance, Business Office and Administration shall work prior to receiving this education. All new employees and any agency will be educated on the above prior to working in resident care area. Facility Staff will be provided this education at least annually via the Director of Nursing or Staff Development Coordinator. This education will be included in the facility's new hire orientation and newly hired Facility Staff will not be permitted to assume their floor responsibilities until they have completed this education. 12. The Administrator and Director of Nursing will complete a root cause analysis by 5/19/17 regarding abuse reporting and investigation within the facility. 13 The Administrator and Director of Nursing will hold weekly staff meetings to review and re-educate Facility staff on Abuse Prohibition. During these meetings the Administrator will reinforce the Resident's Right to remain free from abuse and neglect. 14. It is the responsibility of the Administrator, as the Abuse Coordinator within the facility to ensure	F 490	Manager to interview nursing and non nursing staff to determine if any new alleged allegations are reported. 10 staff members will be interviewed weekly x 6 weeks, then 5 staff members weekly x 6 weeks. Any new reported allegations will be followed up by Administrator and Director of Nursing. Results will be brought to QAPI monthly x 3 to assure compliance.	

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F 490	Continued From page 50 Facility staff are trained regarding the policy for abuse prohibition, to ensure staff and residents understand the process and are comfortable reporting allegations of abuse, to investigate allegations of abuse, and to complete timely 24 hour and 5 day reports to the State agency. The Division Director of Clinical Services will provide weekly support and education to the Administrator regarding her responsibilities to Abuse prohibition in the Facility. 15. On 5/18/17 the Administrator and Director of Nursing implemented a new system to monitor the management of abuse allegations by reviewing all events with the Division Director of Clinical Services (DDCS) 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 review completion of investigations and reporting as required. The credible allegation was verified on 5/18/17 at 5:00 PM as evidenced by staff interviews on abuse policy and procedures, different types of abuse, what to do if a resident displayed aggressive behaviors and actions to be taken if abuse was observed and/or suspected, reporting and resident assessments. Alert and oriented residents were also interviewed to assess if any other residents were affected. Review of in-service records revealed 142 facility staff (licensed nursing staff, unlicensed nursing staff, administrative staff, activities, social worker) had been in-serviced by 5/18/17 and staff who did not have the in-service will be in-serviced prior to working on floor.	F 490		

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F 490	Continued From page 51 Review of list of alert and oriented residents and list of families who were interviewed to assess if any other residents were affected. Review of the 24 hour report to the state agency and a letter that the APS was informed of the incident 5/11/17 with Resident #2 and interview with the Administrator was conducted.	F 490		