STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 483.13 (F223) at J Immediate Jeopardy began on 02/20/16 when NA #1 was witnessed being verbally abuse to Resident #1 and Resident #2 and physically abuse to Resident #2. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more then minimal harm that is not immediate jeopardy) to complete and ensure monitoring systems put into place are effective related to resident rights to be free from abuse. 483.13 (F225) at J Immediate jeopardy began on 12/28/15 when the facility failed to report a bruise of unknown origin (Resident #6) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate Jeopardy began on 02/20/16 for Residents #1 and #2 when the facility also failed to report a witnessed incident of physical abuse (Resident #1) and 2 incidents of verbal abuse (Resident #1 and Resident #2) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer D Dossett	RN Administrator	3/22/16

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 000	Continued From page 1 with the immediate removal of residents from abusive situation and the immediate reporting of witnessed abuse to the management staff. 483.13 (F226) at J Immediate jeopardy began on 12/28/15 when the facility failed to report a bruise of unknown origin (Resident #6) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate Jeopardy began on 02/20/16 for Residents #1 and #2 when the facility also failed to report a witnessed incident of physical abuse (Resident #1) and 2 incidents of verbal abuse (Resident #1 and Resident #2) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective with the immediate removal of residents from abusive situation and the immediate reporting of witnessed abuse to the management staff.	F 000		
F 223 SS=J	483.13(b), 483.13(c)(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,	F 223		

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F 223	Continued From page 2 or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility failed to maintain 2 of 6 sampled residents rights to be free from verbal abuse (Resident #1 and Resident #2) and failed to maintain 1 of 6 sampled residents rights to be free from physical abuse (Resident #1). Immediate jeopardy began on 02/20/16 when Nursing Assistant (NA) #1 was physically and verbally abusive to Resident #1 and verbally abuse to Resident #2. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to resident rights to be free from abuse. The findings included: 1. Resident #1 was admitted to the facility on 06/17/12 with diagnoses of multiple cerebral vascular accidents, Alzheimer's disease, and dementia. Review of the most recent quarterly Minimum Data Set (MDS) dated 02/09/16 revealed that Resident #1 was severely cognitively impaired with no behaviors identified. The MDS further indicated that Resident #1 required extensive assistance with activities of daily living (ADLs). Interview with NA #4 on 03/02/16 at 12:03 PM revealed that she had been in the dining room on Saturday 02/20/16 at approximately 5:30 PM	F 223	(1) Residents #1 and #2 were immediately protected from any further verbal and/or physical abuse by NA#1 by the Nursing Supervisor on 2/20/16 when NA#1 was physically removed from their unit. All residents were further protected from any abuse by NA#1 upon her suspension on 2/26/16 and subsequent termination on 2/26/16 by the Director of Nursing. A full body skin assessment was completed on Residents #1 and #2 by Nursing Supervisor with no concerns noted related to potential abuse. Residents #1 and #2 were assessed by the 100 unit Social Services Coordinator to determine any residual effects of physical and/or verbal abuse with no concerns noted. A full investigation of the verbal and physical abuse of Resident #1 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/8/16. A full investigation of the verbal abuse of Resident #2 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/11/16.	2/26/16 3/3/16 3/3/16 3/8/16 3/11/16

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F 223	Continued From page 3 when she overheard NA #1 yelling at Resident #1 to stop touching her and to leave her alone. NA #4 stated that Resident #1 would pat your leg if you were sitting beside her and she was patting NA #1's leg and NA #1 got angry and began yelling at Resident #1. Interview with NA #3 on 03/02/16 at 3:05 PM revealed that she was working in the dining room on the evening of 02/20/16 and witnessed Resident #1 patting the leg of NA #1. NA #1 then stated "oh my God stop it, why do u keep patting me, stop touching me" and then NA #1 leaned into the face of Resident #1 and grabbed her right hand and slammed it into the lap of Resident #1 grazing the edge of the table. NA #3 described it like scolding a child, NA #3 further stated that Resident #1 had no reaction except mumbling. NA #3 stated that she had done a staff statement as directed by her nurse. NA #3 stated that she felt like NA #1 had abused Resident #1. Review of "Staff Statement for Incident/Accident" NA #3 stated that she witnessed NA #1 slam Resident #1's hand and tell her to stop patting her. Another family member also witnessed the way she was talking to the resident and stated that it was inappropriate. Signed by NA #3 and dated 02/20/16. Interview with NA #2 on 03/02/16 at 4:13 PM revealed that she was present in the dining room on 02/20/16 assisting with supper and witnessed NA #1 get very irritated with Resident #1 who was patting her leg and grabbed her hand and slammed it into Resident #1's lap grazing the table and heard NA #1 state to Resident #1 "stop F**king patting my leg." NA #2 stated that what she witnessed between NA #1 and Resident #1 was both physical and verbal abuse because they had just had mandatory training on abuse and were educated on the different types of abuse	F 223	(2) Full body skin assessments were conducted on all residents by Nursing Managers to assess for any signs of potential physical abuse with no concerns noted. 3/4/16 All residents who are alert and oriented were interviewed by the MDS Coordinators to determine any concerns related to abuse with no negative responses. Each resident was also reminded /educated at that time on the proper reporting procedures if abuse occurs. 3/4/16 The Administrator conducted an in-service for all staff between 3/3/16 – 3/4/16 on revisions made to the Abuse Policy & Procedures including: 3/4/16 • definitions, examples, and scenarios of abuse • immediate steps required when abuse is suspected and/or reported including the immediate removal of the resident from the situation, immediate verbal reporting of the facts as witnessed to the direct supervisor or nurse on duty, immediate removal of the accused employee from all duties, and immediate verbal reporting to the DON and Administrator for timely investigating procedures	

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F 223	Continued From page 4 and included examples of each type. Interview with Visitor #1 on 03/04/16 at 9:53 AM revealed that she was a sitter for another resident at that facility. Visitor #1 stated that on 02/20/16 in the dining room at supper time she witnessed Resident #1 rubbing NA #1's leg and NA #1 got so mad at Resident #1 she took her arm and forced it down onto her lap. Visitor #1 stated that NA #1 was very angry and got almost nose to nose with Resident #1 and stated "I told you to stop that" and "keep your hand to yourself." Visitor #1 further stated that she witnessed NA #1 grab the wrist of Resident #1 and shove it into her lap at least 3 times while she was in the dining room tending to the resident she worked for. Interview with NA #1 on 03/04/16 at 10:27 AM confirmed that she was terminated from the facility on 02/26/16. NA #1 stated that on 02/20/16 she was in the dining room at supper time Resident #1 was patting her leg while she was assisting her with supper and NA #1 stated she took the hand of Resident #1 and put it back in her lap and told her to stop hitting NA #1. NA #1 stated that she did this between 10 to 15 times during the course of the meal. NA #1 confirmed that Resident #1 did not understand what she was saying to her. NA #1 stated that Nurse Supervisor had come into the dining room and got her so they could talk. NA #1 stated that Nurse Supervisor stated he had received a complaint that she was rude to one of the residents but did not specify which resident. NA #1 stated that she told Nurse Supervisor that she was upset at the situation and wanted to be switched to a different unit. After the conversation NA #1 stated she was reassigned to the 400 secure memory care unit for the rest of her shift. Interview with Nurse Supervisor on 03/02/16 at 2:34 PM revealed that NA #2 reported to him that	F 223	(3) The Witness/Staff Statement form was revised for staff use when reporting witnessed events related to resident care, including abuse. This form specifically directs staff to only provide the written statement after a verbal report has been given to the nurse on duty. This formalso specifically directs staff to place concerns in direct quotes, to use full names, and to be as specific as possible for further investigation. --All department managers were in-serviced by the Administrator on 3/21/16 on the use of this form in the event they are the manager on duty should abuse be reported directly to them following the Abuse Policy. --All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for obtaining such statements once all immediate steps have been taken following the Abuse Policy for protection of the resident and reporting of the concern. A new "Abuse Investigation" form was created to assist the licensed nurse or department manager on duty at the time abuse is reported on the required steps to be taken and the required timeframe. This form will act as a timeline for the investigation process and includes all immediate steps to be taken by the nurse/manager on duty upon the reporting of abuse as well as the detailed steps of the investigation process itself.	3/26/16

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F 223	Continued From page 5 NA #1 was being verbally aggressive and very hateful to Resident #1, so Nurse Supervisor stated he went to the dining room and asked to speak with NA #1 and asked what was going on. NA #1 stated that Resident #1 was rubbing her leg near her private area and NA #1 stated that she had pushed Resident #1's hand away and told her not to do that. Nurse supervisor stated he asked NA #1 if she was being verbally aggressive and NA #1 stated "NO" and so Nurse Supervisor asked NA #1 if maybe the tone of her voice could be perceived as verbally aggressive and NA #1 relied "maybe." Nurse supervisor again stated that he had reassigned NA #1 to the 400 secure memory care unit for the remained of her shift. Review of email dated 02/21/16 at 7:15 PM from Nurse Supervisor to Director of Nursing (DON) read in part that a visitor had witnessed NA #1 being rude to Resident #1 and shoving her arm when Resident #1 would pat NA #1 on the leg. When I questioned NA #1 about it she became upset, defensive, and with an aggressive attitude. Nurse Supervisor talked to NA #1 under the camera in the 100 medication unit so the DON could observe her body language an attitude. I moved her to the 400 secure memory care unit for the remainder of her shift. Observation of video footage of Nurse Supervisor talking to NA #1 in the medication room was reviewed on 03/02/16 at 6:10 PM. There was no sound to the video. Nurse Supervisor and NA #1 entered the room at 6:17 PM and NA #1 was noted to be standing with both arms crossed looking at the floor while Nurse Supervisor talked to her. At one point in the video NA #1 was observed wiping her face. NA #1 was shaking her head back and forth and using hand gestures during most of the conversation. As the conversation continued on NA #1 appeared to	F 223	--All department managers were in-serviced by the Administrator on 3/21/16 on the use of this form in the event they are the manager on duty should abuse be reported directly to them following the Abuse Policy. 3/26/16 --All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for initiating this form if abuse is reported. (4) All Abuse Investigation forms and Witness/Staff Statements initiated upon the report of abuse will be reviewed thoroughly by the Administrator within 24 hours of the reported abuse or by Monday for any reports occurring after 4:30pm on the previous Friday to ensure all required steps have been taken to protect the resident(s) involved as well as others residents from potential abuse in a timely manner and that detailed steps of the investigation have been initiated in the required timeframe by the Director of Nursing or his designee. The Controller (also a licensed nursing home Administrator) will act in the absence of the Administrator to review these forms. 3/26/16	

