STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	C 04/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH PINES REHABILITATION AND NURSING CENTER	620 JOHNS ROAD LAURINBURG, NC 28352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID DDIT11.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility ' s abuse policies and procedures the facility failed to include procedures in the abuse policies related to not providing personal care to an alleged sexual abuse victim for 1 of 1 residents reviewed for alleged sexual assault (Resident #2). The findings included: The facility ' s Abuse Policy titled Abuse Prevention Program, dated December 2006 did not include instructions for staff related to not providing personal care to an alleged sexual abuse victim. Resident #2 was admitted to the facility on 1/15/15 and had a diagnosis of cerebral palsy,	F 607	F607 Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. 1) On 4/13/2018, facility's abuse policy titled "Abuse Prevention Program" was updated to include instructions for staff related to not providing personal care to any alleged sexual abuse victim. Policy now reads the following: "should a suspicion of sexual assault be present,	4/22/18

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

Electronically Signed | 04/22/2018

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F 607	Continued From page 1 severe intellectual disabilities, aphasia and multiple contractures. The Annual Minimum Data Set (MDS) Assessment dated 2/9/18 revealed the resident was rarely/never understood and had severe cognitive impairment. The MDS noted the resident required extensive to total assistance with all activities of daily living, was non-ambulatory and incontinent of bowel and bladder. A nursing progress note dated 3/28/18 at 9:46 PM revealed the following: NA (Nursing Assistant) reported a male resident was in resident ' s room standing over her. He was immediately removed from the room and taken back to his room. Resident had no marks and brief was still intact. Resident is now resting in bed with safety measures in place. Family and DON (Director of Nursing) notified. An interview was conducted on 4/4/16 at 5:28 PM with NA #1 who was assigned to Resident #2 on the 3 PM to 11 PM shift on 3/28/18. The NA stated she was coming down the hall and saw a walker in the doorway of Resident #2 ' s room. The NA stated when she got to the room she observed a male resident standing at the bedside leaning over Resident #2. The NA further stated the sheet was pulled down and she could see the resident ' s incontinent brief but could not see the male resident ' s hands. The NA further stated the male resident was fully clothed and she did not notice anything unusual about his clothes but did not notice if his pants were unzipped. The NA stated she ran to the nurse ' s station and got the nurse and they both went back to the room where they saw the male resident standing by the bed	F 607	the alleged victim should receive no peri-care, or brief change following development of the suspicion and until directed by the contacted law authority." 2) On 4/16/2018, facility assistant director of nursing services provided employee in-service training on revised abuse policy titled "Abuse Prevention Program" to all staff. 3) Facility will add updated abuse policy titled "Abuse Prevention Program" to annual skills fair which will take place on or around February 2019 and annually thereafter. Facility social worker or designee will review with all staff during facility annual skills fair relevant definitions and how to care of alleged sexual assault victim. 4) Facility will add updated abuse policy to new hire orientation. Facility assistant director of nursing services or designee will review with all new hires during facility orientation relevant definitions and how to care of alleged sexual assault victim. 5) Should revisions be necessary, appropriate staff will be re-in-serviced by Administrator, Director of Nursing Services or appropriate designee.	

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F 607	Continued From page 2	F 607		

facing the door and the nurse told him to get out and he got his walker and left the room. The NA stated she escorted him back to his room and asked him what he was doing in Resident #2 ' s room and he stated he needed sex. The NA stated she returned to the room of Resident #2 and she checked the resident to see if the male resident had done anything to her. The NA further stated the resident had a brownish discharge that had some light pink material in it and the resident had been incontinent of urine and she cleaned her up and disposed of the brief in the trash. The NA stated a family member came in and wanted to check the resident and when the brief was removed there were 2 spots of bright red blood in the brief and when the family member wiped her with pre-moistened wipes there were streaks of blood on the wipes. The NA stated at that point the family member wanted Resident #2 to go to the hospital to be checked and EMS and the police were called and the resident sent to the Emergency Department (ED).

On 4/4/18 at 12:45 PM a Family Member stated on the night of the incident the family received a call from the facility that a male resident had been caught with Resident #2 and someone would call her in the morning. The Family Member stated she went to the facility and she was told the NA (Nursing Assistant) caught a male resident in Resident #2 ' s room with her gown pulled up and the male resident stated he needed sex and the NA made him leave the room. The Family Member further stated the staff had not checked the resident ' s brief and she checked the resident and when she pulled back her brief there was a small amount of blood on the brief and she asked the staff if the resident was on her cycle and was told the resident had no bleeding up to this point.

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F 607	Continued From page 3	F 607		

The Family Member stated she requested the resident be sent to the hospital and EMS (Emergency Medical Services) was called and they came and transported the resident along with the sheets on the bed and she took the brief with her to the hospital. The Family Member further stated the police came to the hospital and asked for the sheets and the brief for evidence.

An interview was conducted on 4/4/16 at 4:40 PM with Nurse #1 who was assigned to Resident #2 on the 3 PM to 11 PM shift on 3/28/18. The interview revealed the following: The NA notified her that a male resident was in Resident #2 ' s room and they both went to the room and observed the male resident standing over Resident #2. The male resident was escorted back to his room by the NA and told him to stay in his room. The gown of resident #2 was pulled up and her incontinent brief exposed but was intact. The Nurse stated the resident had been incontinent and the NA changed the resident and provided peri-care. The family and the DON were notified. The Nurse further stated a family member came in about 20 minutes later and wanted to check the resident and when the brief was removed there were 2 small spots of bright red blood in the brief. The family member used pre-moistened wipes to wipe the resident and noted streaks of blood on the wipe. The police and EMS (Emergency Medical Services) were called and the resident was transported to the Emergency Department (ED) for evaluation. The family member took the brief with her to the ED.

On 4/5/18 at 4:50 PM an interview was conducted with the Administrator and the Facility Consultant. The Consultant stated their abuse policies and procedures did not include procedures related to

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F 607	Continued From page 4 not providing personal care to an alleged sexual abuse victim.	F 607		