

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2012
NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139	
(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)

F 000 INITIAL COMMENTS

Immediate jeopardy began on 1/29/2012 when staff became aware of Resident #2 inappropriately touching Resident #8. The administrator was notified of the Immediate jeopardy on 02/8/2012 at 9:50 AM. Immediate jeopardy was removed on 02/10/2012 when the facility provided and implemented an acceptable credible allegation of compliance.

F 223 483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to assure that four (4) of five (5) sampled cognitively impaired female residents had an environment that was free from sexual abuse. The facility had not consistently identified the victims, had not conducted investigations and had not implemented effective preventative measures to protect the female residents from actual and potential sexual abuse. Facility staff had knowledge of the inappropriate sexual behaviors of one male resident (Resident #2) toward four (4) sampled female residents (Residents #1, 8, 9, and 10).

Immediate jeopardy began on 1/29/2012 when

F 000 Preparation and execution of this plan does not constitute admission or agreement by the provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by provisions of the State and Federal Law.

F 223

The facility does protect all of its residents from Abuse, properly investigate, screen and coordinate with law enforcement officials

RESIDENT IDENTIFIED
On 2/3/12 at 11:00 pm, resident #2 was assigned a staff member to be with him at all times. This intervention continued until resident was discharged from the facility on 2/8/12.

IDENTIFYING OTHER RESIDENTS AT RISK
1. On 2/6/2012 complete body audits done by the Unit Charge Nurses to assess any obvious

3/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Susan Fair, Administrator _____ 2/26/12

deficiency statement ending with an asterisk (*) denotes a deficiency which ... providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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MAR 6 2012
BY: *DRW*

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F 223	<p>Continued From page 1</p> <p>staff became aware of Resident #2 inappropriately touching Resident #8. The administrator was notified of the immediate jeopardy on 02/8/2012 at 9:50 AM. Immediate jeopardy was removed on 02/10/2012 when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems put in place are effective.</p> <p>The findings are:</p> <p>Resident #2 was admitted on 09/02/11 with diagnoses including Coronary Artery disease, Renal Insufficiency and above the left knee amputation. Review of the most recent Minimum Data Set (MDS) assessment dated 12/04/2011 revealed the resident was identified as cognitively intact, able to understand and make himself understood with no behaviors identified. The MDS also identified the resident as once assisted into his wheelchair being able to move about the facility independently. Review of current care plans reviewed in December 2011 revealed no care plans related to resident behaviors.</p> <p>Resident #2 was observed exhibiting inappropriate sexual behaviors towards female residents on the following dates:</p> <p>A. Sunday 01/29/12:</p> <p>Review of nursing notes on 01/29/12 at 3:49 PM revealed Licensed Nurse (LN) #1 documented</p>	F 223	<p>physical injury, on resident #1, #8, #9 and #10, who were touched by resident #2. Results of this audit revealed no visible bruising or signs of physical trauma.</p> <p>2. On 2/6/2012, residents # 1, #8, #9, and #10 's families were contacted by the Director of Nursing to notify them of their family member being inappropriately touched . They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional concerns were identified.</p> <p>3. 2/7/12 and 2/8/12 The Nursing staff were instructed to observe resident's #1, #8, #9 and #10, for and signs, such as crying, increased anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in theses</p>	

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F 223	<p>Continued From page 2</p> <p>Resident #2 was observed by Activity Assistant (AA) #1 touching a female resident's breast. The note stated this behavior was documented in the Physician's communication book.</p> <p>Review of the Physician's communication book revealed an entry by LN #1 dated 01/29/12 (no time) which stated staff noted Resident #2 touching Resident #8's breast.</p> <p>Review of nursing notes on 01/29/12 at 11:12 PM, LN #2 documented Resident #2 was seen touching female residents on their upper arms and trying to hold their hands. One resident yelled at him, told him not to touch her and he let go. The nurse reminded him it was inappropriate to touch other residents without their consent.</p> <p>Review of the "Manager's on Duty" report dated 01/29/12 included in part: LN #2 reported Resident #2 was found in Resident #8's room holding her hand.</p> <p>Subsequent interviews with staff concerning these incidents revealed:</p> <p>An interview was conducted with activity assistant (AA) #1 on 02/07/12 at 10:00 AM. AA #1 stated she observed Resident #2 touch Resident #8's breast over her clothing around lunch time on 01/29/12. AA #1 further stated that she immediately reported the incident to Licensed Nurse (LN) #1 who was Resident #2's and Resident #8's licensed nurse on this shift. The interview further revealed the nursing assistants (NAs) stated they were not aware of Resident #2 inappropriately touching other residents prior to 01/29/12.</p>	F 223	<p>resident's behaviors or demeanor.</p> <p>4. 2/9/12- Twenty- Nine (29) Resident families were contacted by the DON, MDS nurse or Social Worker, to determine if they were aware of any inappropriate resident to resident contact/abuse and educated to immediately report any concerns. Messages were left with 11 additional families. No family contacted reported any concerns.</p> <p>5. On 2/8/12 the Social Worker completed interviews, with thirty four (34) alert and interviewable residents, to ascertain if there were any other incidents of inappropriate resident to resident contact noted. They were asked if they felt safe or if anyone had made them feel uncomfortable. No additional concerns were identified.</p> <p>6. 2/8/12 and 2/9/12 – Ninety-two employees were interviewed by department</p>	

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F 223	<p>Continued From page 3</p> <p>A telephone interview on 02/07/12 at 11:00 AM with LN #1 revealed that AA #1 told her that she observed Resident #2 touch Resident #8's breast over her clothing around lunch time on 01/29/12. LN #1 recalled Resident #2 was removed from the hall near the nurse's station and assisted to bed by a nursing assistant. LN #1 stated she documented the incident in the Physician's communication book, her nurse's note, and passed the information on to the second shift (3:00 PM to 11:00 PM) nurse (LN #2). No other interventions were put into place.</p> <p>During a telephone interview on 02/06/12 at 5:35 PM, LN #2 revealed on 01/29/12 she reported to the Activity Director (AD) (manager on duty), that Resident #2 was touching female residents. LN #2 revealed the AD told her that she would inform the DON and Administrator.</p> <p>On 02/07/12 at 10:10 AM the Activity Director (AD) confirmed she was the Manager on Duty on 01/29/12. The AD revealed LN #2 reported Resident #2 was holding female residents' hands and staff was having a hard time keeping him out of female residents' rooms. The AD stated she did not address Resident #2's behavior herself on 01/29/12 but made sure it was discussed during the facility's morning meeting on 01/30/12. The AD stated the conclusion at the 01/30/12 morning meeting was staff would monitor Resident #2 for inappropriate behaviors.</p> <p>B. Monday 01/30/12:</p> <p>Nursing notes dated 01/30/12 at 11:32 AM revealed LN #4 documented Resident #2 had</p>	F 223	<p>heads, and asked if they have observed any inappropriate resident to resident contact. All staff members who were not available for interview will be removed from the schedule until such interview is completed by the department head. No additional concerns were identified.</p> <p><u>PROCESS IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</u></p> <p>1. On 2/7 and 2/8/12 all available persons employed by this facility were in-serviced. All department heads were in-serviced by the Regional Vice President of Operations. Staff Development Coordinator, Nurse Managers, in-serviced the nurses. All other staff was in-serviced by their department managers. In-services contained the following: 100% completed on 2/12/12.</p>	

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F 223	<p>Continued From page 4</p> <p>constantly gone up to several female residents this morning and tried to touch them.</p> <p>Review of the physician verbal orders dated 01/30/12 revealed an order for Celexa 10mg every day for depression. Review of Medication Administration Records (MAR) revealed Resident #2 received the Celexa at 9:00 AM starting on 01/31/12 and 02/01/12.</p> <p>Subsequent interviews with staff concerning this incident revealed:</p> <p>During interview on 02/06/12 at 12:46 PM, LN #4 revealed Resident #2's behaviors started on 01/29/12 and continued on 01/30/12, but she could not recall who Resident #2 was approaching those days.</p> <p>During interview on 02/06/12 at 1:20 PM, the Director of Nursing (DON) stated she was aware Resident #2 was "having behaviors" on 01/30/12 and asked the social worker to "look into it." She further stated she did not follow up on the report about Resident #2's behaviors.</p> <p>C. Wednesday 02/01/12:</p> <p>Review of the nursing notes revealed the only documentation of Resident #2's behaviors was documented by LN #5 on 02/01/12 at 10:15 PM. LN #5 documented Resident #2 was observed wandering the halls grabbing female residents' breasts and groins. Resident #2 was redirected several times and cursed at staff. Resident #2 was assigned a Nursing Assistant (NA) for observation when he threatened to punch staff in the head and told another resident that he was</p>	F 223	<p>a. The facilities Abuse policy and procedure states that abuse can be considered physical touching that is inappropriate, if it is uninvited by the person being touched.</p> <p>b. Immediately protect all residents when inappropriate resident to resident contact is identified, by staying with the resident to protect them. You must immediately notify the administrator.</p> <p>c. Immediately report all events of inappropriate resident to resident contact to the Administrator. If the Administrator is not available, the employee reporting the alleged abuse should report it to his/her supervisor who contacts the Administrator or Director of Nursing.</p> <p>d. 2/8/12 Abuse policy revised to state nurses are to immediately fill out an incident report and submit it to the DON; call the</p>	

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F 223 Continued From page 5
"trying to be bad." The Director of Nursing (DON) was notified.

Facility record review revealed no documentation regarding one on one supervision provided on 02/01/11 and no incident report was completed.

Subsequent interviews with staff concerning this incident revealed:

During an interview on 02/06/12 at 12:05 PM, nursing assistant (NA) #1 revealed, that on 02/01/12, while working on the first shift she had pulled Resident #2 in his wheelchair away from Resident #8 four times. NA #1 stated she reported to LN #4, that Resident #2 had been rubbing the leg of Resident #8 up to her groin. NA #1 further revealed later that day the Director of Nursing (DON) came to the nursing station. She informed the DON of what happened. NA #1 was instructed by the DON to "keep an eye" on Resident #2 and not let him around the female residents.

LN #4 stated on 02/06/12 at 3:25 PM that on 02/01/12 the NAs (she did not recall whom) reported to her they had observed Resident #2 inappropriately touching female residents, including Resident #1 and Resident #8. LN #4 further revealed she considered Resident #2's behaviors as sexual abuse, so on 02/01/12 she reported it to the DON per facility policy. The DON told her to chart Resident #2's actions under behaviors in the resident's medical record.

An interview on 02/06/12 at 3:20 PM with LN #5 revealed Resident #2 was observed on 02/01/12 during the 3:00 PM to 11:00 PM shift grabbing

F 223 physician; notify family/responsible party at the time of the occurrence. In-service was conducted by the Unit Managers, DON, department heads on 2/8/12. The Nurse's Responsibilities when alleged abuse is suspected and the facility's Policy and Procedure on Abuse was placed at each Nurses station.

e. All staff should report to their immediate supervisor and expect feedback from that supervisor that an investigation has been initiated, if feedback not provided, staff should contact Administrator directly. The Administrators contact information is posted at every Nurses station and in every ancillary department.

f. Any staff member that is unable to attend the Abuse in-service will not be allowed to work until they receive this in-

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F 223 Continued From page 6
female residents' (Resident #1 and Resident #8) breasts and groins over their clothing. LN #5 stated Resident #2 was redirected, the DON was notified and a NA was assigned to sit with Resident #2. LN #5 was not aware of how long the one to one supervision continued after she left that evening. LN #5 further stated she asked the DON if she needed to fill out an incident report and was instructed only to document her findings in the behavior section of the medical record.