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F 223	Continued From page 6 somewhat calm down and again wiped her face and at 6:27 PM both NA #1 and Nurse Supervisor exit the medication room and the video ended. 2. Resident #2 was admitted to the facility on 10/17/15 with diagnoses that included diabetes mellitus, hypertension, Alzheimer's disease, and dementia. Review of the most recent comprehensive admission MDS dated 10/26/15 revealed that Resident #2 was severely cognitively impaired and no behaviors were identified. The MDS also indicated that Resident #2 required extensive assistance with ADLs. Review of care plan dated 10/27/15 read in part Resident #2 had impaired thought process and was forgetful at times. The goal of stated care plan was to accept judgment of staff/significant other as appropriate and interventions included approach resident warmly and positively and in a calm manner and calmly talk with resident and offer reassurance prior to initiating care. Interview with NA #1 on 03/03/16 at 10:27 AM revealed that on 02/20/16 they were in the dining room waiting on supper and Resident #2 was trying to leave the dining room and had got his wheelchair caught on the chair she was sitting in. NA #1 stated she got up to untangle the wheelchair and the chair and Resident #2 grabbed her right arm and would not let go NA #1 stated "let go of my arm" and then jerked her arm away from Resident #2, then Resident #2 grabbed her left arm and was twisting NA #1's pointer finger and again NA #1 stated she jerked her arm from Resident #2 and then walked out of dining room to calm down. Interview with NA #2 on 03/02/16 at 5:09 PM revealed that on 02/20/16 at approximately 5:00 PM Resident #2 was in the dining room waiting for supper and had become anxious and uncooperative and tried to leave the dining room.	F 223	3/26/16 Throughout an abuse investigation, the Director of Nursing will review all steps taken thus far in the process daily with the Administrator (the Controller in the absence of the Administrator) including a thorough review of all witness/staff statements obtained for further direction. 3/26/16 The Director of Nursing will review all findings and conclusions of the detailed investigation with the Administrator (the Controller in the absence of the Administrator) prior to final submission of the final report to ensure completion of all steps of the investigation process and determination of the final outcome related to the accused employee. 3/26/16 Any staff member who fails to follow any step of the Abuse Policy as written, including the completion of the Abuse Investigation Form, will be subject to discipline including unpaid suspension up to and including termination. 3/26/16 All reports of abuse including findings and results of the investigation will be reported to the monthly QA&A Committee by the Director of Nursing for any further recommendations to ensure continued compliance.	

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F 223	Continued From page 7 NA #2 stated that she took Resident #2 to see a family member who also resided at the facility to see if that would calm Resident #2 down. NA #2 stated that after Resident #2 had visited with the family member for a few minutes he had calmed down and NA #2 was able to return Resident #2 to the dining room. NA #2 further stated that when she returned Resident #2 to the dining room NA #1 asked NA #2 "what is his issue?" NA #2 stated to NA #1 that Resident #2 had delusions that his daughter had been killed. NA #2 stated that NA #1 then approached Resident #2 and got down in his face and stated "that was a stupid reason to hit me and you had no reason to act like way" in a very aggressive and threatening tone. NA #2 also stated that NA #1 was very hateful in the way NA #1 spoke to Resident #2 that evening in the dining room. Review of email sent on 02/21/16 at 7:15 PM from nurse supervisor to the DON read in part on Saturday evening 02/20/16 NA #2 witnessed NA #1 being verbally aggressive to Resident #2 when Resident #2 had become combative. Nurse supervisor stated in the email that he had talked to NA #1 and NA #1 stated she was being picked on by everyone and had already gotten in trouble with the DON. NA #1 informed nurse supervisor that she hated working at the facility and it was the most pathetic place she had ever worked at before. NA #1 claimed that the staff did not like her because she was a Yankee. NA #1's body language and attitude was aggressive and more defensive. NA #1 stated that she had changed shifts because she could not get along with her coworkers and now she could not get along with the staff that was there on Saturday. NA #1 agreed to stay for the rest of the shift and I moved her to the 400 secure memory care unit for the remainder of her shift.	F 223		

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F 223	Continued From page 8 Observation of video footage of Nurse Supervisor talking to NA #1 in the medication room was reviewed on 03/02/16 at 6:10 PM. There was no sound to the video. Nurse Supervisor and NA #1 entered the room at 6:17 PM and NA #1 was noted to be standing with both arms crossed looking at the floor while Nurse Supervisor talked to her. At one point in the video NA #1 was observed wiping her face. NA #1 was shaking her head back and forth and using hand gestures during most of the conversation. As the conversation continued on NA #1 appeared to somewhat calm down and again wiped her face and at 6:27 PM both NA #1 and Nurse Supervisor exit the medication room and the video ended. The administrator and DON were notified on 03/03/16 at 2:30 PM of immediate jeopardy. The administrator provided acceptable credible allegation of compliance on 03/04/16 at 6:45 PM. Credible Allegation of Compliance F: 223 On 2/20/16 at 11:00pm, Nursing Assistant (NA) #1, who physically and/or verbally abused Residents #1 and #2 on 02/20/16, left the facility after working her entire shift. On 2/22/16 at 3:23 pm, the accused CNA was suspended (she had not returned to work since leaving on 2/20/16 @ 11:00pm) and was ultimately terminated from employment on 2/26/16 at 1:20pm. On 02/22/16 an investigation was initiated on the abuse of Resident #2 by the Director of Nursing which resulted in termination of NA #1 on 2/26/16 at 1:20pm. On 02/22/16 the family of Resident #2 was involved in the investigation and was made aware of the investigation initiated on 2/22/16 as well as of the outcome of the investigation on 2/26/16 by the Director of Nursing.	F 223		

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F 223	Continued From page 9 On 03/03/16, the Nursing Supervisor was placed on suspension pending further investigation of his role in the allegations of abuse, which occurred on 02/20/16, for failure to protect residents and properly report resident abuse. As of 03/04/16 the results of this investigation are pending and the Nursing Supervisor will remain on suspension until the investigation is complete. On 03/03/16 at 2:19 pm The 24 hour Health Care Personnel Registry (HCPR) abuse/neglect investigation report form for Resident #1 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. On 03/03/16 a head to toe skin assessment was completed on Residents #1 and #2 by the 1st and 2nd shift House Supervisors with no concerns related to potential physical abuse. On 03/03/16 The 100 unit Social Services Coordinator met with Residents #1 and #2. Each was interviewed regarding the physical and/or verbal abuse that occurred on 2/20/16 to determine any residual effects from the alleged physical/verbal abuse with no concerns noted. On 03/03/16 The Administrator revised the facility's Abuse/Neglect Policy and Procedures. These revisions included: Immediate removal of the resident from the abusive situation by the employee who witnesses the abuse. ·Immediate reporting of the abusive situation by the employee who witnesses the abuse to the direct supervisor or any other member of management currently on duty. ·Immediate suspension of the alleged employee	F 223		

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F 223	Continued From page 10 by the direct supervisor or member of management. ·Immediate reporting of the abusive situation by the direct supervisor or member of management to the Director of Nursing or the Administrator. On 03/04/16 at 8:42 am The Responsible Party of Resident #1 was notified of the allegations of physical abuse by the Director of Nursing via phone as well as the pending investigation with results to follow. On 03/04/16 at 9:00 am, the Director of Nursing completed the NC Board of Nursing Complaint Evaluation Tool to determine reporting requirements for the Nursing Supervisor and obtained a score of 11 which indicated NC Board of Nursing consultation but no requirement for reporting. The Director of Nursing contacted the NC Board of Nursing for the required consultation on 03/04/16 at 10:00am. The Director of Nursing was given a phone appointment for further review on Monday, 03/07/16 at 1:30pm. On 03/04/16 all other residents who are alert and oriented were interviewed by the 100 unit Social Services Coordinator and MDS Coordinators to determine if there were any reports of abuse and/or neglect with no negative responses. On 03/04/16 head to toe skin assessments were completed on all residents to assess for possible signs of abuse by the Nursing Supervisors, MDS Coordinators, and Risk Management Coordinator. Skin assessments revealed no signs of potential abuse. Between 03/03/16 and 03/04/16 an in-service was conducted by the Administrator for all staff on	F 223		

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F 223	Continued From page 11 duty regarding resident abuse. The in-service agenda included: 1. Revised Abuse & Neglect policy/procedure to: · Immediate removal of the resident from the abusive situation by the employee who witnesses the abuse · Immediate reporting of the abusive situation by the employee who witnesses the abuse to the direct supervisor or any other member of management currently on duty · Immediate suspension of the alleged employee by the direct supervisor or member of management · Immediate reporting of the abusive situation by the direct supervisor or member of management to the Director of Nursing or the Administrator 2. Definitions of physical and verbal abuse including tone of voice and temperament used towards any resident including scenarios of both physical and verbal abuse. 3. Definition of how to make the immediate notification of abuse allegations and the expectation that such allegations will be reported verbally. 4. Expectations for the immediate protection of any resident in which abuse/neglect are suspected. No staff member, including contract staff, will be allowed to perform any work-related duties until the in-service has been completed following the final In-service on 03/04/16. All in-services were given directly by the Administrator. Any new employees hired after the final in-service	F 223		

