STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345492	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS NURSING HOME	**214 COCHRAN AVENUE FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		12/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/11/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above 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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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to thoroughly investigate an abuse allegation by not interviewing and gathering written statements from facility staff working with a resident alleging sexual abuse (Resident #1) for 1 of 3 residents reviewed for abuse. Findings included: Resident #1 was admitted to the facility 10/05/10 with cumulative diagnosis of dementia, hypertension and diabetes. The most recent Minimum Data Set dated 11/11/14 indicated Resident #1 was cognitively intact without behaviors and required extensive assistance with his activities of daily living (ADLs). There was an allegation of a sexual assault made by Resident #1 on 11/14/14 involving a reported incident occurring in his room around 3:00 AM that morning. A review was conducted of the investigation of the alleged anal rape verbally reported by Resident #1 to his assigned nursing assistant on 11/14/14 at approximately 6:30 PM. This investigation did not include written and signed statements from the staff working with Resident #1 during the time of the alleged incident on 11/14/14 at approximately 3:00 AM. The allegation was unsubstantiated based on the outcome of the facility and police investigation. In an interview on 11/25/14 at 2:50 PM, the director of nursing (DON) confirmed she was the abuse coordinator. She confirmed she conducted the abuse investigation dated 11/14/14 for Resident #1. The DON stated she did not get written statements nor did she interview the staff working during the time of the alleged incident at	F 225	Step 1 - Resident affected will maintain a positive well-being and quality of life. The facility protected Resident #1 and his well-being by initiating our investigation immediately which included: * Filing a police report with the police department who thoroughly investigated by interviewing Resident #1, his roommate,staff on shift at the time, and video footage of the area where the alleged incident occurred. The investigation was unsubstantiated at that time by the police department. * Resident #1 was sent to the hospital emergency room, where he was examined and interviewed again. The hospital emergency room unsubstantiated the allegations and veteran was sent back to the facility. * Director of Nursing initiated the immediate investigation and interviewed: * Direct care staff member who worked both nights * Staff members working the night of the report * Resident #1 * Resident #1's roommate * Staff members who worked the night of the alleged incident * The veteran was moved on 11/19/2014 to a private room to reduce any fear of abuse from his roommate. * Resident #1 will be followed by our in-house psych services weekly x 4 weeks for support and monitoring for behaviors. * Resident #1 will be given further support of active listening, and various activities to	

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F 225	Continued From page 2 approximately 3:00 AM on 11/14/14. The DON stated she only interviewed the staff present working with Resident #1 at the time he reported incident the evening of 11/14/14. The DON recalled being at the facility when Resident #1 verbalized the allegation at approximately 6:30 PM. The facility notified the police, the physician, emergency medical services and the responsible party. The DON stated she was present during the police interview with Resident #1 and his roommate. She stated she was present with the police during the review of the video surveillance footage for third shift on 11/14/14. There was no male shown entering or exiting Resident # 1's room during the entire shift. The DON stated there was no medical evidence of a rape on his hospital evaluation either. The DON stated it was an oversight that she did not interview and obtain written statements from the staff who worked after midnight on 11/14/14 as part of the facility investigation. In an interview on 11/25/14 at 3:50 PM, the administrator stated the abuse investigation should have included interviews and written statements from staff working at the time of the alleged incident involving Resident #1.	F 225	perform to divert his mind to more pleasant thoughts. Additionally, the Chaplain will continue to provide 1:1 visits and spiritual care. Step 2 - 100% audit was performed on residents who reported abuse in the last six months and the investigations were conducted according to policy. Step 3 - 1. All current staff and new hire staff will be in-serviced on reporting abuse/alleged abuse to the Director of Nursing, or to the Administrator immediately. If neither is present the staff member will report to the RN Supervisor who will then notify the Director of Nursing and Administrator immediately. 2. The Director of Nursing, Administrator, Social Worker's, and all Registered Nurses (RN's) will be in-serviced on the "Abuse Investigating" (ABUSE 1.108) policy and the Director of Nursing will monitor completion. Step 4 - Monitoring of the abuse investigating will be monitored by the Performance Improvement Nurse (RN), Social Workers, Director of Nursing (RN), and Administrator to ensure all abuse allegations are investigated per policy. Continued monitoring will then occur 5 x weekly x 2 weeks, 3 x weekly x 2 weeks, weekly x 2 weeks, and monthly x 2 months.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		12/15/14