D. Thursday 02/02/12:

Review of nursing notes dated 02/02/12 at 3:18 PM revealed LN #4 documented Resident #2 had frequently touched female residents inappropriately this shift.

Review of physician verbal order dated 02/02/12 revealed a new order for Lexapro (antidepressant) 5mg every day and Estrace (female hormone) 1mg every day, both "for sexual behaviors."

Review of the MAR revealed Resident #2 received the Lexapro and Estrace on 02/03/12 at 8:00 AM in addition to the daily dose of Celexa.

Review of Resident #2's Social Service Notes, a late entry dated 02/03/12 revealed on 02/02/12 the social worker spoke directly with Resident #2 regarding "his sexually inappropriate touching of staff, as well as residents." The note stated Resident #2 verbally agreed to not touch residents in a sexual manner.

Review of nursing notes dated 02/02/12 at 11:13

F 223 service by the Unit Manager or Department Head or Staff Development Nurse. 100% completed on 2/10/12.

g. The Administrator or DON will immediately report any allegations of abuse to the Regional Vice President of Operations or Chief Clinical officer for proper guidance.

2. The 24 hour report is a reflection of any unusual changes in resident's conditions and behaviors in the last 24 hours. Effective 2/9/2012, the Director of Nursing and Unit Managers and Weekend Supervisor will review the 24 hour nurses report daily to note any instances of behavior changes and/or occurrences of inappropriate resident to resident contact. On 2/9/12 nurses were in-serviced on including more information on resident behaviors. Any Allegations that are identified will be immediately reported to the

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PM revealed LN #2 documented staff had attempted to constantly watch Resident #2 due to him touching female residents inappropriately. The nurse aides observed him rubbing on a female resident's shoulder in the main dining room during supper and redirected Resident #2 away from her. In addition, another female resident had to be moved out into the hall due to Resident #2's numerous attempts to touch her. The social worker was in this evening to talk to him about his inappropriate touching of female residents. Review of the 24 hour shift report for 02/02/12 revealed during the first shift Resident #2 continued "to touch" female residents; during the second shift Resident #2 required constant watching to keep him from touching female residents; and during third shift Resident #2 continued "to touch" female residents.

Subsequent interviews with staff concerning these incidents revealed:

An interview with Licensed Nurse Unit Manager (LNUM) #2 on 02/07/12 at 11:20 AM revealed that LN #4 informed her on 02/02/12 that Resident #2 was behaving inappropriately and trying to touch other residents. She further stated she did not ask for specific details regarding Resident #2's behaviors at that time. LNUM #2 also stated she did not notify the Director of Nursing or the Administrator because she did not know the extent of his behaviors. She further stated she did not follow up with staff regarding Resident #2's behavior.

During an interview on 02/07/12 at 4:30 PM the Social Worker (SW) stated Resident #2 grabbed at staff members and was combative with care

F 223 Administrator. These will be discussed in the morning meeting.

3. On 2/9/12 a Quality Assurance Tool was started. This tool will have department heads make rounds 5 times per week, monitoring for inappropriate behaviors, interviews with staff and residents related to this topic, until Substantial Compliance is obtained. After that, should no further instances of non-compliance be identified, rounds will be completed weekly by the managers thereafter. This information will be monitored by the Quality Assurance Committee monthly and any necessary actions taken. The Quality Assurance Tool instructs the staff member to observe, and question residents and staff to see if there was any inappropriate resident to resident contact; heard any resident/family complaints; observe or receive a report of

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F 223	<p>Continued From page 8</p> <p>when he was first admitted to the facility. The SW further stated Resident #2's behaviors were discussed during the facility's morning meeting on 02/02/12 and the Administrator asked her to meet with Resident #2 and discuss his sexually inappropriate behavior. SW further stated she met with Resident #2 late in the afternoon on 02/02/12.</p> <p>E. Friday 02/03/12:</p> <p>Nursing notes dated 02/03/12 at 6:56 AM revealed LN #3 documented Resident #2 continued to touch female residents inappropriately. He watched for the nurse to go into a room then he moved closer to the female resident. Resident #2 was kept in sight of the nurse since he got up at 5:00 AM.</p> <p>Nursing notes on 02/03/12 at 3:04 PM revealed LN #4 documented Resident #2 continued to touch several female residents inappropriately frequently during this shift.</p> <p>Nursing notes dated 02/03/12 at 4:48 PM revealed LN #2 documented Activities Assistant (AA) #1 reported to the nurse Resident #2 was seen by a visitor touching Resident #10's breasts. AA #1 separated Resident #10 and Resident #2. The nurse documented she notified the social worker (SW) and the DON of this incident and assigned all staff on A hall to monitor Resident #2 and know where he was.</p> <p>Review of nursing notes dated 02/03/12 at 11:48 PM revealed LN #2 documented AA #2 reported at 8:21 PM she saw Resident #2 in Resident #9's room with his hand on the resident's groin. AA #2</p>	F 223	<p>Inappropriate resident to resident contact. They will ask 2 employees the first thing they are to do when they observe or hear of inappropriate resident to resident contact, ask employee to whom they should report this. This will be conducted on all shifts. The Quality Assurance Tool will gather the relevant information, which will be taken to the morning meeting, where it will be discussed and any negative responses will be handled immediately by the administrator or his/her designee.</p> <p>4. Beginning on 2/9/12 any residents displaying inappropriate behaviors were assessed and their care plans were reviewed and updated for appropriate actions. This was completed by the MDS nurses.</p> <p>5. On 2/17/12 all Nurse Managers were in-serviced by the Chief Clinical Officer on;</p>	

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attempted to remove Resident #2 from the room and Resident #2 became combative and tried to hit her. Resident #2 was removed from the room and placed at the nurse's desk. LN #2 contacted the Nurse Practitioner (NP) about Resident #2's behaviors who subsequently called the DON. The DON called LN #2 back and was told to have an NA with Resident #2 at all times. Resident #2's physician (MD) called at 10:30 PM. LN #2 explained Resident's #2's behavior had escalated on 02/03/12. The MD asked for the DON's phone number. The MD called LN #2 back at 10:50 PM with new orders for an antipsychotic and antianxiety medication. Also the MD stated the DON would be calling in the morning (02/04/12) to arrange for Resident #2's transfer to a hospital.

Review of the physician verbal orders dated 02/03/12 revealed Lexapro was discontinued and the Celexa was increased to 20mg every day. In addition, an antipsychotic medication, Haldol 1mg IM (intramuscular) was ordered now, then 1mg either by mouth or IM every 8 hours on schedule. An antianxiety medication, Ativan 0.5 mg was ordered now and every 6 hours as needed.

Review of facility documentation revealed one on one supervision was started on 02/03/12 at 11:00 PM and continued until 02/08/12 at 12:05 PM when Resident #2 was transferred to the hospital.

Subsequent interviews with staff concerning these incidents revealed:

During a telephone interview on 02/07/12 at 2:55 PM, LN #3 stated at approximately 6:00 AM on 02/03/12, she observed Resident #2 with his hand on Resident #9's stomach. LN #3 further

F 223

a. The facility's Skin tear/bruise Policy and Procedure.

b. Properly investigating Skin Tears and Bruises to rule out Abuse.

c. How to properly investigate possible causative factors that may have contributed to the skin tear or bruise such as; Resident and staff statements, medications, behaviors, medical conditions and environmental factors.

d. The facility's Quality Assurance Investigational tool for Skin Tears and Bruises.

e. The requirement that these be reviewed dally as they occur, orders obtained as needed, interventions implemented as appropriate, care plans updated and revised as necessary and Suspicious skin tears/bruises that a plausible causative factor could not be derived from a investigation be reported as and

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F 223 Continued From page 10
stated she redirected Resident #2 to his room and kept Resident #9 with her. She stated she did not fill out an incident report but did report this information to the oncoming nurse (LN #4).

During an interview on 02/07/12 at 4:30 PM the Social Worker (SW) explained she shared her meeting with Resident #2 on 02/02/12 during the facility's 02/03/12 morning meeting and staff discussed the need for a family meeting.

During interview on 02/07/12 at 10:00 AM, AA #1 stated that on 02/03/12 a visitor reported Resident #2 was touching Resident #10's breast over her clothing while they were seated in the dining room. AA #1 stated that she moved Resident #10 to another table and reported the incident to LN #2.

During a telephone interview on 02/06/12 at 5:35 PM, LN #2 stated that on 02/03/12 she told the DON Resident #2 was observed inappropriately touching Resident #10's breasts. LN #2 asked the DON if she should fill out an incident report and the DON told her to document Resident #2's behaviors in the chart. She further stated the DON called back after 9:00 PM, after being contacted by the nurse practitioner (NP), and instructed staff to put Resident #2 on one on one supervision.

During the interview on 02/06/12 at 12:50 PM, the MD revealed the facility physician on call contacted him at home on Friday (02/03/12) evening about Resident #2 exhibiting inappropriate sexual behaviors. The MD stated he called the DON on 02/03/12 and told her it would be best to send Resident #2 to the hospital

F 223 treated as a possible Abuse scenario. If Abuse can not be ruled out, these events will be reported and investigated as Alleged Abuse cases.

6. The 7 types of abuse was posted in numerous visual areas in the facility on 2/14/12.

7. The contact phone numbers for the Administrator, Director of Nursing, Social Service Director and the Corporate Compliance Hotline was posted in numerous visual areas in the facility on 2/13/12. This will allow staff, families and outside vendors to immediately contact Key facility staff if they have concerns.

8. On 2/10/12 the facility implemented a weekly Resident Council meeting. This meeting will allow the residents to voice any concerns that they may have. If concerns are identified, these will be immediately reported to the Administrator per the grievance policy.

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F 223 Continued From page 11
for a psychiatric evaluation. During continued interview the MD noted he had ordered "sedatives" until the next morning when Resident #2 could be sent to the hospital.

The DON stated on 02/06/12 at 1:20 PM, she and the Administrator decided to place the resident on one on one supervision on Friday night (02/03/12).

H. Saturday 02/04/12:

Review of the 02/04/12 MAR revealed Resident #2 was administered Haldol 1 mg IM at 11:00 PM and Ativan 0.5 mg by mouth at 11:00 PM. There were no documented behaviors for which these as needed medications were administered.

Subsequent interviews with staff concerning this incident revealed:

During continued interview on 02/06/12 at 1:20 PM, the MD revealed he called the facility on the afternoon of 02/04/12 to see if Resident #2 had been sent out to the hospital and was told by nursing staff that the DON was "working on it."

I. Sunday 02/05/12:

Review of nursing notes dated 02/05/12 at 5:53 AM revealed Resident #2 was up at long intervals. He was noted to be agitated, cursing, and threatened to hit staff.

Review of the MAR for 02/05/12 revealed Resident #2 received Ativan at 1:30 AM, 1:05 PM and 8:17 PM in addition to his regularly scheduled medications.

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9. On 2/17/12 a all staff Directed in-service was conducted by a representative of The Adult Protective Services Department. This In-service included:

- Signs and symptoms of abuse.
- Types of abuse.
- Preventing abuse.
- Protection against abuse.
- Protection of residents when abuse is suspected.
- Immediately reporting abuse.

MONITORING

1. The DON and Unit Managers will continue review the facility's 24 hour report to for any documented instances of inappropriate resident to resident contact or any allegations of abuse. Further Education and possible disciplinary action will occur as needed.

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Review of the physician communication book revealed an entry on 02/05/12 documenting Resident #2 was still having "aggressive sexual behaviors."

Review of nursing notes dated 02/05/12 at 9:21 PM revealed Resident #2 was trying to approach Resident #10. The nursing note stated Resident #2 was redirected, was on one on one supervision and received as needed medication.