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F 223	Continued From page 12 on 03/04/16 will receive a review of the revised abuse policy/procedures by the HR Director and/or the Staff Development.Coordinator before any duties are performed. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when staff interviews with nursing staff, administrative staff, and non-nursing staff confirmed that they had received in service training on the facilities revised policy on abuse and neglect, the immediate removal of resident from the abusive situation, and the immediate reporting of the abusive situation to the direct supervisor or any other member of the management on duty.	F 223		
F 225 SS=J	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	F 225	(1) Residents #1 and #2 were immediately protected from any further verbal and/or physical abuse by NA#1 by the Nursing Supervisor on 2/20/16 when NA#1 was Physically removed from their unit. All residents were further protected from any further abuse by NA#1 upon her suspension on 2/26/16 and subsequent termination on 2/26/16 by the Director of Nursing. A full body skin assessment was completed on Residents #1, #2, and #6 by Nursing Supervisors with no concerns noted related to potential abuse. Residents #1, #2, and #6 were assessed by the 100 unit Social Services Coordinator to determine any residual effects of physical and/or verbal abuse with no concerns noted.	2/26/16 3/3/16 3/3/16

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F 225	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to thoroughly investigate and submit 24 hour and 5 working day reports to the North Carolina Health Care Personnel Registry (state agency) for a resident with a bruise of unknown origin (Resident #6). The facility also failed to immediately stop verbal abuse when observed (Resident #1 and Resident #2) which led to witnessed physical abuse (Resident #1), failed to remove the perpetrator from resident areas, failed to immediately notify the Administrator and once notified the facility failed to report the incidents of verbal and physical abuse to the North Carolina Health Care Personnel Registry in 24 hours and the investigative findings in the 5 working day report for 3 of 6 sampled residents for abuse (Resident #6, #1 and #2). Immediate jeopardy began on 12/28/15 when the facility failed to report a bruise of unknown origin	F 225	The Director of Nursing who failed to complete the required 24 hour and 5 day reports with a complete investigation for Residents #1, #2, and #6 was suspended on 3/4/16 with disciplinary action as required by the NC Board of Nursing upon return to work on 3/8/16. A full investigation of the verbal and physical abuse of Resident #1 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/8/16. A full investigation of bruise of unknown origin of Resident #6 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/9/16. A full investigation of the verbal abuse of Resident #2 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/11/16. The Nursing Supervisor who failed to immediately protect Resident #1 and #2 from reported abuse and also failed to immediately report the abuse to the Director of Nursing was suspended on 3/4/16 with disciplinary action as required by the NC Board of Nursing upon return to work on 3/12/16.	3/8/16 3/8/16 3/9/16 3/11/16 3/12/16

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F 225	Continued From page 14 (Resident #6) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate Jeopardy began on 02/20/16 for Residents #1 and #2 when the facility also failed to report a witnessed incident of physical abuse (Resident #1) and 2 incidents of verbal abuse (Resident #1 and Resident #2) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective with the immediate removal of residents from abusive situation and the immediate reporting of witnessed abuse to the management staff. Findings included: 1. Resident #6 was admitted to the facility on 11/02/11 with diagnoses listed on the diagnosis list in the electronic medical record of congestive heart failure, high blood pressure, type 1 diabetes, Alzheimer's disease, dementia, anxiety and depression. A review of the most recent annual Minimum Data Set (MDS) dated 12/30/15 indicated Resident #6 had short and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #6 was totally dependent on	F 225	(2) Full body skin assessments were conducted on all residents by Nursing Managers to assess for any signs of potential physical abuse with no concerns noted. All residents who are alert and oriented were interviewed by the MDS Coordinators to determine any concerns related to abuse with no negative responses. Each resident was also reminded /educated at that time on the proper reporting procedures if abuse occurs. The Administrator conducted an in-service for all staff between 3/3/16 – 3/4/16 on revisions made to the Abuse Policy & Procedures including: --definitions, examples, and scenarios of abuse --immediate steps required when abuse is suspected and/or reported including the immediate removal of the resident from the situation, immediate verbal reporting of the facts as witnessed to the direct supervisor or nurse on duty, immediate removal of the accused employee from all duties, and immediate verbal reporting to the DON and Administrator for timely investigating procedures	3/4/16 3/4/16 3/4/16

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F 225	Continued From page 15 staff for activities of daily living and exhibited no behaviors. A review of an incident report dated 12/28/15 at 1:45 AM revealed Nurse Aide (NA) # 5 reported to Nurse # 2 that Resident #6 had a 5 inch x 4 inch bruise on her left upper arm. The report indicated Resident #6 was sleeping when the bruise was found during the first round on the night shift. The report further indicated the bruise was located on the upper front, inside and outside left arm and was purple in color and the possible causes were listed as unknown. Nurse #2's handwritten statement revealed NA #5 called for her to look at Resident #6 and upon assessment, there was a 5 inch x 4 inch purple bruise on Resident #6's upper left arm. Nurse #2 documented she asked Resident #6 if she was in any pain and she stated "yeah" and when Nurse #2 touched the bruise, Resident #6 grimaced and pulled away. A review of a handwritten witness statement by NA #5 revealed she went into Resident #6's room to check and change her. She documented Resident #6 seemed to be in a lot of pain so NA #5 checked her over and noticed Resident #6's upper left arm was very badly bruised and swollen and she notified Nurse #2. A section for an explanation and detailed circumstances surrounding the bruise revealed a bruised area covered most of Resident #6's left upper arm (5 inches x4 inches) and was swollen. The notes indicated when the bruise was touched it was hard and knotted and Resident #6 grimaced and vocalized sounds. The report further revealed NA #1 and NA #3 had been assigned to work on the hall where Resident #6 lived on second shift from 3:00 PM until 11:00 PM on 12/27/15. However, when NA #5 clocked in and went to the nurse's station for report NA #1	F 225	(3) The Witness/Staff Statement form was revised for staff use when reporting witnessed events related to resident care, including abuse. This form specifically directs staff to only provide the written statement after a verbal report has been given to the nurse on duty. This form also specifically directs staff to place concerns in direct quotes, to use full names, and to be as specific as possible for further investigation. --All department managers were in-serviced by the Administrator on 3/21/16 on the use of this form in the event they are the manager on duty should abuse be reported directly to them following the Abuse Policy. --All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for obtaining such statements once all immediate steps have been taken following the Abuse Policy for protection of the resident and reporting of the concern.	3/26/16

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F 225	Continued From page 16 had left without telling anyone. NA #3 gave report to NA #5 but did not report any bruising on Resident #6's left upper arm. A review of a nurse's note dated 12/28/16 at 7:34 AM revealed NA #5 informed Nurse #2 that Resident #6 had "a huge bruise" on her left upper arm. The notes indicated Nurse #2 assessed the area and Resident #6 had a bruise that was 5 inches tall and 4 inches wide and covered the entire front of Resident #6's left upper arm. The notes revealed Resident #6 was unable to state how the bruise was obtained and Nurse #2 asked Resident #6 if she was in pain, and she replied "yeah" and when the left upper arm was touched or moved, Resident #6 grimaced, grunted and pulled away. The notes further revealed Nurse #2 gave Resident #6 Acetaminophen for pain and left a note in the physician's communication book for review. A review of a nurse's note dated 12/28/15 at 10:02 AM indicated an X-ray was obtained of Resident #6's left upper arm due to bruising, swelling and was painful to touch. A review of x-ray results dated 12/28/15 revealed 2 views of the left humerus (upper arm bone) and the impression was mild arthrosis (wear and tear on the joints) with moderate demineralization (dissolving bone). A review of a typed document dated 12/28/15 and signed by the Director of Nursing (DON) indicated it was brought to his attention that Resident #6 had bruising to her left arm 5 inches x 4 inches. The document revealed this was discovered according to an incident report dated 12/28/15 at 1:45 AM which had been presented to the DON	F 225	A new "Abuse Investigation" form was created to assist the licensed nurse or department manager on duty at the time abuse is reported on the required steps to be taken and the required timeframe. This form will act as a timeline for the investigation process and includes all immediate steps to be taken by the nurse/manager on duty upon the reporting of abuse as well as the detailed steps of the investigation process itself. The form more specifically addresses injuries of unknown origin to direct the licensed nurse to: 1. complete a full body skin assessment to ensure no other areas of concern 2. complete an Incident/Accident report 3. follow all immediate reporting requirements following the Abuse policy for timely investigation All department managers were in-serviced by the Administrator on 3/21/16 on the use of this form in the event they are the manager on duty should abuse be reported directly to them following the Abuse Policy. All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for initiating this form if abuse is reported as well as the specific directions related to injuries of unknown source. 3/26/16	