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F 226	Continued From page 3 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 staff interviews and record review, the facility failed to implement their abuse investigation policy by not interviewing and gathering written statements from facility staff working with a resident alleging sexual abuse (Resident #1) for 1 of 3 residents reviewed for abuse. Findings included: The facility policy titled "Abuse Investigating" dated 2006 read the following: "Investigation documentation will include, but not be limited to signed statements from pertinent parties." Resident #1 was admitted to the facility 10/05/10 with cumulative diagnosis of dementia, hypertension and diabetes. The most recent Minimum Data Set dated 11/11/14 indicated Resident #1 was cognitively intact without behaviors and required extensive assistance with his activities of daily living (ADLs). There was an allegation of a sexual assault made by Resident #1 on 11/14/14 involving a reported incident occurring in his room around 3:00 AM that morning. A review was conducted of the investigation of the alleged anal rape verbally reported by Resident #1 to his assigned nursing assistant on 11/14/14 at approximately 6:30 PM. This investigation did not include written and	F 226	Step 1 - Resident affected will maintain a positive well-being and quality of life. The facility protected Resident #1 and his well-being by initiating our investigation immediately which included: * Filing a police report with the police department who thoroughly investigated by interviewing Resident #1, his roommate,staff on shift at the time, and video footage of the area where the alleged incident occurred. The investigation was unsubstantiated at that time by the police department. * Resident #1 was sent to the hospital emergency room, where he was examined and interviewed again. The hospital emergency room unsubstantiated the allegations and veteran was sent back to the facility. * Director of Nursing initiated the immediate investigation and interviewed: * Direct care staff member who worked both nights * Staff members working the night of the report * Resident #1 * Resident #1's roommate * Staff members who worked the night of the alleged incident	

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F 226	Continued From page 4 signed statements from the staff working with Resident #1 during the time of the alleged incident on 11/14/14 at approximately 3:00 AM. The allegation was unsubstantiated based on the outcome of the facility and police investigation. In an interview on 11/25/14 at 2:50 PM, the director of nursing (DON) confirmed she was the abuse coordinator. She confirmed she conducted the abuse investigation dated 11/14/14 for Resident #1. The DON stated she did not get written statements nor did she interview the staff working during the time of the alleged incident at approximately 3:00 AM on 11/14/14. The DON stated she only interviewed the staff present working with Resident #1 at the time he reported incident the evening of 11/14/14. The DON recalled being at the facility when Resident #1 verbalized the allegation at approximately 6:30 PM. The facility notified the police, the physician, emergency medical services and the responsible party. The DON stated she was present during the police interview with Resident #1 and his roommate. She stated she was present with the police during the review of the video surveillance footage for third shift on 11/14/14. There was no male shown entering or exiting Resident #1's room during the entire shift. The DON stated there was no medical evidence of a rape on his hospital evaluation either. The DON stated it was an oversight that she did not interview and obtain written statements from the staff who worked after midnight on 11/14/14 as part of the facility investigation. In an interview on 11/25/14 at 3:50 PM, the administrator stated the abuse investigation should have included interviews and written statements from staff working at the time of the	F 226	* The veteran was moved on 11/19/2014 to a private room to reduce any fear of abuse from his roommate. * Resident #1 will be followed by our in-house psych services weekly x 4 weeks for support and monitoring for behaviors. * Resident #1 will be given further support of active listening, and various activities to perform to divert his mind to more pleasant thoughts. Additionally, the Chaplain will continue to provide 1:1 visits and spiritual care. Step 2 - 100% audit was performed on residents who reported abuse in the last six months and the investigations were conducted according to policy. Step 3 - 1. All current staff and new hire staff will be in-serviced on reporting abuse/alleged abuse to the Director of Nursing, or to the Administrator immediately. If neither is present the staff member will report to the RN Supervisor who will then notify the Director of Nursing and Administrator immediately. 2. The Director of Nursing, Administrator, Social Worker's, and all Registered Nurses (RN's) will be in-serviced on the "Abuse Investigating" (ABUSE 1.108) policy and the Director of Nursing will monitor completion. Step 4 - Monitoring of the abuse investigating will be monitored by the Performance Improvement Nurse (RN), Social Workers, Director of Nursing (RN), and Administrator to ensure all abuse	

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F 226	Continued From page 5 alleged incident involving Resident #1 as indicated in their facility policy.	F 226	allegations are investigated per policy. Continued monitoring will then occur 5 x weekly x 2 weeks, 3 x weekly x 2 weeks, weekly x 2 weeks, and monthly x 2 months.	