J. Monday 02/06/12:

Review of the Social Service Notes dated 02/06/12 revealed the Administrator requested a family meeting to be scheduled immediately due to Resident #2's ongoing sexually inappropriate behavior.

Subsequent interviews with staff concerning this incident revealed:

During an interview on 02/06/12 at 3:50 PM, the Administrator explained prior to 02/03/12 at 10:30 PM, her understanding was Resident #2 had been holding hands and touching female resident's legs. The Administrator stated she did not usually review the 24 hour reports, nursing notes or Physician communication book but expected her clinical staff to inform her of any changes in resident's condition.

The administrator was notified of the immediate jeopardy on 02/8/12 at 9:50 AM. The facility provided a credible allegation of compliance on 02/10/12 at 4:24 PM. The following interventions were put into place by the facility to remove the

F 223

2. The Department heads will continue to complete the daily Quality Assurance rounds for abuse until substantial compliance is obtained. At that time the Quality Assurance committee will review this process and these rounds will be conducted weekly thereafter by each Department Head.

3. All allegations of Abuse will be immediately reported to the Administrator. The allegations will be fully investigated and reported per regulations. The Administrator will notify the Regional Vice President and/or the Chief Clinical Officer for guidance and to ensure that the facility's policy has been followed.

4. The Regional Vice President and/or the Chief Clinical Officer will provide guidance and support to the facility on each reported Abuse scenario.

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F 223 Continued From page 13
Immediate Jeopardy:

Credible Allegation of Compliance:

02/03/12 at 11:00 pm, resident #2 was assigned a staff member to be with him at all times. The intervention continued until resident #2 was transferred from the facility to the hospital on 02/08/12 at 12:05 p.m.

02/08/12 Administrator called the County Sheriffs Office to report a possible crime, related to the inappropriate behavior of resident #2.
PROCESS TO IDENTIFY OTHER RESIDENTS AT RISK

1. 2/6/12 and 2/8/12 the Social Worker completed interviews, with thirty four (34) alert and interviewable residents, to ascertain if there were any other incidents of inappropriate resident to resident contact noted. They were asked if they felt safe or if anyone had made them feel uncomfortable. No additional concerns were identified.
2. On 2/6/2012 complete body audits done by the Unit Charge Nurses to assess any obvious physical injury, on residents #1, #8, #9 and #10, who were identified as being inappropriately touched by resident #2. Results of this audit revealed no visible bruising or signs of physical trauma.
3. On 2/6/2012, residents # 1, #8, #9, and #10's families/responsible parties were contacted by the Director of Nursing to notify them of their family member being inappropriately touched. They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional concerns were identified.

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5. The weekly Resident Council Meeting will continue until Substantial Compliance is obtained. At that time the Resident Council will vote on whether to continue this practice.

6. The results of the Quality Assurance monitoring tool, 24 hour report, and investigations of any inappropriate resident contact will be reviewed and analyzed in the monthly Quality Assurance Committee meeting for three months and quarterly thereafter until deemed resolved by the committee.

7. Monthly in-services will be provided to all facility staff for the next 3 months, then quarterly there after. These in-services will review the Facility's Abuse Policy and Procedure. The facility will attempt to arrange Outside speakers with Abuse Prevention knowledge to provide these in-services.

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4. 2/7/12 and 2/8/12 The Nursing staff were instructed by the Director of Nursing to observe resident ' s #1, #8, #9 and #10, for and signs, such as crying, increased anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in theses resident ' s behaviors or demeanor.

5. 2/9/12- Twenty- Nine (29) Resident families/responsible parties were selected at random and contacted by the DON, MDS nurse or Social Worker, to determine if they were aware of any inappropriate resident to resident contact/abuse and educated to immediately report any concerns. Messages were left with 11 additional families. No family contacted reported any concerns.

6. 2/8/12 and 2/9/12 - Ninety-two employees were interviewed by department heads, and asked if they have observed any inappropriate resident to resident contact. All staff members who were not available for interview will be removed from the schedule until such interview is completed by the department head. No additional concerns were identified.

PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES

1. On 2/7 and 2/8/12 all available persons employed by this facility were In-serviced. All department heads were in-service by the Regional Vice President of Operations. Staff Development Coordinator, Nurse Managers, in-service the nurses. All other staff was in-serviced by their department managers. In-services contained the following:
a. The facility ' s Abuse policy and procedure states that abuse can be considered physical touching that is inappropriate, if it is uninvited by

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8. The Medical Director was consulted on these allegations, the facilities processes, interventions implemented, suggestions and/or guidance. The facility will continue to involve the Medical Director in the Quality Assurance process and seek guidance, support and further educational needs.

9. The Administrator is responsible for compliance.

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the person being touched.

b. Immediately protect all residents when inappropriate resident to resident contact is identified, by staying with the resident to protect them. You must immediately notify the administrator.

c. Immediately report all events of inappropriate resident to resident contact to the Administrator. If the Administrator is not available, the employee reporting the alleged abuse should report it to his/her supervisor who contacts the Administrator or Director of Nursing.

d. 2/8/12 Abuse policy revised to state nurses are to immediately fill out an incident report and submit it to the DON; call the physician; notify family/responsible party and the administrator at the time of the occurrence. In-service was conducted by the Unit Managers, DON, department heads on 2/8/12.

e. All staff should report to their immediate supervisor and expect feedback from that supervisor that an investigation has been initiated, if feedback not provided, staff should contact Administrator directly. The Administrators contact information is posted at every Nurses station and in every ancillary department.

f. Any staff member that is unable to attend the Abuse In-service will not be allowed to work until they receive this in-service by the Unit Manager or Department Head or Staff Development Nurse.

g. The Administrator or DON will immediately report any allegations of abuse to the Regional Vice President of Operations or Chief Clinical officer for proper guidance. The Administrator of Director of Nursing will report to the proper authorities within 2 hours if serious bodily injury occurs, or within 24 hours of a suspicion of crime.

h. The 24 hour report is a reflection of any

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F 223	<p>Continued From page 16</p> <p>unusual changes in resident ' s conditions and behaviors in the last 24 hours. Effective 2/9/2012,the Director of Nursing and Unit Managers and Weekend Supervisor will review the 24 hour nurses report daily to note any instances of behavior changes and/or occurrences of inappropriate resident to resident contact. On 2/9/12 nurses were in serviced on including more information on resident behaviors. Any Allegations of abuse that are on the 24 hour report identified will be immediately reported to the Administrator.</p> <p>2. On 2/9/12 a Quality Assurance Tool will be started. This tool will have department heads make rounds 5 times per week, monitoring for inappropriate behaviors, interviews with staff and residents related to this topic, for the next 3 weeks. After that, should no occurrences of abuse be reported, rounds will be made weekly. This information will be monitored by the Quality Assurance Committee monthly and any necessary actions taken. The Quality Assurance Tool instructs the staff member to observe, and question residents and staff to see if there was any Inappropriate resident to resident contact; heard any resident/family complaints; observe or receive a report of inappropriate resident to resident contact. They will ask 2 employees the first thing they are to do when they observe or hear of inappropriate resident to resident contact, ask employee to whom they should report this. This will be conducted on all shifts. The Quality Assurance Tool will gather the relevant information, which will be taken to the morning meeting, where It will be discussed and any negative responses will be handled immediately by the administrator or Director of Nursing.</p> <p>3. Beginning on 2/9/12 any residents displaying</p>	F 223		

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inappropriate behaviors will be assessed and have their care plans reviewed and updated for appropriate actions within 24 hours of occurrence. Corrections or additions will be made. This will be completed by the MDS nurses.

MONITORING

1. The DON and Unit Managers will continue review the facility ' s 24 hour report to for any documented instances Of inappropriate resident to resident contact or any allegations of abuse. Further Education and possible disciplinary action will occur as needed.
2. The Department heads will continue to complete the daily Quality Assurance rounds for abuse until substantial compliance is obtained. At that time the Quality Assurance committee will review this process and these rounds will determine the frequency that rounds are to continue to be completed as a Quality Assurance process.
3. All allegations of Abuse will be immediately reported to the Administrator. The allegations will Be fully investigated and reported per regulations. The Administrator will notify the Regional Vice President And/or the Chief Clinical Officer for guidance and to ensure that the facility ' s policy has been followed.
4. The results of the Quality Assurance monitoring tool, 24 hour report, and investigations of any inappropriate resident contact will be reviewed and analyzed in the monthly Quality Assurance Committee meeting for three months and quarterly thereafter until deemed resolved by the committee.

The immediate jeopardy was removed on 02/10/12 at 5:15 PM following interviews with administrative, licensed and direct care staff on all three shifts related to mandatory education on

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F 223	Continued From page 18 abuse; interviews with residents; interviews with families; review of in-service rosters on education of staff on abuse; review of revised abuse policy; review of the 24 hours communication sheets; and review of the quality assurance tool put into place.	F 223	Preparation and execution of this plan does not constitute admission or agreement by the provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by provisions of the State and Federal Law.		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to implement abuse policies and procedures related to identification, prevention, protection, investigation and reporting for four (4) of five (5) cognitively impaired residents. (Resident #1, #8, #9, and #10) Immediate jeopardy began on 1/29/2012 when staff became aware of Resident #2 inappropriately touching Resident #8. The administrator was notified of the immediate jeopardy on 02/8/2012 at 9:50 AM. Immediate jeopardy was removed on 02/10/2012 when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems put in place are	F 226	F 226 The facility does protect all of its residents from Abuse, properly investigate, screen and coordinate with law enforcement officials <u>RESIDENT IDENTIFIED</u> On 2/3/12 at 11:00 pm, resident #2 was assigned a staff member to be with him at all times. This intervention continued until resident was discharged from the facility on 2/8/12. <u>IDENTIFYING OTHER RESIDENTS AT RISK</u> 1. On 2/6/2012 complete body audits done by the Unit Charge Nurses to assess any obvious physical injury, on resident	3/2/12	

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F 226	Continued From page 19 effective. Findings include: The facility abuse policy dated 7/27/11 reads in part: POLICY STATEMENT The Facility and its staff are committed to maintaining a safe and abuse-free environment for all residents. IDENTIFICATION During orientation and throughout the year, staff will be educated on observation and reporting important information about resident care, condition or behavior. Staff and vendors are mandated to report, intervene in situations in which abuse and neglect has occurred or suspicion of occurrence. Staff is to immediately report allegations and or observations of abuse and neglect. Administrative and supervisory staff will supervise staff to identify inappropriate behaviors. PREVENTION Provide staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution; and provide feedback regarding the concerns that have been expressed. The facility will review reports of abuse and neglect and incidents in an effort to identify trends/patterns and to maintain a safe environment for residents and staff. PROTECTION The facility will immediately protect the resident,	F 226	#1, #8, #9 and #10, who were touched by resident #2. Results of this audit revealed no visible bruising or signs of physical trauma. 2. On 2/6/2012, residents # 1, #8, #9, and #10 's families were contacted by the Director of Nursing to notify them of their family member being inappropriately touched . They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional concerns were identified. 3. 2/7/12 and 2/8/12 The Nursing staff were instructed to observe resident's #1, #8, #9 and #10, for and signs, such as crying, increased anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in theses		

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NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139
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F 226 Continued From page 20
 identify the perpetrator, remove the resident from the resident care area and notify the Administrator and Director of Nurses. Other residents who may have potentially been affected or at risk will be identified and a plan of care will be developed or revised as appropriate to ensure their safety.

INVESTIGATION

All Abuse allegations and actual or suspicious crimes will be reported and investigated.