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F 225	Continued From page 17 by the Risk Management Nurse for follow up. The document revealed the DON spoke to Resident #6's family who indicated she had a history of bruising and then reviewed Resident #6's clinical record and noted she required a lift for transfers. The document revealed on 12/28/15 at 3:15 PM the DON observed Resident #6's lift transfer by NA #6 who was assigned to care for Resident #6 and noted Resident #6 had her arms folded across her chest during the transfer. The document revealed at that time the resident's bruise was unrelated to any staff harm and had no indications it originated from any harm caused by a staff member. The document further indicated it was not established that NA #1 had caused the injury but if at any time any new information was presented that would indicate NA #1 caused the injury, either intentionally or otherwise, a formal investigation would be opened and submitted to the licensure agency per facility policy. A review of handwritten notes on a sheet of notebook paper dated 12/28/15 at 3:15 PM by the DON revealed NA #1's name at the top of the page highlighted with yellow highlighter and notes revealed Resident #6 "on lift properly may be of concern" (NA #6 "did good"), "concerns related to bruises on both legs and arm on 2 lift occasions." During an interview on 03/03/16 at 12:08 PM the Administrator explained she expected to be notified by the DON anytime an investigation of abuse was started and if the DON had any questions then she would assist as needed. The Administrator stated with any investigation staff was expected to complete a full investigation that included interviews with all staff involved so a thorough investigation would be completed and	F 225	The "Questions After A Bruise/Skin Tear" form, which is completed by the licensed nurse to accompany the Incident/Accident report was revised to specifically Direct the nurse in the event a bruise is of unknown origin/source to: 1. report to the Nurse Manager or manager on duty to begin the required investigation and reporting process 2. obtain a statement from the resident if he/she is able to do so 3. indicate if abuse is suspected and if so—report following Abuse policy and procedures All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for initiating this form if abuse is reported. 3/26/16 (4) The Risk Management Coordinator will review all Incident/Accident reports within 24 hours of the reported abuse or by Monday for any reports occurring after 4:30pm on the previous Friday specifically for injuries of an unknown source to ensure all investigations have been properly initiated per the Abuse and Incident/Accident policies. Any incident report with an injury of unknown origin that has not had the proper investigation initiated or any that is questionable for the need for a formal investigation will be immediately reported to the Director of Nursing for further review. The Director of Nursing will assign this review to another Nursing Manager in the absence of the Risk Management Coordinator. 3/26/16	

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F 225	Continued From page 18 the incidents reported to the North Carolina Health Care Personnel Registry on the initial 24 hour report and the 5 working day report. During an interview on 03/04/16 at 9:32 AM the Risk Management Nurse stated it was her usual routine when she came to the facility in the morning to make rounds and she picked up 24 hour reports and incident reports from the day before. She stated on 12/28/15 she took documents to her desk and sorted through them and found Resident #6 had a bruise on her left upper arm. She further stated it looked like a big bruise so she reviewed Resident #6's skin assessments and medications and then she went to Resident #6's room and looked at the bruise. She explained the bruise was on Resident #6's left upper arm and was very purple and looked like a new bruise. She further explained the whole upper left arm was purple and she knew Resident #6 was transferred with a lift but she did not know if staff had positioned Resident #6 in the lift correctly during transfers. She stated she was at a loss as to what had caused the bruise and recalled she had asked the DON to look into the bruise and he took it from there. She stated she did not participate in any investigation related to the bruise on Resident #6's left upper arm. During an interview on 03/04/16 at 11:04 AM, Nurse #2 stated she remembered the bruise on Resident 6's left upper arm at the end of December 2015. She explained NA #1 and NA #3 were supposed to be sharing work on the evening shift from 3:00 PM until 11:00 PM on 12/27/15 and they were supposed to stay for report with night shift staff at 11:00 PM but NA #1 left without telling anyone and didn't stay for report. She confirmed the bruise had not been	F 225	The Nursing Supervisor on each shift, including weekends, will conduct (3) random full body skin assessments per shift (1 on each unit) daily x 2 weeks, weekly x 4 weeks, and then finally monthly x 3 months beginning on 3/25/16 to provide oversight and ensure continued compliance with reporting of injuries of unknown origin. Any concerns noted will be immediately investigated following the Abuse and Incident/Accident policies. The ADON will conduct (15) random full body skin assessment audits weekly (5 on each unit) x 1 month and then monthly x 2 months beginning on 3/25/16 to provide oversight and ensure continued compliance with proper Incident/Accident reporting and subsequent investigation procedures for those noted as injuries of unknown source. All concerns and corrective action will be reported to the QA&A Committee monthly for further discussion and review. Each Social Services Coordinator will conduct random interviews on his/her assigned unit who are alert and oriented to determine resident understanding/awareness of the Abuse policy for reporting concerns and what to do if abuse occurs or is witnessed. These interviews will be done for (4) residents weekly x 1 month and then monthly x 2 months. All concerns and corrective action will be reported to the QA&A Committee monthly for further discussion and review.	3/26/16 3/26/16 3/26/16

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F 225	Continued From page 19 reported to her by the 3:00 PM to 11:00 PM nurse at shift change during report on 12/27/15. She explained NA #5 was making her first round on the night shift on 12/28/15 after 1:00 AM and noticed Resident #6's gown needed to be changed. She further explained when NA #5 removed Resident #6's gown she saw the bruising and swelling on Resident #6's left upper arm and reported it to Nurse #2. She explained Resident #6 had bruising on her left upper arm and when she first saw it Resident #6's left upper arm was really swollen and further described it as huge. She stated the area was warm to touch and felt firm and hard and was purple and looked like it was a new bruise. She explained the bruise was located above Resident #6's left elbow and up in the center of her upper arm and it kind of looked like the size of a hand but she did not see any fingerprints or indentions in the area. She stated it alarmed her because of the size. She further explained Resident #6 was immobile and could not move herself in bed. She stated Resident #6 could not verbalize anything but grunted and made a frown face and she could tell it hurt her when they moved her left arm and she reported the bruising to the first shift nurse during the change of shift report around 7:00 AM on 12/28/15. She explained she completed the incident report and wrote her statement on the report and passed the paperwork on when she gave report to the first shift nurse on 12/28/15 but no one from Administration had asked her about it and she did not know anything about an investigation. During an interview on 03/04/16 at 12:36 PM the DON explained he received the incident report for Resident #6's bruise on her upper left arm from the Risk Management Nurse on 12/28/15. He	F 225	All Abuse Investigation forms and Witness/Staff Statements initiated upon the report of abuse will be reviewed thoroughly by the Administrator within 24 hours of the reported abuse or by Monday for any reports occurring after 4:30pm on the previous Friday to ensure all required steps have been taken to protect the resident(s) involved as well as others residents from potential abuse in a timely manner and that detailed steps of the investigation have been initiated in the required timeframe by the Director of Nursing or his designee. The Controller (also a licensed nursing home Administrator) will act in the absence of the Administrator to review these forms. 3/26/16 Throughout an abuse investigation, the Director of Nursing will review all steps taken thus far in the process daily with the Administrator (the Controller in the absence of the Administrator) including a thorough review of all witness/staff statements obtained for further direction. 3/26/16 The Director of Nursing will review all findings and conclusions of the detailed investigation with the Administrator (the Controller in the absence of the Administrator) prior to final submission of the final report to ensure completion of all steps of the investigation process and determination of the final outcome related to the accused employee. 3/26/16	

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F 225	Continued From page 20 stated he was concerned her arm might have been injured during a lift transfer and wanted to see her transferred in the lift. He explained he observed NA #6 transfer Resident #6 but he did not observe NA #1 or NA #3 transfer the resident. He stated during the lift transfer Resident #6 had her arms folded across her chest and he felt the bruise was due to the position of the resident in the lift when her arms were pressed together when the lift was raised. He explained he talked to Resident #6's family who stated she bruised easily. He confirmed he did not investigate further and did not interview staff who had provided care to Resident #6 prior to the bruise found on 12/28/15. He also confirmed he did not submit a 24 hour or 5 working day report to the state agency because at the time he did not consider the bruise was caused by an injury of unknown origin. During a telephone interview on 03/04/16 at 3:30 PM, NA #5 explained she remembered the bruise on Resident #6's left upper arm at the end of December 2015. She explained she received shift report from NA #3 because NA #1 had left without telling anyone. She stated NA #3 did not report anything about a bruise on Resident #6's arm but during her first round of the shift she noticed Resident #6's gown was soiled and when she changed it she saw the bruise on Resident #6's left upper arm, chest and armpit. NA #5 stated it upset her when she saw it and she wanted to know what had happened and wondered how could it have happened. She explained she immediately notified Nurse #2 who came to Resident #6's room and looked at it and the bruising went down from her left arm under her armpit and on her chest and partially around her breast and the color of the bruise was	F 225	Any staff member who fails to follow any step of the Abuse Policy as written, including the completion of the Abuse Investigation Form, will be subject to discipline including unpaid suspension up to and including termination. 3/26/16 All reports of abuse including findings and results of the investigation will be reported to the monthly QA&A Committee by the Director of Nursing for any further recommendations to ensure continued compliance. 3/26/16	

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purplish. She explained Resident #6 was moaning and she could tell by Resident #6's facial expression she was in pain. She stated Nurse #2 assessed Resident #6 and wrote a statement and NA #5 stated she wrote a statement. She confirmed no one from administration called her or talked to her to ask about Resident #6's bruise or what had happened so she assumed someone took care of it.

On 03/04/16 at 3:43 PM attempts were made to contact NA #3 by phone but there was no answer. A message was left for her to return the call however, NA #3 did not return the phone call.

On 03/04/16 at 3:55 PM attempts were made to contact NA #7 who was assigned to care for Resident #6 on the day shift on 12/27/15. There was no answer and there was no voicemail option to leave a message for her to return the call.

On 03/04/16 at 4:23 PM an attempt to contact NA #1 who no longer worked at the facility was made by phone. There was no answer and a message was left for her to return the call however, NA #1 did not return the phone call.

During a follow up interview on 03/04/16 at 2:00 PM the Administrator stated she was made aware of the bruise on Resident #6's left upper arm during the morning meeting but now had been further brought up to speed about the incident. She stated it was her expectation that nursing staff should assess immediately for possible causes of an injury before they handed the information off to upper management and a thorough investigation should be completed and the 24 hour and 5 working day reports should be submitted as required.

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F 225	Continued From page 22 2. Resident #1 was admitted to the facility on 06/17/12 with diagnoses of multiple cerebral vascular accidents, Alzheimer's disease, and dementia. Review of the most recent quarterly Minimum Data Set (MDS) dated 02/09/16 revealed that Resident #1 was severely cognitively impaired with no behaviors identified. The MDS further indicated that Resident #1 required extensive assistance with activities of daily living (ADLs). Interview with Nursing Assistant (NA) #4 on 03/02/16 at 12:03 PM revealed that she had been in the dining room on Saturday 02/20/16 at approximately 5:30 PM when she overheard NA #1 yelling at Resident #1 to stop touching her and to leave her alone. NA #4 stated that Resident #1 would pat your leg if you were sitting beside her and she was patting NA #1's leg and NA #1 got angry and began yelling at Resident #1. NA #4 stated that when she finished feeding the resident she was assisting she had reported it to a nurse but could not recall which one. No written statement by NA #4 about this incident was available. Interview with NA #3 on 03/02/16 at 3:05 PM revealed that she was working in the dining room on the evening of 02/20/16 and witnessed Resident #1 patting the leg of NA #1. NA #3 stated that NA #1 then stated "oh my God stop it, why do u keep patting me, stop touching me" and then NA #1 leaned into the face of Resident #1 and grabbed her right hand and slammed it into the lap of Resident #1 grazing the edge of the table. NA #3 described it like scolding a child, NA #3 further stated that Resident #1 had no reaction except mumbling. NA #3 stated that she felt like NA #1 had abused Resident #1. NA #3 stated she had reported the incident to Nurse #1 and had wrote a statement about the incident as instructed	F 225		

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F 225	Continued From page 23 by Nurse #1. Review of "Staff Statement for Incident/Accident" written by NA #3 stated that she witnessed NA #1 slam Resident #1's hand and told her to stop patting her. Another family member also witnessed the way she was talking to the resident and stated that it was inappropriate. Signed by NA #3 and dated 02/20/16. Interview with NA #2 on 03/02/16 at 4:13 PM revealed that she was present in the dining room on 02/20/16 assisting with supper and witnessed NA #1 get very irritated with Resident #1 who was patting her leg and grabbed her hand and slammed it into Resident #1's lap grazing the table and heard NA #1 state to Resident #1 "stop F**king patting my leg." NA #2 stated that what she witnessed between NA #1 and Resident #1 was both physical and verbal abuse because they had just had mandatory training on abuse and were educated on the different types of abuse and included examples of each type. NA #2 stated she had reported the incident to the Nurse Supervisor. No written statement by NA #2 about this incident was available. Interview with Visitor #1 on 03/04/16 at 9:53 AM revealed that she was a sitter for another resident at that facility. Visitor #1 stated that on 02/20/16 in the dining room at supper time she witnessed Resident #1 rubbing NA #1's leg and NA #1 got so mad at Resident #1 she took her arm and forced it down onto her lap. Visitor #1 stated that NA #1 was very angry and got almost nose to nose with Resident #1 and stated "I told you to stop that" and "keep your hand to yourself." Visitor #1 further stated that she witnessed NA #1 grab the wrist of Resident #1 and shove it into her lap at least 3 times while she was in the dining room tending to the resident she worked for. Visitor #1 stated that she had reported the	F 225		

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incident to a nurse and that later that evening the Nurse Supervisor came and thanked her for reporting the incident. No written statement by Visitor #1 about this incident was available.
Interview with Nurse #1 on 03/02/16 at 3:20 PM revealed that NA #3 reported the incident with NA #1 and Resident #1 in the dining room on 02/20/16 at approximately 6:30 PM. Nurse #1 stated the Nurse supervisor was already aware. Nurse #1 thanked NA #3 for reporting the incident to him and instructed NA #3 to write a statement about what she witnessed. Nurse #1 further stated that he did nothing further because he took for granted the Nurse Supervisor was taking care of the situation. No written statement by Nurse #1 about this incident was available.
Interview with Nurse Supervisor on 03/02/16 at 2:34 PM revealed that NA #2 reported to him that NA #1 was being verbally aggressive and very hateful to Resident #1. Nurse Supervisor stated he went to the dining room and asked to speak with NA #1 and asked what was going on. NA #1 stated that Resident #1 was rubbing her leg near her private area and NA #1 stated that she had pushed Resident #1's hand way and told her not to do that. Nurse supervisor stated he asked NA #1 if she was being verbally aggressive and NA #1 stated "NO" and so Nurse Supervisor asked NA #1 if maybe the tone of her voice could be perceived as verbally aggressive and NA #1 relied "maybe." Nurse supervisor again stated that he had reassigned NA #1 to the 400 secure memory care unit for the remained of her shift. Nurse Supervisor confirmed that he had not spoken to the DON but had sent an email notifying him of the incidents that happened on 02/20/16. Nurse Supervisor further stated that his only other action besides talking to NA #1 was to reassign her to another unit for the remainder of

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F 225	Continued From page 25 her shift. No written statement by Nurse Supervisor about this incident was available. Review of email dated 02/21/16 at 7:15 PM from Nurse Supervisor to Director of Nursing (DON) read in part that a visitor had witnessed NA #1 being rude to Resident #1 and shoving her arm when Resident #1 would pat NA #1 on the leg. When I questioned NA #1 about it she became upset, defensive, and with an aggressive attitude. Nurse Supervisor talked to NA #1 under the camera in the 100 medication unit so the DON could observe her body language an attitude. I moved her to the 400 secure memory care unit for the remainder of her shift. Interview with DON on 03/02/16 at 3:37 PM revealed that he was made aware of the incident on 02/20/16 via email from Nurse Supervisor that he received on 02/22/16 when he arrived at work. The DON stated that NA #1 thought the staff did not like her because she was a Yankee. NA #1 told DON that Resident #1 was putting her hand on NA #1's leg and NA #1 was placing it back on Resident #1. The DON confirmed that there was no investigation completed on the incident with Resident #1 and had not been reported to the North Carolina Health Care Personnel Registry via the initial 24 hour report or the 5 working day report. The DON further stated he had not talked to the sitter/visitor that was present in the dining room that day because he had no contact information for that sitter/visitor, and the DON confirmed that he had not spoken to the other NA's that were working that evening. The DON stated that if abuse had been reported to Nurse Supervisor the expectation is that Nurse Supervisor would contact the DON or the administrator immediately. Interview with the Administrator on 03/03/16 at 12:08 PM revealed that she was notified by the	F 225		

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F 225	Continued From page 26 DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON and/or administrator. The administrator went on to say that with any investigation staff is expected to complete a full investigation that included interviews with all staff involved and the nurse supervisor was fully capable of starting the investigation which should have included the immediate suspension of NA #1 and immediately notifying the DON so a thorough investigation could be completed and the incidents reported to the Health Care Personnel Registry via the initial 24 hour report and the 5 working day report. Review of 24 hour initial report dated 03/03/16 was filed by DON stated that report was given to DON regarding staff member "slamming" resident hand off of the employee's knee and putting it back on the residents knee. On 03/02/16 during conversation with state surveyor it was asked if I was "aware of any verbal abuse toward resident" to which nothing had been reported, prompting this investigation to be opened. Signed by the DON on 03/03/16. 3. Resident #2 was admitted to the facility on 10/17/15 with diagnoses that included diabetes mellitus, hypertension, Alzheimer's disease, and dementia. Review of the most recent comprehensive admission Minimum Data Set (MDS) dated 10/26/15 revealed that Resident #2 was severely cognitively impaired and no behaviors were identified. The MDS also indicated that Resident #2 required extensive assistance with ADLs. Interview with NA #2 on 03/02/16 at 5:09 PM revealed that on 02/20/16 at approximately 5:00 PM Resident #2 was in the dining room waiting	F 225		

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F 225	Continued From page 27 for supper and had become anxious and uncooperative and tried to leave the dining room. NA #2 stated that she took Resident #2 to see a family member who also resided at the facility to see if that would calm Resident #2 down. NA #2 stated that after Resident #2 had visited with the family member for a few minutes he had calmed down and NA #2 was able to return Resident #2 to the dining room. NA #2 further stated that when she returned Resident #2 to the dining room NA #1 asked NA #2 "what is his issue?" NA #2 stated to NA #1 that Resident #2 had delusions that his daughter had been killed. NA #2 stated that NA #1 then approached Resident #2 and got down in his face and stated "that was a stupid reason to hit me and you had no reason to act like way" in a very aggressive and threatening tone. NA #2 also stated that NA #1 was very hateful in the way NA #1 spoke to Resident #2 that evening in the dining room. NA #2 stated she reported this to the Nurse Supervisor at approximately 5:15 PM. The written statement obtained from NA #2 about this incident read in part that she had help calm Resident #2 down when he became worried and combative about delusions that his daughter had been killed in a car accident. NA #2 stated she was able to calm Resident #1 down and NA #1 grew upset with Resident #2 and starting fussing at Resident #2 and stated "he had no reason to treat her that way." Interview with Nurse supervisor on 03/02/16 at 2:34 PM stated that on 2/20/16 at approximately 5:15 PM NA #2 reported to him that NA #1 had been very hateful to Resident #2 and was talking very loudly, more loudly then she should have been to Resident #2 in the dining room. Nurse Supervisor confirmed that he had not spoken to the DON but had sent an email notifying him of the incidents that happened on 02/20/16. Nurse	F 225		