REPORTING

Report all alleged Abuse violations and all substantiated incidents to the State Agency and to all other required agencies as required, and take all necessary corrective actions depending on the results of the investigation. Report to the State agency and local law enforcement agency any suspicion of a crime.

1. Resident #1 was admitted to the facility with diagnoses including senile dementia, anxiety and osteoporosis.

Review of the latest Annual Minimum Data Set (MDS) dated 11/07/11 revealed Resident #1 was not ambulatory and totally dependent on staff for transfers and all Activities of Daily Living (ADL). In addition the MDS revealed Resident #1 had range of motion limitations and was impaired bilaterally in both upper and lower extremities. She was identified on the MDS with severely impaired cognition.

Review of the nursing progress notes for

F 226 resident's behaviors or demeanor.
 4. 2/9/12- Twenty- Nine (29) Resident families were contacted by the DON, MDS nurse or Social Worker, to determine if they were aware of any inappropriate resident to resident contact/abuse and educated to immediately report any concerns. Messages were left with 11 additional families. No family contacted reported any concerns.
 5. On 2/8/12 the Social Worker completed interviews, with thirty four (34) alert and interviewable residents, to ascertain if there were any other incidents of inappropriate resident to resident contact noted. They were asked if they felt safe or if anyone had made them feel uncomfortable. No additional concerns were identified.
 6. 2/8/12 and 2/9/12 – Ninety-two employees were interviewed by department

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F 226	<p>Continued From page 21</p> <p>Resident #1 revealed the following documentation: 02/06/12 at 10:51 PM Occurrence type: Inappropriately touched by male resident, (Resident #2) as a late entry for: 02/01/12 at 9:30 PM Resident #1 was sitting in the hallway in her wheelchair when the occurrence happened. Also noted the Physician was notified on 02/02/12, family RP will be notified in AM on 02/07/12. 02/08/12 at 2:42PM family RP notified at 9:00 AM.</p> <p>An interview on 02/06/12 at 3:20 PM with LN #5 revealed Resident #2 was observed on 02/01/12 during the 3:00 PM to 11:00 PM shift grabbing female residents' (Resident #1 and Resident #8) breasts and groins over their clothing. LN #5 stated Resident #2 was redirected, the DON was notified and a NA was assigned to sit with Resident #2. LN #5 was not aware of how long the one to one supervision continued after she left that evening. LN #5 further stated she asked the DON if she needed to fill out an incident report and was instructed only to document her findings in the behavior section of the medical record.</p> <p>LN #4 stated on 02/06/12 at 3:25 PM that on 02/01/12 the NAs (she did not recall whom) reported to her they had observed Resident #2 inappropriately touching female residents, including Resident #1 and Resident #8. LN #4 further revealed she considered Resident #2's behaviors as sexual abuse, so on 02/01/12 she reported it to the DON per facility policy. The DON told her to chart Resident #2's actions under behaviors in the resident's medical record.</p>	F 226	<p>heads, and asked if they have observed any inappropriate resident to resident contact. All staff members who were not available for interview will be removed from the schedule until such interview is completed by the department head. No additional concerns were identified.</p> <p><u>PROCESS IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</u></p> <p>1. On 2/7 and 2/8/12 all available persons employed by this facility were in-serviced. All department heads were in-serviced by the Regional Vice President of Operations. Staff Development Coordinator, Nurse Managers, in-serviced the nurses. All other staff was in-serviced by their department managers. In-services contained the following: 100% completed on 2/12/12.</p> <p>a. The facilities Abuse policy and procedure states that abuse can</p>

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F 226	<p>Continued From page 22</p> <p>Review of the facility abuse investigations since the last survey revealed no abuse investigations on file for this occurrence involving Resident #1.</p> <p>The DON was interviewed on 2/6/2012 at 1:20 PM. During the interview the DON revealed she knew of Resident #2's behaviors on 1/30/12 and had the SW look in to it but did not follow up on the behaviors. The DON stated she and the Administrator decided on Friday (02/03/12) night to address the situation on 2/6/2012 as Resident #2 was on one on one supervision. The DON noted Resident #2 had been on one on one supervision over the past weekend and the MD was now trying to get a referral for a psychiatric evaluation. The DON further stated she had not yet started her investigation of Resident #2's inappropriate behaviors. The DON confirmed that neither she nor the Administrator came by the facility during the weekend of 02/04/12 through 02/05/12.</p> <p>During an interview on 02/06/12 at 3:50 PM the Administrator stated that prior to the phone call from the DON at 10:30 PM on 02/03/12 she did not understand Resident 2's behaviors as sexually inappropriate. The Administrator further stated when abuse is identified she would expect the resident(s) to be protected, an incident report to be filed, a full investigation to be completed, family and physician to be contacted, resident(s) to be observed for change in behaviors or demeanor and interventions put into place.</p> <p>Review of the facility documents revealed the twenty-four (24) hour initial report to the North Carolina Health Care Personnel Registry was faxed on 02/06/12 at 9:46 PM by the DON and</p>	F 226	<p>be considered physical touching that is inappropriate, if it is uninvited by the person being touched. This in-service also included;</p> <p>1. Identification:</p> <ul style="list-style-type: none"> - Staff and vendors are mandated to report, intervene in situations in which abuse and neglect based on facility reporting policy, - Staff is to immediately report allegations and/or observations of abuse and neglect based on facility reporting policy, - The facility will facilitate assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect based on individualized assessment. <p>2. Prevention:</p> <ul style="list-style-type: none"> - Provide resident, families, and staff information on how and

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F 226	Continued From page 23 the Sheriff's office was notified by the Administrator on 02/08/12 at 10:45 AM. 2. Resident #8 was admitted to the facility with diagnoses including dementia, polyarthritis, and anxiety. Review of the latest Minimum Data Set (MDS) dated 12/21/11 revealed Resident #8 was not ambulatory and required extensive assistance for Activities of Daily Living (ADL). In addition the MDS revealed Resident #8 was impaired bilaterally on lower extremities. She was identified on the MDS with severely impaired cognition. Review of the nursing progress notes for Resident #8 revealed the following documentation: 02/06/12 at 10:47 PM Occurrence type: Inappropriately touched by male resident, (Resident #2) as a late entry for: 02/01/12 at 9:30 PM Resident #8 was sitting in the hallway in her wheelchair when the occurrence happened. Also noted the Physician was notified on 02/02/12, family RP notified on 2/6/12 at 9:10 PM. 02/06/12 at 10:48 PM Occurrence type: Inappropriately touched by male resident, (Resident #2) as a late entry for: 01/29/12 at 3:49 PM Resident #8 was sitting in the hallway when the occurrence happened. Also noted: "physician notified put on MD book for review on 01/30/12." family RP notified on 2/6/12 at 9:10 PM. Review of the Physician's communication book revealed an entry by LN #1 dated 01/29/12 (no	F 226	to whom they may report concerns, incidents, and grievances without fear of retribution; and provide feedback regarding the concerns that have been expressed. - The facility will review reports of abuse and neglect, injury of unknown origins, incidents in an effort to identify trends/patterns and to maintain a safe environment for residents and staff. Analysis and corrective/responsible action plans will be coordinated with the Quality Assurance Committee. 3. Protection - When abuse or a crime is witnessed the 1 ST that has to be done is to protect the resident and all other residents from further abuse or crimes. - Once you as the employee suspect abuse or a crime you must stay with the resident in the situation to protect them.	

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F 226	Continued From page 24 time) which stated staff noted Resident #2 touching Resident #8's breast. Review of the "Manager's on Duty" report dated 01/29/12 included in part: LN #2 reported Resident #2 was found in Resident #8's room holding her hand. During an interview on 02/06/12 at 12:05 PM, Nursing Assistant (NA) #1 revealed, that on 02/01/12, while working on the first shift she had pulled Resident #2 in his wheelchair away from Resident #8 four times. NA #1 stated she reported to LN #4, that Resident #2 had been rubbing the leg of Resident #8 up to her groin. NA #1 further revealed later that day the Director of Nursing (DON) came to the nursing station. She informed the DON of what happened. NA #1 was instructed by the DON to "keep an eye" on Resident #2 and not let him around the female residents. An interview on 02/06/12 at 3:20 PM with LN #5 revealed Resident #2 was observed on 02/01/12 during the 3:00 PM to 11:00 PM shift grabbing female residents' (Resident #1 and Resident #8) breasts and groins over their clothing. LN #5 stated Resident #2 was redirected, the DON was notified and a NA was assigned to sit with Resident #2. LN #5 was not aware of how long the one to one supervision continued after she left that evening. LN #5 further stated she asked the DON if she needed to fill out an incident report and was instructed only to document her findings in the behavior section of the medical record. LN #4 stated on 02/06/12 at 3:25 PM that on	F 226	- You then must then contact help to report "who" the alleged perpetrator is. - This can be reported to a charge nurse or department head. - You must not leave the resident while the reporting occurs. - Once the Nurse or Department head arrives, report what you observed and who is the alleged perpetrator. - The Nurse/Department Head must then immediately locate the perpetrator and immediately remove them from area of all residents. - You must not leave the abused perpetrator alone. - You must then immediately notify the Administrator of the situation.	

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F 226 Continued From page 25

02/01/12 the NAs (she did not recall whom) reported to her they had observed Resident #2 inappropriately touching female residents, including Resident #1 and Resident #8. LN #4 further revealed she considered Resident #2's behaviors as sexual abuse, so on 02/01/12 she reported it to the DON per facility policy. The DON told her to chart Resident #2's actions under behaviors in the resident's medical record.

Subsequent interviews with staff concerning these incidents revealed:

An interview was conducted with activity assistant (AA) #1 on 02/07/12 at 10:00 AM. AA #1 stated she observed Resident #2 touch Resident #8's breast over her clothing around lunch time on 01/29/12. AA #1 further stated that she immediately reported the incident to Licensed Nurse (LN) #1 who was Resident #2's and Resident #8's licensed nurse on this shift.

A telephone interview on 02/07/12 at 11:00 AM with LN #1 revealed that AA #1 told her that she observed Resident #2 touch Resident #8's breast over her clothing around lunch time on 01/29/12. LN #1 recalled Resident #2 was removed from the hall near the nurse's station and assisted to bed by a nursing assistant. LN #1 stated she documented the incident in the Physician's communication book, her nurse's note, and passed the information on to the second shift (3:00 PM to 11:00 PM) nurse (LN #2). No other interventions were put into place.

Review of the facility abuse investigations since the last survey revealed no abuse investigations on file for this occurrence involving Resident #8.

F 226

- From this point you follow the direction of the Administrator.

4. Investigate:

- The Administrator or Director of Nursing will immediately begin the investigative process to include:

- Interview the residents involved
- Interview of staff that had contact with the residents involved in the allegation of abuse
- Interview other alert and oriented residents who had the opportunity to observe the alleged abuse.
- Interview any known witness.
- assess all involved residents for signs and symptoms of abuse.