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F 225	Continued From page 28 Supervisor further stated that his only other action besides talking to NA #1 was to reassign her to another unit for the remainder of her shift. No written statement by Nurse Supervisor about this incident was available. Review of email sent on 02/21/16 at 7:15 PM from nurse supervisor to Director of Nursing (DON) read in part on Saturday evening 02/20/16 NA #2 witnessed NA #1 being verbally aggressive to Resident #2 when Resident #2 had become combative. Nurse supervisor stated in the email that he had talked to NA #1 and NA #1 stated she was being picked on by everyone and had already gotten in trouble with the DON. NA #1 informed nurse supervisor that she hated working at the facility and it was the most pathetic place she had ever worked at before. NA #1 claimed that the staff did not like her because she was a Yankee. NA #1's body language and attitude was aggressive and more defensive. NA #1 stated that she had changed shifts because she could not get along with her coworkers and now she could not get along with the staff that was there on Saturday. NA #1 agreed to stay for the rest of the shift and I moved her to the 400 secure memory care unit for the remainder of her shift. Interview with DON on 03/02/16 at 3:37 PM stated that he was not made aware of the incident until Monday 02/22/16 when he arrived at work and read the email from Nurse Supervisor. The DON confirmed that there was no investigation completed on Resident #2 and the incident was not reported to the North Carolina Health Care Personnel Registry via the 24 hour initial report and 5 working day report. The DON also stated he had not spoken to the NA's that where working that evening about the incident and had not obtained statements from them regarding the incident. The DON further stated that he trusted	F 225		

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F 225	Continued From page 29 the Nurse supervisor because he was present at the time and had a better idea of what happened. The DON stated if any abuse was reported to Nurse Supervisor he should immediately notify the DON. The DON again confirmed this incident was not investigated and was not reported to the Health Care Personnel Registry. Interview with the Administrator on 03/03/16 at 12:08 PM revealed that she was notified by the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON and/or administrator. The administrator went on to say that with any investigation staff is expected to complete a full investigation that included interviews with all staff involved and the nurse supervisor was fully capable of starting the investigation which should have included the immediate suspension of NA #1 and immediately notifying the DON so a thorough investigation could be started and the incidents reported to the Health Care Personnel Registry via the initial 24 hour report and the 5 working day report. The administrator and DON were notified on 03/03/16 at 2:30 PM of immediate jeopardy. The administrator provided acceptable credible allegation of compliance on 03/04/16 at 6:45 PM. Credible Allegation of Compliance F 225: (1) On 12/28/15, Resident #6 had a bruise of unknown origin with no 24 hour report or 5 day working report submitted to the NC Health Care Personnel Registry and a thorough investigation was not completed. On 2/20/16 at 11:00pm, Nursing Assistant (NA) #1, who physically and/or verbally abused	F 225		

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F 225	Continued From page 30 Residents #1 and #2 on 02/20/16, left the facility after working her entire shift. On 2/22/16 at 3:23pm, the accused CNA was suspended (she had not returned to work since leaving on 2/20/16 @ 11:00pm) and was ultimately terminated from employment on 2/26/16 at 1:20pm. On 02/22/16 an investigation was initiated on the abuse of Resident #2 by the Director of Nursing which resulted in termination of NA #1 on 2/26/16 at 1:20pm. On 02/22/16 the family of Resident #2 was involved in the investigation and was made aware of the investigation initiated on 2/22/16 as well as of the outcome of the investigation on 2/26/16 by the Director of Nursing. On 03/03/16, the Nursing Supervisor was placed on suspension pending further investigation of his role in the allegations of abuse for Residents #1 and #2, which occurred on 02/20/16, for failure to protect residents and properly report resident abuse. As of 03/04/16. The results of this investigation are pending and the Nursing Supervisor will remain on suspension until the investigation is complete. On 03/03/16 at 2:19 pm The 24 hour Health Care Personnel Registry (HCPR) abuse/neglect investigation report form for Resident #1 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. On 03/03/16 @ 2:19pm the 24 hour abuse/neglect investigation report form for Resident #1 was completed and faxed for further investigation of alleged abuse.	F 225		

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F 225	Continued From page 31 On 03/03/16 @ 3:20pm, Nursing Assistant (NA) #2 and Nursing Assistant (NA) #3 who failed to immediately report allegations of abuse towards Resident #1 and Resident #2 were suspended pending further investigation of their actions related to the allegations. NA #2 and NA #3received written disciplinary actions for failure to immediately report allegations of abuse according to the Abuse/Neglect policy on 03/04/16 and will return to work as of 03/05/16. On 3/4/16 at 9:00 am, the Director of Nursing completed the NC Board of Nursing Complaint Evaluation Tool to determine reporting requirements for the Nursing Supervisor and obtained a score of 11 which indicated NC Board of Nursing consultation but no requirement for reporting. The Director of Nursing contacted the NC Board of Nursing for the required consultation on 03/04/16 at 10:00am. The Director of Nursing was given a phone appointment for further review on Monday, 3/7/16 at 1:30pm. On 03/04/16 @5:19pm, the 24 hour Health Care Personnel Registry (HCPR) abuse/neglect investigation report form for Resident #6 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. (2) Residents #1, #2, and #6 were assessed by the 100 unit Social Services Coordinator on 03/03/16 for any residual effects from the alleged physical/verbal abuse with no concerns noted. An in-service was conducted by the Administrator for all staff on duty on 03/03/16 regarding resident abuse. The in-service agenda included: 1. Revised Abuse & Neglect policy/procedure to:	F 225		

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F 225	Continued From page 32 · Immediate removal of the resident from the abusive situation by the employee who witnesses the abuse · Immediate reporting of the abusive situation by the employee who witnesses the abuse to the direct supervisor or any other member of management currently on duty · Immediate suspension of the alleged employee by the direct supervisor or member of management · Immediate reporting of the abusive situation by the direct supervisor or member of management to the Director of Nursing or the Administrator 2. Definitions of physical and verbal abuse including tone of voice and temperament used towards any resident including scenarios of both physical and verbal abuse. 3. Definition of how to make the immediate notification of abuse allegations and the expectation that such allegations will be reported verbally. 4. Expectations for the immediate protection of any resident in which abuse/neglect are suspected. No staff member will be allowed to perform any work-related duties until the In-service has been completed. On 03/04/16 all residents who are alert and oriented were interviewed by the 100 unit Social Services Coordinator and MDS Coordinators to determine if there were any reports of abuse and/or neglect with no negative responses. On 03/04/16 head to toe skin assessments were completed on all residents (including Residents #1, #2, and #6) to assess for possible signs of abuse by the Nursing Supervisors, MDS	F 225		

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F 225	Continued From page 33 Coordinators, and Risk Management Coordinator. Skin assessments revealed no signs of potential abuse. On 03/04/16 @ 5:18pm, the Administrator in-serviced the Director of Nursing on his specific role and responsibility in immediately reporting any allegations of abuse/neglect or suspicions of abuse/neglect including bruising of unknown origin and beginning the appropriate investigations in the required timeframe per policy (upon 24 hours of verbal notice). On 03/04/16 at 5:21pm, the Administrator completed the NC Board of Nursing Complaint Evaluation Tool to determine reporting requirements for the Director of Nursing based on his role in the failure to complete the required reporting and investigations of allegations of abuse for Resident #6 and obtained a score of 11 which indicated NC Board of Nursing consultation but no requirement for reporting. The Administrator contacted the NC Board of Nursing for the required consultation on 03/04/16 at 5:28pm and was made aware that the office is closed. The Director of Nursing was suspended on 03/04/16 @ 5:40pm with a pending appointment with the NC Board of Nursing for Monday 03/07/16 for further direction. On 03/04/16 @5:45pm, the Administrator in-serviced all Nursing Managers, which includes all shift supervisors, on their specific role in immediately reporting and beginning the appropriate investigation for all reported concerns of potential abuse and/or neglect including bruising of unknown origin. No nursing manager will be allowed to perform any work-related duties until this in-service has been completed.	F 225		

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F 225	Continued From page 34 Immediate jeopardy was removed on 03/04/16 at 7:05 PM when staff interviews with nursing staff, administrative staff, and non-nursing staff confirmed that they had received in service training on the immediate reporting of the abusive situation to the direct supervisor or any other member of the management team on duty and the immediate start of a full investigation of the reported abusive situation.	F 225		
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 record reviews and staff interviews the facility failed to operationalize policy and procedures to thoroughly investigate and submit 24 hour and 5 working day reports to the North Carolina Health Care Personnel Registry (state agency) for a resident with a bruise of unknown origin (Resident #6). The facility also failed to immediately stop verbal abuse when observed (Resident #1 and Resident #2) which led to witnessed physical abuse (Resident #1), failed to remove the perpetrator from resident areas, failed to immediately notify Administrator and once notified the facility failed to report the incidents of verbal and physical abuse to the North Carolina Health Care Personnel Registry in 24 hours and the investigative findings in the 5 working day	F 226	(1) Residents #1 and #2 were immediately protected from any further verbal and/or physical abuse by NA#1 by the Nursing Supervisor on 2/20/16 when NA#1 was Physically removed from their unit. All residents were further protected from any further abuse by NA#1 upon her suspension on 2/26/16 and subsequent termination on 2/26/16 by the Director of Nursing. 2/26/16 A full body skin assessment was completed on Residents #1, #2, and #6 by Nursing Supervisors with no concerns noted related to potential abuse. 3/3/16 Residents #1, #2, and #6 were assessed by the 100 unit Social Services Coordinator to determine any residual effects of physical and/or verbal abuse with no concerns noted. 3/3/16	

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F 226	Continued From page 35 report for 3 of 6 sampled residents for abuse (Resident #6, #1 and #2). Immediate jeopardy began on 12/28/15 when the facility failed to report a bruise of unknown origin (Resident #6) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate Jeopardy began on 02/20/16 for Residents #1 and #2 when the facility also failed to report a witnessed incident of physical abuse (Resident #1) and 2 incidents of verbal abuse (Resident #1 and Resident #2) within 24 hours to the Health Care Personnel Registry and failed to conduct a thorough investigation and report those findings in the 5 working day report. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective with the immediate removal of residents from abusive situation and the immediate reporting of witnessed abuse to the management staff. Findings included: A review of a facility policy titled "Abuse and Neglect" with a revised date of 02/04/13 revealed in part the facility prohibits mistreatment, neglect, and abuse of residents and misappropriation of resident's property. It is the responsibility of all staff members to respect resident's rights by not using verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion for	F 226	The Director of Nursing who failed to complete the required 24 hour and 5 day reports with a complete investigation for Residents #1, #2, and #6 was suspended on 3/4/16 with disciplinary action as required by the NC Board of Nursing upon return to work on 3/8/16. A full investigation of the verbal and physical abuse of Resident #1 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/8/16. A full investigation of bruise of unknown origin of Resident #6 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/9/16. A full investigation of the verbal abuse of Resident #2 was completed with all required reporting to the NC Health Care Personnel Registry by the Administrator on 3/11/16. The Nursing Supervisor who failed to immediately protect Resident #1 and #2 from reported abuse and also failed to immediately report the abuse to the Director of Nursing was suspended on 3/4/16 with disciplinary action as required by the NC Board of Nursing upon return to work on 3/12/16.	3/8/16 3/8/16 3/9/16 3/11/16 3/12/16

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F 226	Continued From page 36 any resident in the facility. The facility shall ensure that all alleged violations involving mistreatment, neglect, abuse, or injuries of unknown source, and misappropriation of residents property are reported immediately to the Administrator and the state survey and certification agency. The facility shall investigate all alleged violations and will protect the resident from further potential abuse while the investigation is in progress. The results of all investigations will be reported to the Administrator and the State survey certification agency within five working days of the incident. A section labeled identification revealed a definition of abuse which is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. The document indicated any staff member is expected to identify any known and/or suspected case of abuse and/or neglect and to report those suspicions to their supervisor or any other member of management immediately. This may include suspicious bruising or any occurrences, patterns, and trends that may constitute abuse. The Director of Nursing/Assistant Director of Nursing and/or the Administrator is to be notified of suspicious events or allegations of abuse/neglect immediately for the safety of all residents. A section labeled Investigation/Protection indicated if an individual employee is suspected of abuse/neglect, he or she will be placed on suspension pending the outcome of the investigation to ensure the safety of residents. If Administration is unable to determine that there is a clear suspect, all staff assigned to the resident prior to the incident/injury will be interviewed in an effort to identify who may be responsible. A section labeled Reporting indicated the Director	F 226	(2) Full body skin assessments were conducted on all residents by Nursing Managers to assess for any signs of potential physical abuse with no concerns noted. All residents who are alert and oriented were interviewed by the MDS Coordinators to determine any concerns related to abuse with no negative responses. Each resident was also reminded /educated at that time on the proper reporting procedures if abuse occurs. The Administrator conducted an in-service for all staff between 3/3/16 – 3/4/16 on revisions made to the Abuse Policy & Procedures including: --definitions, examples, and scenarios of abuse --immediate steps required when abuse is suspected and/or reported including the immediate removal of the resident from the situation, immediate verbal reporting of the facts as witnessed to the direct supervisor or nurse on duty, immediate removal of the accused employee from all duties, and immediate verbal reporting to the DON and Administrator for timely investigating procedures	3/4/16 3/4/16 3/4/16

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F 226	Continued From page 37 of Nursing will be responsible for completing all steps of the investigation process, reviewing with the Administrator daily until the investigation is complete. The Director of Nursing and the Administrator will review all investigations upon completion to evaluate accuracy, timeliness, and completion of all required information prior to making the final decision and/or faxing the final report to the state agency for review. 1. Resident #6 was admitted to the facility on 11/02/11 with diagnoses listed on the diagnosis list in the electronic medical record of congestive heart failure, high blood pressure, type 1 diabetes, Alzheimer's disease, dementia, anxiety and depression. A review of the most recent annual Minimum Data Set (MDS) dated 12/30/15 indicated Resident #6 had short and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #6 was totally dependent on staff for activities of daily living and exhibited no behaviors. A review of an incident report dated 12/28/15 at 1:45 AM revealed Nurse Aide (NA) # 5 reported to Nurse # 2 Resident #6 had a 5 inch x 4 inch bruise on her left upper arm. The report indicated Resident #6 was sleeping when the bruise was found during the first round on the night shift. The report further indicated the bruise was on the upper front, inside and outside left arm and was purple in color and the possible causes were listed as unknown. Nurse #2's handwritten statement revealed NA #5 called for her to look at Resident #6 and upon assessment, there was a 5 inch x 4 inch purple bruise on Resident #6's	F 226	(3) The Witness/Staff Statement form was revised for staff use when reporting witnessed events related to resident care, including abuse. This form specifically directs staff to only provide the written statement after a verbal report has been given to the nurse on duty. This form also specifically directs staff to place concerns in direct quotes, to use full names, and to be as specific as possible for further investigation. --All department managers were in-serviced by the Administrator on 3/21/16 on the use of this form in the event they are the manager on duty should abuse be reported directly to them following the Abuse Policy. --All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for obtaining such statements once all immediate steps have been taken following the Abuse Policy for protection of the resident and reporting of the concern.	3/26/16

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F 226	Continued From page 38 upper left arm. Nurse #2 documented she asked Resident #6 if she was in any pain and she stated "yeah" and when Nurse #2 touched the bruise, Resident #6 grimaced and pulled away. A review of a handwritten witness statement by NA #5 revealed she went into Resident #6's room to check and change her. She documented Resident #6 seemed to be in a lot of pain so NA #5 checked her over and noticed Resident #6's upper left arm was very badly bruised and swollen and she notified Nurse #2. A section for an explanation and detailed circumstances surrounding the bruise revealed a bruised area covered most of Resident #6's left upper arm (5 inches x4 inches) and was swollen. The notes indicated when the bruise was touched it was hard and knotted and Resident #6 grimaced and vocalized sounds. The report revealed NA #1 and NA #3 were assigned to work on the hall where Resident #6 lived but when NA #5 clocked in and went to the nurse's station for report NA #1 had left without telling anyone. NA #3 gave report but did not report any bruising on Resident #6's left upper arm. A review of a nurse's note dated 12/28/16 at 7:34 AM revealed NA #5 informed Nurse #2 that Resident #6 had "a huge bruise" on her left upper arm. The notes indicated Nurse #2 assessed the area and Resident #6 had a bruise that was 5 inches tall and 4 inches wide and covered the entire front of Resident #6's left upper arm. The notes revealed Resident #6 was unable to state how the bruise was obtained and Nurse #2 asked Resident if she was in pain, and she replied "yeah" and when the left upper arm was touched or moved, Resident #6 grimaced, grunted and pulled away. The notes further revealed Nurse #2 gave Resident #6 Acetaminophen for pain and	F 226	A new "Abuse Investigation" form was created to assist the licensed nurse or department manager on duty at the time abuse is reported on the required steps to be taken and the required timeframe. This form will act as a timeline for the investigation process and includes all immediate steps to be taken by the nurse/manager on duty upon the reporting of abuse as well as the detailed steps of the investigation process itself. The form more specifically addresses injuries of unknown origin to direct the licensed nurse to: 1. complete a full body skin assessment to ensure no other areas of concern 2. complete an Incident/Accident report 3. follow all immediate reporting requirements following the Abuse policy for timely investigation All department managers were in-serviced by the Administrator on 3/21/16 on the use of this form in the event they are the manager on duty should abuse be reported directly to them following the Abuse Policy. All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for initiating this form if abuse is reported as well as the specific directions related to injuries of unknown source. 3/26/16	

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F 226	Continued From page 39 left a note in the physician's communication book for review. A review of a nurse's note dated 12/28/15 at 10:02 AM indicated an X-ray was obtained of Resident #6's left upper arm due to bruising, swelling and was painful to touch. A review of x-ray results dated 12/28/15 revealed 2 views of the left humerus (upper arm bone) and the impression was mild arthrosis (wear and tear on the joints) with moderate demineralization (dissolving bone). A review of a typed document dated 12/28/15 by the Director of Nursing (DON) indicated it was brought to his attention that Resident #6 had bruising to her left arm 5 inches x 4 inches. The document revealed this was discovered according to an incident report dated 12/28/16 at 1:45 AM and had been presented to the DON by the Risk Management Nurse for follow up. The document revealed the DON spoke to Resident #6's family who indicated she had a history of bruising and then reviewed Resident #6's clinical record and noted she required a lift for transfers. The document revealed on 12/28/15 at 3:15 PM the DON observed Resident #6's lift transfer by NA #6 who was assigned to care for Resident #6 and noted Resident #6 had her arms folded across her chest during the transfer. The document revealed at that time it was determined the resident bruise was unrelated to any staff harm and that the resident bruise had no indications that it originated from any harm caused by a staff member. The document further revealed it was not established that NA #1 had caused the injury but if at any time any new information was presented that would indicate NA	F 226	The "Questions After A Bruise/Skin Tear" form, which is completed by the licensed nurse to accompany the Incident/Accident report was revised to specifically Direct the nurse in the event a bruise is of unknown origin/source to: 1. report to the Nurse Manager or manager on duty to begin the required investigation and reporting process 2. obtain a statement from the resident if he/she is able to do so 3. indicate if abuse is suspected and if so—report following Abuse policy and procedures All licensed nurses will be in-serviced by the Staff Development Coordinator between 3/23/16 and 3/25/16 on the use of this form as they will be responsible for initiating this form if abuse is reported.	3/26/16