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F 226	Continued From page 26 The DON was interviewed on 2/6/2012 at 1:20 PM. During the interview the DON revealed she knew of Resident #2's behaviors on 1/30/12 and had the SW look in to it but did not follow up on the behaviors. The DON stated she and the Administrator decided on Friday (02/03/12) night to address the situation on 2/6/2012 as Resident #2 was on one on one supervision. The DON noted Resident #2 had been on one on one supervision over the past weekend and the MD was now trying to get a referral for a psychiatric evaluation. The DON further stated she had not yet started her investigation of Resident #2's inappropriate behaviors. The DON confirmed that neither she nor the Administrator came by the facility during the weekend of 02/04/12 through 02/05/12. During an interview on 02/06/12 at 3:50 PM the Administrator stated that prior to the phone call from the DON at 10:30 PM on 02/03/12 she did not understand Resident 2's behaviors as sexually inappropriate. The Administrator further stated when abuse is identified she would expect the resident(s) to be protected, an incident report to be filed, a full investigation to be completed, family and physician to be contacted, resident(s) to be observed for change in behaviors or demeanor and interventions put into place. Review of the facility documents revealed the twenty-four (24) hour initial report to the North Carolina Health Care Personnel Registry was faxed on 02/06/12 at 9:46 PM by the DON and the Sheriff's office was notified by the Administrator on 02/08/12 at 10:45 AM.	F 226	5. Reporting - The Administrator or Director of Nursing will be responsible for reporting the abuse allegation to all State and Local Authorities per required time frames as mandated by regulation. b. Immediately protect all residents when inappropriate resident to resident contact is identified, by staying with the resident to protect them. You must immediately notify the administrator. c. Immediately report all events of inappropriate resident to resident contact to the Administrator. If the Administrator is not available, the employee reporting the alleged abuse should report it to his/her supervisor who contacts the Administrator or Director of Nursing.		

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F 226	Continued From page 27 3. Resident #9 was admitted to the facility with diagnoses including dementia and anxiety. Review of the quarterly Minimum Data Set (MDS) dated 12/9/11 revealed Resident #9 was non ambulatory and required extensive assistance for activities of Daily Living (ADL). She was identified on the MDS with severely impaired cognition. Review of the nursing progress notes for Resident #9 revealed the following documentation: 02/06/12 at 10:55 PM Occurrence type: Inappropriately touched by male resident, (Resident #2) as a late entry for: 02/03/12 at 8:21 PM Resident #8 was sitting in the hallway when the occurrence happened. Also noted the Physician was notified on 02/02/12, family RP notified on 02/06/12 at 9:00 PM. Review of nursing notes dated 02/03/12 at 11:48 PM revealed LN #2 documented AA #2 reported at 8:21 PM she saw Resident #2 in Resident #9's room with his hand on the resident's groin. AA #2 attempted to remove Resident #2 from the room and Resident #2 became combative and tried to hit her. Resident #2 was removed from the room and placed at the nurse's desk. LN #2 contacted the Nurse Practitioner (NP) about Resident #2's behaviors who subsequently called the DON. The DON called LN #2 back and was told to have an NA with Resident #2 at all times. Resident #2's physician (MD) called at 10:30 PM. LN #2 explained Resident's #2's behavior had escalated on 02/03/12. The MD asked for the DON's phone number. The MD called LN #2 back at 10:50 PM with new orders for an antipsychotic and	F 226	d. 2/8/12 Abuse policy revised to state nurses are to immediately fill out an incident report and submit it to the DON; call the physician; notify family/responsible party at the time of the occurrence. In-service was conducted by the Unit Managers, DON, department heads on 2/8/12. The Nurse's Responsibilities when alleged abuse is suspected and the facility's Policy and Procedure on Abuse was placed at each Nurses station. e. All staff should report to their immediate supervisor and expect feedback from that supervisor that an investigation has been initiated, if feedback not provided, staff should contact Administrator directly. The Administrators contact information is posted at every Nurses station and in every ancillary department.		

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F 226	Continued From page 28 antianxiety medication. Also the MD stated the DON would be calling in the morning (02/04/12) to arrange for Resident #2's transfer to a hospital. Subsequent interviews with staff concerning these incidents revealed: During a telephone interview on 02/07/12 at 2:55 PM, LN #3 stated at approximately 6:00 AM on 02/03/12, she observed Resident #2 with his hand on Resident #9's stomach. LN #3 further stated she redirected Resident #2 to his room and kept Resident #9 with her. She stated she did not fill out an incident report but did report this information to the oncoming nurse (LN #4). Review of the facility abuse investigations since the last survey revealed no abuse investigations on file for this occurrence involving Resident #9. The DON was interviewed on 2/6/2012 at 1:20 PM. During the interview the DON revealed she knew of Resident #2's behaviors on 1/30/12 and had the SW look in to it but did not follow up on the behaviors. The DON stated she and the Administrator decided on Friday (02/03/12) night to address the situation on 2/6/2012 as Resident #2 was on one on one supervision. The DON noted Resident #2 had been on one on one supervision over the past weekend and the MD was now trying to get a referral for a psychiatric evaluation. The DON further stated she had not yet started her investigation of Resident #2's inappropriate behaviors. The DON confirmed that neither she nor the Administrator came by the facility during the weekend of 02/04/12 through 02/05/12.	F 226	f. Any staff member that is unable to attend the Abuse in-service will not be allowed to work until they receive this in-service by the Unit Manager or Department Head or Staff Development Nurse. 100% completed on 2/12/12. g. The Administrator or DON will immediately report any allegations of abuse to the Regional Vice President of Operations or Chief Clinical officer for proper guidance. The Administrator or Director of Nursing will report to the proper authorities within 2 hours if serious bodily injury occurs, or if there is a reasonable suspicion of crime. 2. The 24 hour report is a reflection of any unusual changes in resident's conditions and behaviors in the last 24 hours. Effective 2/9/2012, the Director of Nursing and Unit Managers		

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F 226	Continued From page 29 During an interview on 02/06/12 at 3:50 PM the Administrator stated that prior to the phone call from the DON at 10:30 PM on 02/03/12 she did not understand Resident 2 ' s behaviors as sexually inappropriate. The Administrator further stated when abuse is identified she would expect the resident(s) to be protected, an incident report to be filed, a full investigation to be completed, family and physician to be contacted, resident(s) to be observed for change in behaviors or demeanor and interventions put into place. Review of the facility documents revealed the twenty-four (24) hour initial report to the North Carolina Health Care Personnel Registry was faxed on 02/06/12 at 9:46 PM by the DON and the Sheriff's office was notified by the Administrator on 02/08/12 at 10:45 AM. 4. Resident #10 was admitted to the facility with diagnoses including Alzheimer's disease and depressive disorder. Review of the Annual Minimum Data Set (MDS) dated 12/7/11 revealed Resident #10 was not ambulatory and required extensive assistance for activities of Daily Living (ADL). She was identified on the MDS with severely impaired cognition. Review of the nursing progress notes for Resident #10 revealed the following documentation: 02/06/12 at 10:54 PM Occurrence type: Inappropriately touched by male resident, (Resident #2) as a late entry for: 02/03/12 at 2:45 PM Resident #10 was sitting in the dining room when the occurrence happened. Also noted the	F 226	and Weekend Supervisor will review the 24 hour nurses report daily to note any instances of behavior changes and/or occurrences of inappropriate resident to resident contact. On 2/9/12 nurses were in-serviced on including more information on resident behaviors. Any Allegations that are identified will be immediately reported to the Administrator. These will be discussed in the morning meeting. 3. On 2/9/12 a Quality Assurance Tool was started. This tool will have department heads make rounds 5 times per week, monitoring for inappropriate behaviors, interviews with staff and residents related to this topic, until Substantial Compliance is obtained. After that, should no further instances of non-compliance be identified, rounds will be completed weekly by the managers thereafter. This information will be monitored by	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2012
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NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139
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F 226 Continued From page 30
Physician was notified on 02/03/12, family RP notified on 02/06/12 at 9:15 PM.

Nursing notes dated 02/03/12 at 4:48 PM revealed LN #2 documented Activities Assistant (AA) #1 reported to the nurse Resident #2 was seen by a visitor touching Resident #10's breasts. AA #1 separated Resident #10 and Resident #2. The nurse documented she notified the social worker (SW) and the DON of this incident and assigned all staff on A hall to monitor Resident #2 and know where he was.

Subsequent interviews with staff concerning these incidents revealed:

During interview on 02/07/12 at 10:00 AM, AA #1 stated that on 02/03/12 a visitor reported Resident #2 was touching Resident #10's breast over her clothing while they were seated in the dining room. AA #1 stated that she moved Resident #10 to another table and reported the incident to LN #2.

During a telephone interview on 02/06/12 at 5:35 PM, LN #2 stated that on 02/03/12 she told the DON Resident #2 was observed inappropriately touching Resident #10's breasts. LN #2 asked the DON if she should fill out an incident report and the DON told her to document Resident #2's behaviors in the chart. She further stated the DON called back after 9:00 PM, after being contacted by the nurse practitioner (NP), and instructed staff to put Resident #2 on one on one supervision.

Review of nursing notes dated 02/05/12 at 9:21 PM revealed Resident #2 was trying to approach

F 226 the Quality Assurance Committee monthly and any necessary actions taken. The Quality Assurance Tool instructs the staff member to observe, and question residents and staff to see if there was any inappropriate resident to resident contact; heard any resident/family complaints; observe or receive a report of inappropriate resident to resident contact. They will ask 2 employees the first thing they are to do when they observe or hear of inappropriate resident to resident contact, ask employee to whom they should report this. This will be conducted on all shifts. The Quality Assurance Tool will gather the relevant information, which will be taken to the morning meeting, where it will be discussed and any negative responses will be handled immediately by the administrator or his/her designee.

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F 226	Continued From page 31 Resident #10. The nursing note stated Resident #2 was redirected, was on one on one supervision and received as needed medication. Review of the facility abuse investigations since the last survey revealed no abuse investigations on file for this occurrence involving Resident #10. The DON was interviewed on 2/6/2012 at 1:20 PM. During the interview the DON revealed she knew of Resident #2's behaviors on 1/30/12 and had the SW look in to it but did not follow up on the behaviors. The DON stated she and the Administrator decided on Friday (02/03/12) night to address the situation on 2/6/2012 as Resident #2 was on one on one supervision. The DON noted Resident #2 had been on one on one supervision over the past weekend and the MD was now trying to get a referral for a psychiatric evaluation. The DON further stated she had not yet started her investigation of Resident #2's inappropriate behaviors. The DON confirmed that neither she nor the Administrator came by the facility during the weekend of 02/04/12 through 02/05/12. During an interview on 02/06/12 at 3:50 PM the Administrator stated that prior to the phone call from the DON at 10:30 PM on 02/03/12 she did not understand Resident 2's behaviors as sexually inappropriate. The Administrator further stated when abuse is identified she would expect the resident(s) to be protected, an incident report to be filed, a full investigation to be completed, family and physician to be contacted, resident(s) to be observed for change in behaviors or demeanor and interventions put into place.	F 226	4. Beginning on 2/9/12 any residents displaying inappropriate behaviors were assessed and their care plans were reviewed and updated for appropriate actions. This was completed by the MDS nurses. 5. On 2/17/12 all Nurse Managers were in-serviced by the Chief Clinical Officer on; a. The facility's Skin tear/bruise Policy and Procedure. b. Properly investigating Skin Tears and Bruises to rule out Abuse. c. How to properly investigate possible causative factors that may have contributed to the skin tear or bruise such as; Resident and staff statements, medications, behaviors, medical conditions and environmental factors. d. The facility's Quality Assurance Investigational tool for Skin Tears and Bruises.		

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F 226	<p>Continued From page 32</p> <p>Review of the facility documents revealed the twenty-four (24) hour initial report to the North Carolina Health Care Personnel Registry was faxed on 02/06/12 at 9:46 PM by the DON and the Sheriff's office was notified by the Administrator on 02/08/12 at 10:45 AM.</p> <p>The administrator was notified of the immediate jeopardy on 02/8/12 at 9:50 AM. The facility provided a credible allegation of compliance on 02/10/12 at 4:24 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy:</p> <p>Credible Allegation of Compliance:</p> <p>02/03/12 at 11:00 pm, Resident #2 was assigned a staff member to be with him at all times. The intervention continued until resident #2 was transferred from the facility to the hospital on 02/08/12 at 12:05 p.m.</p> <p>02/08/12 Administrator called the County Sheriffs Office to report a possible crime, related to the inappropriate behavior of resident #2.</p> <p>PROCESS TO IDENTIFY OTHER RESIDENTS AT RISK</p> <p>1. 2/6/12 and 2/8/12 the Social Worker completed interviews, with thirty four (34) alert and interviewable residents, to ascertain if there were any other incidents of inappropriate resident to resident contact noted. They were asked if they felt safe or if anyone had made them feel uncomfortable. No additional concerns were identified.</p> <p>2. On 2/6/2012 complete body audits done by the Unit Charge Nurses to assess any obvious physical injury, on residents #1, #8, #9 and #10,</p>	F 226	<p>e. The requirement that these be reviewed daily as they occur, orders obtained as needed, interventions implemented as appropriate, care plans updated and revised as necessary and Suspicious skin tears/bruises that a plausible causative factor could not be derived from a investigation be reported as a treated as a possible Abuse scenario. If Abuse can not be ruled out, these events will be reported and investigated as Alleged Abuse cases.</p> <p>6. The 7 types of abuse was posted in numerous visual areas In the facility on 2/14/12</p> <p>7. The contact phone numbers for the Administrator, Director of Nursing, Social Service Director and the Corporate Compliance Hotline was posted in numerous visual areas in the facility on 2/13/12. This will allow staff, families and outside vendors to immediately contact Key facility staff if they have concerns.</p>		

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F 226	Continued From page 33 who were identified as being inappropriately touched by resident #2. Results of this audit revealed no visible bruising or signs of physical trauma. 3. On 2/6/2012, residents # 1, #8, #9, and #10's families/responsible parties were contacted by the Director of Nursing to notify them of their family member being inappropriately touched . They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional concerns were identified. 4. 2/7/12 and 2/8/12 The Nursing staff were instructed by the Director of Nursing to observe resident ' s #1, #8, #9 and #10, for and signs, such as crying, Increased anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in theses resident's behaviors or demeanor. 5. 2/9/12- Twenty- Nine (29) Resident families/responsible parties were selected at random and contacted by the DON, MDS nurse or Social Worker, to determine if they were aware of any inappropriate resident to resident contact/abuse and educated to immediately report any concerns. Messages were left with 11 additional families. No family contacted reported any concerns. 6. 2/8/12 and 2/9/12 - Ninety-two employees were interviewed by department heads, and asked if they have observed any inappropriate resident to resident contact. All staff members who were not available for interview will be removed from the schedule until such interview is completed by the department head. No additional concerns were identified. PROCESSES IMPLEMENTED TO PREVENT	F 226	8. On 2/10/12 the facility implemented a weekly Resident Council meeting. This meeting will allow the residents to voice any concerns that they may have. If concerns are identified, these will be immediately reported to the Administrator per the grievance policy. 9. On 2/17/12 the Administrator and Director of Nursing were placed on a mentorship program. This mentorship will be provided by the Regional Vice President and the Chief Clinical Officer. The mentorship will be conducted weekly for 4 weeks. At that time an evaluation of progress will be completed for the goals set forth. After the 4 weeks the Corporate Executive Staff will review this plan and at that time make the necessary revisions to ensure that the residents of the facility are properly cared for. This program will;		

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F 226	<p>Continued From page 34</p> <p>FURTHER OCCURRENCES</p> <p>1. On 2/7 and 2/8/12 all available persons employed by this facility were in-service. All department heads were in-service by the Regional Vice President of Operations. Staff Development Coordinator, Nurse Managers, in-service the nurses. All other staff was in-service by their department managers. In-services contained the following:</p> <p>a. The facility's Abuse policy and procedure states that abuse can be considered physical touching that is inappropriate, if it is uninvited by the person being touched.</p> <p>b. Immediately protect all residents when inappropriate resident to resident contact is identified, by staying with the resident to protect them. You must immediately notify the administrator.</p> <p>c. Immediately report all events of inappropriate resident to resident contact to the Administrator. If the Administrator is not available, the employee reporting the alleged abuse should report it to his/her supervisor who contacts the Administrator or Director of Nursing.</p> <p>d. 2/8/12 Abuse policy revised to state nurses are to immediately fill out an incident report and submit it to the DON; call the physician; notify family/responsible party and the administrator at the time of the occurrence. In-service was conducted by the Unit Managers, DON, department heads on 2/8/12.</p> <p>e. All staff should report to their immediate supervisor and expect feedback from that supervisor that an investigation has been initiated, if feedback not provided, staff should contact Administrator directly. The Administrators contact information is posted at every Nurses station and in every ancillary department.</p>	F 226	<p>a. Identify strengths</p> <p>b. Identify areas that need improvement.</p> <p>c. Provide Corporate direction and guidance.</p> <p>d. Direction on State/Federal and corporate expectations.</p> <p>e. Provide realistic goals.</p> <p>f. Provide weekly documentation and feedback towards the achievement of the goals.</p> <p>10. On 2/17/12 a all staff Directed in-service was conducted by a representative of The Adult Protective Services Department. This In-service included:</p> <p>a. Signs and symptoms of abuse.</p> <p>b. Types of abuse.</p> <p>c. Preventing abuse.</p> <p>d. Protection against abuse.</p>	

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F 226 Continued From page 35

f. Any staff member that is unable to attend the Abuse in-service will not be allowed to work until they receive this in-service by the Unit Manager or Department Head or Staff Development Nurse.

g. The Administrator or DON will immediately report any allegations of abuse to the Regional Vice President of Operations or Chief Clinical officer for proper guidance. The Administrator of Director of Nursing will report to the proper authorities within 2 hours if serious bodily injury occurs, or within 24 hours of a suspicion of crime.

h. The 24 hour report is a reflection of any unusual changes in resident ' s conditions and behaviors in the last 24 hours. Effective 2/9/2012, the Director of Nursing and Unit Managers and Weekend Supervisor will review the 24 hour nurses report daily to note any instances of behavior changes and/or occurrences of inappropriate resident to resident contact. On 2/9/12 nurses were in serviced on including more information on resident behaviors. Any Allegations of abuse that are on the 24 hour report identified will be immediately reported to the Administrator.

2. On 2/9/12 a Quality Assurance Tool will be started. This tool will have department heads make rounds 5 times per week, monitoring for inappropriate behaviors, interviews with staff and residents related to this topic, for the next 3 weeks. After that, should no occurrences of abuse be reported, rounds will be made weekly. This information will be monitored by the Quality Assurance Committee monthly and any necessary actions taken. The Quality Assurance Tool instructs the staff member to observe, and question residents and staff to see if there was any inappropriate resident to resident contact; heard any resident/family complaints; observe or

F 226

e. Protection of residents when abuse is suspected.

f. Immediately reporting abuse.

MONITORING

1. The DON and Unit Managers will continue review the facility's 24 hour report to for any documented instances of inappropriate resident to resident contact or any allegations of abuse. Further Education and possible disciplinary action will occur as needed.

2. The Department heads will continue to complete the daily Quality Assurance rounds for abuse until substantial compliance is obtained. At that time the Quality Assurance committee will review this process and these rounds will be conducted weekly there after by each Department Head.

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F 226	Continued From page 36 receive a report of inappropriate resident to resident contact. They will ask 2 employees the first thing they are to do when they observe or hear of inappropriate resident to resident contact, ask employee to whom they should report this. This will be conducted on all shifts. The Quality Assurance Tool will gather the relevant information, which will be taken to the morning meeting, where it will be discussed and any negative responses will be handled immediately by the administrator or Director of Nursing. 3. Beginning on 2/9/12 any residents displaying inappropriate behaviors will be assessed and have their care plans reviewed and updated for appropriate actions within 24 hours of occurrence. Corrections or additions will be made. This will be completed by the MDS nurses. MONITORING 1. The DON and Unit Managers will continue review the facility's 24 hour report to for any documented instances Of inappropriate resident to resident contact or any allegations of abuse. Further Education and possible disciplinary action will occur as needed. 2. The Department heads will continue to complete the daily Quality Assurance rounds for abuse until substantial compliance is obtained. At that time the Quality Assurance committee will review this process and these rounds will determine the frequency that rounds are to continue to be completed as a Quality Assurance process. 3. All allegations of Abuse will be immediately reported to the Administrator. The allegations will Be fully investigated and reported per regulations. The Administrator will notify the Regional Vice President And/or the Chief Clinical Officer for guidance and to ensure that the facility's policy	F 226	3. All allegations of Abuse will be immediately reported to the Adminstrator. The allegations will be fully investigated and reported per regulations. The Administrator will notify the Regional Vice President and/or the Chief Clinical Officer for guidance and to ensure that the facility's policy has been followed. 4. The Regional Vice President and/or the Chief Clinical Officer will provide guidance and support to the facility on each reported Abuse scenario. 5. The weekly Resident Council Meeting will continue until Substantial Compliance is obtained. At that time the Resident Council will vote on whether to continue this practice. 6. The results of the Quality Assurance monitoring tool, 24 hour report, and investigations of		

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F 226 Continued From page 37
has been followed.
4. The results of the Quality Assurance monitoring tool, 24 hour report, and investigations of any inappropriate resident contact will be reviewed and analyzed in the monthly Quality Assurance Committee meeting for three months and quarterly thereafter until deemed resolved by the committee.
The immediate jeopardy was removed on 02/10/12 at 5:15 PM following interviews with administrative, licensed and direct care staff on all three shifts related to mandatory education on abuse; interviews with residents; interviews with families; review of in-service rosters on education of staff on abuse; review of revised abuse policy; review of the 24 hours communication sheets; and review of the quality assurance tool put into place.

F 490 483.75 EFFECTIVE
SS-J ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to assure that four (4) of five (5) sampled cognitively impaired female residents had an environment that was free from sexual abuse. The facility had not consistently identified the victims, had not conducted investigations and had not implemented effective preventative measures to protect the female residents from

F 226

any inappropriate resident contact will be reviewed and analyzed in the monthly Quality Assurance Committee meeting for three months and quarterly thereafter until deemed resolved by the committee.

F 490

7. Monthly in-services will be provided to all facility staff for the next 3 months, then quarterly there after. These in-services will review the Facility's Abuse Policy and Procedure. The facility will attempt to arrange Outside speakers with Abuse Prevention knowledge to provide these in-services.

8. The Medical Director was consulted on these allegations, the facilities processes, interventions implemented, suggestions and/or guidance. The facility will continue to involve the Medical Director in the Quality Assurance process and seek guidance, support and

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F 490	Continued From page 38 actual and potential sexual abuse. In addition, the facility administration failed to implement their abuse policy to identify, prevent, protect and investigate an allegation of abuse. Facility staff had knowledge of the inappropriate sexual behaviors of one male resident (Resident #2) toward four (4) sampled female residents (Residents #1, 8, 9, and 10). Immediate jeopardy began on 1/29/2012 when staff became aware of Resident #2 inappropriately touching Resident #8. The administrator was notified of the immediate jeopardy on 02/8/2012 at 9:50 AM. Immediate jeopardy was removed on 02/10/2012 when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems put in place are effective. The findings are: 1. Cross Reference F223. Based on staff interviews and record review, the facility failed to assure four of five cognitively impaired residents (Residents #1, 8, 9, 10) were protected following an allegation of abuse. Facility staff had knowledge of the inappropriate sexual behaviors of one male resident (Resident #2) toward four (4) sampled female residents (Residents #1, 8, 9, and 10). 2. Cross Reference F226. Based on staff interviews and record review, the facility failed to	F 490	further educational needs. 9. The Regional Vice President and/or the Chief Clinical officer will provide weekly onsite guidance for the next 30 days. After 30 days a Corporate Executive Meeting will occur to review the facility's progress in obtaining substantial compliance. After 30 days a Corporate Executive Meeting will occur to review the facility's progress in obtaining substantial compliance. Executive Meeting will occur to review the facility's progress in obtaining substantial compliance. 10. On 2/17/12 the Administrator and Director of Nursing were placed on a mentorship program. This mentorship will be provided by the Regional Vice President and the Chief Clinical Officer. The mentorship will be conducted weekly for 4 weeks. At that time an evaluation of progress will be completed for the goals set forth.	

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F 490	Continued From page 39 implement abuse policies and procedures for four (4) of five (5) cognitively impaired residents. (Resident #1, #8, #9, and #10) resident's condition. The administrator was notified of the immediate jeopardy on 02/8/12 at 9:50 AM. The facility provided a credible allegation of compliance on 02/10/12 at 4:24 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy: Credible Allegation of Compliance: 2/3/12 at 11:00 pm, resident #2 was assigned a staff member to be with him at all times. The intervention continued until resident #2 was transferred from the facility to the hospital on 2/8/12 at 12:05 p.m. 2/8/12 Administrator called the County Sheriffs Office to report a possible crime, related to the inappropriate behavior of resident #2. B. For residents#1, #8, #9, and #10: On 2/6/2012 complete body audits done by the Unit Charge Nurses to assess any obvious physical injury, on resident #1, #8, #9 and #10, who were identified as being improperly touched by resident #2. On 2/6/2012, residents # 1, #8, #9, and #10's families were contacted by the Director of Nursing to notify them of their family member being inappropriately touched. They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional instances were reported. On 2/7/12 and 2/8/12 The Nursing staff were instructed to observe resident's #1, #8, #9 and #10, for and signs, such as crying, increased	F 490	After the 4 weeks the Corporate Executive Staff will review this plan and at that time make the necessary revisions to ensure that the residents of the facility are properly cared for. 11. The Administrator is responsible for compliance.		

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F 490	Continued From page 40 anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in theses resident's behaviors or demeanor. PROCESS TO IDENTIFY OTHER RESIDENTS AT RISK 1. 2/6/12 and 2/8/12 the Social Worker completed interviews, with all thirty four (34) alert and interviewable residents, to ascertain if there were any other incidents of inappropriate resident to resident contact noted. They were asked if they felt safe or if anyone had made them feel uncomfortable. No additional concerns were identified. 2. On 2/6/2012 body audits done by the Unit Charge Nurses to assess any obvious physical injury, on residents #1, #8, #9 and #10, who were identified as being inappropriately touched by resident #2. Results of this audit revealed no visible bruising or signs of physical trauma. 3. On 2/6/2012, residents #1, #8, #9 and #10's families/responsible parties were contacted by the Director of Nursing to notify them of their family member being inappropriately touched. They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional concerns were identified. 4. On 2/7/2012 and 2/8/2012 the Nursing staff were instructed by the Director of Nursing to observe resident's #1, #8, #9, #10, for signs, such as crying, increased anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in these resident's behaviors or demeanor. 5. 2/9/12- Twenty- Nine (29) Resident families/responsible parties were contacted by	F 490	Preparation and execution of this plan does not constitute admission or agreement by the provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by provisions of the State and Federal Law. F 490 The facility does protect all of its residents from Abuse, properly investigate, screen and coordinate with law enforcement officials RESIDENT IDENTIFIED On 2/3/12 at 11:00 pm, resident #2 was assigned a staff member to be with him at all times. This intervention continued until resident was discharged from the facility 2/8/12.	3/2/12	

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F 490 - Continued From page 41
the DON, MDS nurse or Social Worker, to determine if they were aware of any inappropriate resident to resident contact/abuse and educated to immediately report any concerns. Messages were left with 11 additional families. No family contacted reported any concerns.
6. 2/8/12 and 2/9/12 - Ninety-two employees were interviewed by department heads, and asked if they have observed any inappropriate resident to resident contact. All staff members who were not available for interview will be removed from the schedule until such interview is completed by the department head. No additional concerns were identified.

PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURANCES

1. On 2/7 and 2/8/12 all available persons employed by this facility were in-serviced. All department heads were in-service by the Regional Vice President of Operations. Staff Development Coordinator, Nurse Managers, in-service the nurses. All other staff was in-serviced by their department managers. In-services contained the following:
 - A. Identification:
 - Staff and vendors are mandated to report, intervene in situations in which abuse and neglect based on facility reporting policy,
 - Staff is to immediately report allegations and/or observations of abuse and neglect based on facility reporting policy,
 - The facility will facilitate assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect based on individualized assessment.
 - B. Prevention:
 - Provide resident, families, and staff information

F 490 **IDENTIFYING OTHER RESIDENTS AT RISK**
1. On 2/6/2012 complete body audits done by the Unit Charge Nurses to assess any obvious physical injury, on resident #1, #8, #9 and #10, who were touched by resident #2. Results of this audit revealed no visible bruising or signs of physical trauma.
2. On 2/6/2012, residents # 1, #8, #9, and #10 's families were contacted by the Director of Nursing to notify them of their family member being inappropriately touched . They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional concerns were identified.
3. 2/7/12 and 2/8/12 The Nursing staff were instructed to observe resident's #1, #8, #9 and

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F 490	Continued From page 42 on how and to whom they may report concerns, incidents, and grievances without fear of retribution; and provide feedback regarding the concerns that have been expressed. - The facility will review reports of abuse and neglect, injury of unknown origins, incidents in an effort to identify trends/patterns and to maintain a safe environment for residents and staff. Analysis and corrective/responsible action plans will be coordinated with the Quality Assurance Committee. C. Protection - When abuse or a crime is witnessed the 1ST that has to be done is to protect the resident and all other residents from further abuse or crimes. - Once you as the employee suspect abuse or a crime you must stay with the resident in the situation to protect them. - You then must then contact help to report "who" the alleged perpetrator is. - This can be reported to a charge nurse or department head. - You must not leave the resident while the reporting occurs. - Once the Nurse or Department head arrives, report what you observed and who is the alleged perpetrator. - The Nurse/Department Head must then immediately locate the perpetrator and immediately remove them from area of all residents. - You must not leave the abused perpetrator alone. - You must then immediately notify the Administrator of the situation. - From this point you follow the direction of the Administrator. D. Investigate:	F 490	#10, for and signs, such as crying, increased anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in theses resident's behaviors or demeanor. 4. 2/9/12- Twenty- Nine (29) Resident families were contacted by the DON, MDS nurse or Social Worker, to determine if they were aware of any inappropriate resident to resident contact/abuse and educated to immediately report any concerns. Messages were left with 11 additional families. No family contacted reported any concerns. 5. On 2/8/12 the Social Worker completed interviews, with thirty four (34) alert and interviewable residents, to ascertain if there were any other incidents of inappropriate resident to resident contact noted. They		

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F 490	Continued From page 43 - The Administrator or Director of Nursing will immediately begin the investigative process to include: - Interview the residents Involved - Interview of staff that had contact with the residents involved in the allegation of abuse - Interview other alert and oriented residents who had the opportunity to observe the alleged abuse. - Interview any known witness. - assess all involved residents for signs and symptoms of abuse. E. Reporting - The Administrator or Director of Nursing will be responsible for reporting the abuse allegation to all State and Local Authorities per required time frames as mandated by regulation. F. 2/8/12 Abuse policy revised to state nurses are to immediately fill out an incident report and submit it to the DON; call the physician; notify family/responsible party and the Administrator at the time of the occurrence. In-service was conducted by the Unit Managers, DON, department heads on 2/8/12. G. All staff should report to their immediate supervisor and expect feedback from that supervisor that an investigation has been initiated, if feedback not provided, staff should contact Administrator directly. The Administrators contact information is posted at every Nurses station and in every ancillary department. H. Any staff member that is unable to attend the Abuse in-service will not be allowed to work until they receive this in-service by the Unit Manager or Department Head or Staff Development Nurse. I. The Administrator or DON will immediately report any allegations of abuse to the Regional Vice President of Operations or Chief Clinical officer for proper guidance. The Administrator or	F 490	were asked if they felt safe or if anyone had made them feel uncomfortable. No additional concerns were identified. 6. 2/8/12 and 2/9/12 – Ninety-two employees were interviewed by department heads, and asked if they have observed any inappropriate resident to resident contact. All staff members who were not available for interview will be removed from the schedule until such interview is completed by the department head. No additional concerns were identified. <u>PROCESS IMPLEMENTED TO PREVENT FURTHER OCCURRENCES</u> 1. On 2/7 and 2/8/12 all available persons employed by this facility were in-serviced. All department heads were inserviced by the Regional Vice President of Operations. Staff Development Coordinator, Nurse Managers ,		

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F 490	Continued From page 44 Director of Nursing will report to the proper authorities within 2 hours if serious bodily injury occurs, or within 24 hours of a suspicion of crime. J. The 24 hour report is a reflection of any unusual changes in resident 's conditions and behaviors in the last 24 hours. Effective 2/9/2012, the Director of Nursing and Unit Managers and Weekend Supervisor will review the 24 hour nurses report daily to note any instances of behavior changes and/or occurrences of inappropriate resident contact. On 2/9/2012, nurses were in-serviced on including more information on resident behaviors. Any allegations of abuse that are on the 24 hour report identified will be immediately reported to the Administrator. K. A Directed in-service will be conducted by the Ombudsman on Abuse. The facility has been unable to schedule a date as of this writing, but no later than February 17,, 2012. 2. On 2/9/12 a Quality Assurance Tool will be started. This tool will have department heads make rounds 5 times per week, monitoring for inappropriate behaviors, interviews with staff and residents related to this topic, for the next 3 weeks. After that, should no occurrences of abuse be reported, rounds will be made weekly. This information will be monitored by the Quality Assurance Committee monthly and any necessary actions taken. The Quality Assurance Tool instructs the staff member to observe, and question residents and staff to see if there was any inappropriate resident to resident contact; heard any resident/family complaints; observe or receive a report of inappropriate resident to resident contact. They will ask 2 employees the first thing they are to do when they observe or hear of inappropriate resident to resident contact, ask employee to whom they should report this.	F 490	inserviced the nurses. All other staff was in-serviced by their department managers. In-services contained the following: 100% completed on 2/12/12. a. The facilities Abuse policy and procedure states that abuse can be considered physical touching that is inappropriate, if it is uninvited by the person being touched. This in-service also included; 1. Identification: - Staff and vendors are mandated to report, intervene in situations in which abuse and neglect based on facility reporting policy, - Staff is to immediately report allegations and/or observations of abuse and neglect based on facility reporting policy, - The facility will facilitate assessment, care planning, and		

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F 490 Continued From page 45

This will be conducted on all shifts. The Quality Assurance Tool will gather the relevant information, which will be taken to the morning meeting, where it will be discussed and any negative responses will be handled immediately by the administrator or his/her designee.

3. Beginning on 2/9/12 any residents displaying inappropriate behaviors will be assessed and have their care plans reviewed and updated for appropriate actions within 24 hours of occurrence. Corrections or additions will be made. This will be completed by the MDS nurses.

MONITORING

1. The DON and Unit Managers will continue review the facility's 24 hour report to for any documented instances Of any allegations of abuse. Further Education and possible disciplinary action will occur as needed.

2. The Department heads will continue to complete the daily Quality Assurance rounds for abuse until substantial compliance is obtained. At that time the Quality Assurance committee will review this process and these rounds will determine the frequency that rounds are to continue to be completed as a Quality Assurance process.

3. All allegations of Abuse will be immediately reported to the Administrator. The allegations will be fully investigated and reported per regulations. The Administrator will notify the Regional Vice President and/or the Chief Clinical Officer for guidance and to ensure that the facility's policy has been followed.

4. The results of the Quality Assurance monitoring tool, 24 hour report, and investigations of any inappropriate resident contact will be reviewed and analyzed in the monthly Quality Assurance Committee meeting for three months

F 490

monitoring of residents with needs and behaviors which might lead to conflict or neglect based on individualized assessment.

2. Prevention:

- Provide resident, families, and staff information on how and to whom they may report concerns, incidents, and grievances without fear of retribution; and provide feedback regarding the concerns that have been expressed.
- The facility will review reports of abuse and neglect, injury of unknown origins, incidents in an effort to identify trends/patterns and to maintain a safe environment for residents and staff. Analysis and corrective/responsible action plans will be coordinated with the Quality Assurance Committee.

3. Protection

- When abuse or a crime is

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F 490	Continued From page 46 and quarterly thereafter until deemed resolved by the committee. The immediate jeopardy was removed on 02/10/12 at 5:15 PM following interviews with administrative, licensed and direct care staff on all three shifts related to mandatory education on abuse; interviews with residents; interviews with families; review of in-service rosters on education of staff on abuse; review of revised abuse policy; review of the 24 hours communication sheets; and review of the quality assurance tool put into place.	F 490	witnessed the 1 ST that has to be done is to protect the resident and all other residents from further abuse or crimes. - Once you as the employee suspect abuse or a crime you must stay with the resident in the situation to protect them. - You then must then contact help to report "who" the alleged perpetrator is. - This can be reported to a charge nurse or department head. - You must not leave the resident while the reporting occurs. - Once the Nurse or Department head arrives, report what you observed and who is the alleged perpetrator. - The Nurse/Department Head must then immediately locate the perpetrator and immediately	

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F 490		F 490	<p>remove them from area of all residents.</p> <ul style="list-style-type: none"> - You must not leave the abused perpetrator alone. - You must then immediately notify the Administrator of the situation. - From this point you follow the direction of the Administrator. <p>4. Investigate:</p> <ul style="list-style-type: none"> - The Administrator or Director of Nursing will immediately begin the investigative process to include: <ul style="list-style-type: none"> - Interview the residents involved - Interview of staff that had contact with the residents involved in the allegation of abuse - Interview other alert and oriented residents who had the opportunity to observe the alleged abuse. 	

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F 490		F 490	<p>- Interview any known witness.</p> <p>- assess all involved residents for signs and symptoms of abuse.</p> <p>5. Reporting</p> <p>- The Administrator or Director of Nursing will be responsible for reporting the abuse allegation to all State and Local Authorities per required time frames as mandated by regulation.</p> <p>b. Immediately protect all residents when inappropriate resident to resident contact is identified, by staying with the resident to protect them. You must immediately notify the administrator.</p> <p>c. Immediately report all events of inappropriate resident to resident contact to the Administrator. If the Administrator is not available, the employee reporting the</p>		

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F 490		F 490	<p>alleged abuse should report it to his/her supervisor who contacts the Administrator or Director of Nursing.</p> <p>d. 2/8/12 Abuse policy revised to state nurses are to immediately fill out an incident report and submit it to the DON; call the physician; notify family/responsible party at the time of the occurrence. In-service was conducted by the Unit Managers, DON, department heads on 2/8/12. The Nurse's Responsibilities when alleged abuse is suspected and the facility's Policy and Procedure on Abuse was placed at each Nurses station.</p> <p>e. All staff should report to their immediate supervisor and expect feedback from that supervisor that an investigation has been initiated, if feedback not provided, staff should contact Administrator directly. The Administrators contact information is posted at every</p>		

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F 490		F 490	<p>Nurses station and in every ancillary department.</p> <p>f. Any staff member that is unable to attend the Abuse in-service will not be allowed to work until they receive this in-service by the Unit Manager or Department Head or Staff Development Nurse. 100% completed on 2/12/12.</p> <p>g. The Administrator or DON will immediately report any allegations of abuse to the Regional Vice President of Operations or Chief Clinical officer for proper guidance. The Administrator or Director of Nursing will report to the proper authorities within 2 hours if serious bodily injury occurs, or if there is a reasonable suspicion of crime.</p> <p>2. The 24 hour report is a reflection of any unusual changes in resident's conditions and</p>	

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F 490		F 490	<p>behaviors in the last 24 hours. Effective 2/9/2012, the Director of Nursing and Unit Managers and Weekend Supervisor will review the 24 hour nurses report daily to note any instances of behavior changes and/or occurrences of inappropriate resident to resident contact. On 2/9/12 nurses were in-serviced on including more information on resident behaviors. Any Allegations that are identified will be immediately reported to the Administrator. These will be discussed in the morning meeting.</p> <p>3. On 2/9/12 a Quality Assurance Tool was started. This tool will have department heads make rounds 5 times per week, monitoring for inappropriate behaviors, interviews with staff and residents related to this topic, until Substantial Compliance is obtained. After that, should no further instances of non-compliance be identified, rounds will be completed weekly</p>		

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F 490		F 490	<p>by the managers thereafter. This information will be monitored by the Quality Assurance Committee monthly and any necessary actions taken. The Quality Assurance Tool instructs the staff member to observe, and question residents and staff to see if there was any inappropriate resident to resident contact; heard any resident/family complaints; observe or receive a report of inappropriate resident to resident contact. They will ask 2 employees the first thing they are to do when they observe or hear of inappropriate resident to resident contact, ask employee to whom they should report this. This will be conducted on all shifts. The Quality Assurance Tool will gather the relevant information, which will be taken to the morning meeting, where it will be discussed and any negative responses will be</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2012
NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139		
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F 490		F 490	<p>handled immediately by the administrator or his/her designee.</p> <p>4. Beginning on 2/9/12 any residents displaying inappropriate behaviors were assessed and their care plans were reviewed and updated for appropriate actions. This was completed by the MDS nurses.</p> <p>5. On 2/17/12 all Nurse Managers were in-serviced by the Chief Clinical Officer on;</p> <p>a. The facility's Skin tear/bruise Policy and Procedure.</p> <p>b. Properly investigating Skin Tears and Bruises to rule out Abuse.</p> <p>c. How to properly investigate possible causative factors that may have contributed to the skin tear or bruise such as; Resident and staff statements, medications, behaviors, medical conditions and environmental</p>		

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F 490		F 490	<p>factors.</p> <p>d. The facility's Quality Assurance Investigational tool for Skin Tears and Bruises.</p> <p>e. The requirement that these be reviewed daily as they occur, orders obtained as needed, interventions implemented as appropriate, care plans updated and revised as necessary and Suspicious skin tears/bruises that a plausible causative factor could not be derived from a investigation be reported as a treated as a possible Abuse scenario. If Abuse can not be ruled out, these events will be reported and investigated as Alleged Abuse cases.</p> <p>6. The 7 types of abuse was posted in numerous visual areas in the facility on 2/14/2012.</p> <p>7. The contact phone numbers for the Administrator, Director of Nursing, Social Service Director and the Corporate Compliance Hotline was posted in numerous</p>	

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F 490		F 490	<p>visual areas in the facility on 2/13/12. This will allow staff, families and outside vendors to immediately contact Key facility staff if they have concerns.</p> <p>8. On 2/10/12 the facility implemented a weekly Resident Council meeting. This meeting will allow the residents to voice any concerns that they may have. If concerns are identified, these will be immediately reported to the Administrator per the grievance policy.</p> <p>9. On 2/17/12 the Administrator and Director of Nursing were placed on a mentorship program. This mentorship will be provided by the Regional Vice President and the Chief Clinical Officer. The mentorship will be conducted weekly for 4 weeks. At that time an evaluation of progress will be completed for the goals set forth. After the 4 weeks the Corporate Executive Staff will review this plan and at that time make the necessary revisions to ensure</p>		

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F 480		F 490	<p>that the residents of the facility are properly cared for. This program will;</p> <ol style="list-style-type: none"> a. Identify strengths b. Identify areas that need improvement. c. Provide Corporate direction and guidance. d. Direction on State/Federal and corporate expectations. e. Provide realistic goals. f. Provide weekly documentation and feedback towards the achievement of the goals. <p>10. On 2/17/12 a all staff Directed in-service was conducted by a representative of The Adult Protective Services Department. This In-service included:</p> <ol style="list-style-type: none"> a. Signs and symptoms of abuse. b. Types of abuse. 		

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F 490		F 490	<p>c. Preventing abuse.</p> <p>d. Protection against abuse.</p> <p>e. Protection of residents when abuse is suspected.</p> <p>f. Immediately reporting abuse.</p> <p><u>MONITORING</u></p> <p>1. The DON and Unit Managers will continue review the facility's 24 hour report to for any documented instances of inappropriate resident to resident contact or any allegations of abuse. Further Education and possible disciplinary action will occur as needed.</p> <p>2. The Department heads will continue to complete the daily Quality Assurance rounds for abuse until substantial compliance is obtained. At that time the Quality Assurance committee will review this process and these rounds will conducted weekly there after by</p>	

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F 490		F 490	<p>each Department Head.</p> <p>3. All allegations of Abuse will be immediately reported to the Administrator. The allegations will be fully investigated and reported per regulations. The Administrator will notify the Regional Vice President and/or the Chief Clinical Officer for guidance and to ensure that the facility's policy has been followed.</p> <p>4. The Regional Vice President and/or the Chief Clinical Officer will provide guidance and support to the facility on each reported Abuse scenario.</p> <p>5. The weekly Resident Council Meeting will continue until Substantial Compliance is obtained. At that time the Resident Council will vote on whether to continue this practice.</p> <p>6. The results of the Quality Assurance monitoring tool, 24 hour report, and investigations of</p>		

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F 490		F 490	<p>any inappropriate resident contact will be reviewed and analyzed in the monthly Quality Assurance Committee meeting for three months and quarterly thereafter until deemed resolved by the committee.</p> <p>7. Monthly in-services will be provided to all facility staff for the next 3 months, then quarterly there after. These in-services will review the Facility's Abuse Policy and Procedure. The facility will attempt to arrange Outside speakers with Abuse Prevention knowledge to provide these in-services.</p> <p>8. The Medical Director was consulted on these allegations, the facilities processes, interventions implemented, suggestions and/or guidance. The facility will continue to involve the Medical Director in the Quality Assurance process and seek guidance, support and further educational needs. 5. The</p>		

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F 490		F 490	<p>Regional Vice President and/or the Chief Clinical officer will provide weekly onsite guidance for the next 30 days. After 30 days a Corporate Executive Meeting will occur to review the facility's progress in obtaining substantial compliance.</p> <p>9. The Regional Vice President and/or the Chief Clinical officer will provide weekly onsite guidance for the next 30 days. After 30 days a Corporate Executive Meeting will occur to review the facility's progress in obtaining substantial compliance.</p> <p>10. On 2/17/12 the Administrator and Director of Nursing were placed on a mentorship program. This mentorship will be provided by the Regional Vice President and the Chief Clinical Officer. The mentorship will be conducted weekly for 4 weeks. At that time an evaluation of progress will be completed for the goals set forth. After the 4 weeks the Corporate</p>		

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F 490		F 490	Executive Staff will review this plan and at that time make the necessary revisions to ensure that the residents of the facility are properly cared for. 11. The Administrator is responsible for compliance.		