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F 226	Continued From page 40 #1 caused the injury, either intentionally or otherwise, a formal investigation would be opened and submitted to the licensure agency per facility policy. A review of handwritten notes on a sheet of notebook paper dated 12/28/15 at 3:15 PM by the DON revealed NA #1's name at the top of the page highlighted with yellow highlighter and notes revealed Resident #6 "on lift properly may be of concern" (NA #6 "did good"), "concerns related to bruises on both legs and arm on 2 lift occasions." During an interview on 03/03/16 at 12:08 PM the Administrator explained she was notified by the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The Administrator stated with any investigation staff was expected to complete a full investigation that included interviews with all staff involved so a thorough investigation would be completed and the incidents reported to the North Carolina Health Care Personnel Registry on the initial 24 hour report and the 5 working day report. During an interview on 03/04/16 at 9:32 AM the Risk Management Nurse stated on 12/28/15 she reviewed an incident report which indicated Resident #6 had a bruise on her left upper arm. She further stated she looked at Resident #6's skin assessments and medications and then she went to Resident #6's room and looked at the bruise. She described the bruise was on Resident #6's left upper arm which covered the whole upper arm and was very purple and looked like a new bruise. She stated she was at a loss as to what had caused the bruise and recalled she had asked the DON to look into the bruise and he	F 226	(4) The Risk Management Coordinator will review all Incident/Accident reports within 24 hours of the reported abuse or by Monday for any reports occurring after 4:30pm on the previous Friday specifically for injuries of an unknown source to ensure all investigations have been properly initiated per the Abuse and Incident/Accident policies. Any incident report with an injury of unknown origin that has not had the proper investigation initiated or any that is questionable for the need for a formal investigation will be immediately reported to the Director of Nursing for further review. The Director of Nursing will assign this review to another Nursing Manager in the absence of the Risk Management Coordinator. 3/26/16 The Nursing Supervisor on each shift, including weekends, will conduct (3) random full body skin assessments per shift (1 on each unit) daily x 2 weeks, weekly x 4 weeks, and then finally monthly x 3 months beginning on 3/25/16 to provide oversight and ensure continued compliance with reporting of injuries of unknown origin. Any concerns noted will be immediately investigated following the Abuse and Incident/Accident policies. 3/26/16 The ADON will conduct (15) random full body skin assessment audits weekly (5 on each unit) x 1 month and then monthly x 2 months beginning on 3/25/16 to provide oversight and ensure continued compliance with proper Incident/Accident reporting and subsequent investigation procedures for those noted as injuries of unknown source. All concerns and corrective action will be reported to the QA&A Committee monthly for further discussion and review. 3/26/16	

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F 226	Continued From page 41 took it from there. She confirmed she did not participate in any investigation related to the bruise on Resident #6's left upper arm. During an interview on 03/04/16 at 11:04 AM Nurse #2 stated she remembered the bruise on Resident 6's left upper arm at the end of December 2015. She explained NA #5 was making her first round on the night shift on 12/28/15 after 1:00 AM and noticed Resident #6's gown needed to be changed. She further explained when NA #5 removed Resident #6's gown she saw the bruising and swelling on Resident #6's left upper arm and reported it to Nurse #2. Nurse #2 confirmed the bruise had not been reported to her by the nurse at shift change during report on 12/27/15. She explained when she assessed Resident #6 she had bruising on her left upper arm and described it as huge and swollen. She stated the area was warm to touch and felt firm and hard and was purple and looked like it was a new bruise. She explained the bruise was located above Resident #6's left elbow and up in the center of her upper arm and it kind of looked like the size of a hand but she did not see any fingerprints or indentions in the area. She stated it alarmed her because of the size. She further explained Resident #6 was immobile and could not move herself in bed. She stated Resident #6 could not verbalize anything but grunted and made a frown face and she could tell it hurt her when they moved her left arm and she reported the bruising to the first shift nurse during the change of shift report around 7:00 AM on 12/28/15. She explained she completed the incident report and wrote her statement on the report and passed the paperwork on when she gave report to the first shift nurse on 12/28/15 but no one from Administration had asked her about	F 226	Each Social Services Coordinator will conduct random interviews on his/her assigned unit who are alert and oriented to determine resident understanding/awareness of the Abuse policy for reporting concerns and what to do if abuse occurs or is witnessed. These interviews will be done for (4) residents weekly x 1 month and then monthly x 2 months. All concerns and corrective action will be reported to the QA&A Committee monthly for further discussion and review. 3/26/16 All Abuse Investigation forms and Witness/Staff Statements initiated upon the report of abuse will be reviewed thoroughly by the Administrator within 24 hours of the reported abuse or by Monday for any reports occurring after 4:30pm on the previous Friday to ensure all required steps have been taken to protect the resident(s) involved as well as others residents from potential abuse in a timely manner and that detailed steps of the investigation have been initiated in the required timeframe by the Director of Nursing or his designee. The Controller (also a licensed nursing home Administrator) will act in the absence of the Administrator to review these forms. 3/26/16 Throughout an abuse investigation, the Director of Nursing will review all steps taken thus far in the process daily with the Administrator (the Controller in the absence of the Administrator) including a thorough review of all witness/staff statements obtained for further direction. 3/26/16	

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F 226	Continued From page 42 it and she did not know anything about an investigation. During an interview on 03/04/16 at 12:36 PM the DON explained he received the incident report for Resident #6's bruise on her upper left arm from the Risk Management Nurse on 12/28/15. He stated he was concerned her arm might have been injured during a lift transfer and wanted to see her transferred in the lift so he observed NA #6 transfer Resident #6 with a lift. He confirmed he did not investigate further or observe NA #1 or NA #3 transfer the resident and he did not submit a 24 hour or 5 working day report to the state agency because at the time he did not consider the bruise was caused by an injury of unknown origin. During a telephone interview on 03/04/16 at 3:30 PM, NA #5 explained she remembered the bruise on Resident #6's left upper arm at the end of December 2015. She stated during her first round of the shift she noticed Resident #6's gown was soiled and when she changed it she saw the bruise on Resident #6's left upper arm, chest and armpit. She explained she immediately notified Nurse #2 who came to Resident #6's room and looked at it and the bruising went down from her left arm under her armpit and on her chest and partially around her breast and the color of the bruise was purplish. She explained Resident #6 was moaning and she could tell by Resident #6's facial expression she was in pain. She stated Nurse #2 assessed Resident #6 and wrote a statement and NA #5 stated she wrote a statement. She confirmed no one from administration called her or talked to her to ask about Resident #6's bruise or what had happened so she assumed someone took care of it.	F 226	The Director of Nursing will review all findings and conclusions of the detailed investigation with the Administrator (the Controller in the absence of the Administrator) prior to final submission of the final report to ensure completion of all steps of the investigation process and determination of the final outcome related to the accused employee. 3/26/16 Any staff member who fails to follow any step of the Abuse Policy as written, including the completion of the Abuse Investigation Form, will be subject to discipline including unpaid suspension up to and including termination. 3/26/16 All reports of abuse including findings and results of the investigation will be reported to the monthly QA&A Committee by the Director of Nursing for any further recommendations to ensure continued compliance. 3/26/16	

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F 226	Continued From page 43 On 03/04/16 at 3:43 PM attempts were made to contact NA #3 by phone but there was no answer and a message was left for her to return the call however, NA #3 did not return the phone call. On 03/04/16 at 3:55 PM attempts were made to contact NA #7 who was assigned to care for Resident #6 on the day shift on 12/27/15. There was no answer and there was no voicemail option to leave a message for her to return the call. On 03/04/16 at 4:23 PM an attempt to contact NA #1 who no longer worked at the facility was made by phone but there was no answer and a message was left for her to return the call however, NA #1 did not return the phone call. During a follow up interview on 03/04/16 at 2:00 PM the Administrator stated she was made aware of the bruise on Resident #6's left upper arm during the morning meeting but now had been further brought up to speed about the incident. She stated it was her expectation for a thorough investigation to be completed and the 24 hour and 5 working day reports to be submitted as required. 2. Resident #1 was admitted to the facility on 06/17/12 with diagnoses of multiple cerebral vascular accidents, Alzheimer's disease, and dementia. Review of the most recent quarterly Minimum Data Set (MDS) dated 02/09/16 revealed that Resident #1 was severely cognitively impaired with no behaviors identified. The MDS further indicated that Resident #1 required extensive assistance with activities of daily living (ADLs). Interview with Nursing Assistant (NA) #4 on 03/02/16 at 12:03 PM revealed that she had been	F 226		

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F 226	Continued From page 44 In the dining room on Saturday 02/20/16 at approximately 5:30 PM when she overheard NA #1 yelling at Resident #1 to stop touching her and to leave her alone. NA #4 stated that Resident #1 would pat your leg if you were sitting beside her and she was patting NA #1's leg and NA #1 got angry and began yelling at Resident #1. NA #4 stated that when she finished feeding the resident she was assisting she had reported it to a nurse but could not recall which one. No written statement by NA #4 about this incident was available. Interview with NA #3 on 03/02/16 at 3:05 PM revealed that she was working in the dining room on the evening of 02/20/16 and witnessed Resident #1 patting the leg of NA #1. NA #3 stated that NA #1 then stated "oh my God stop it, why do you keep patting me, stop touching me" and then NA #1 leaned into the face of Resident #1 and grabbed her right hand and slammed it into the lap of Resident #1 grazing the edge of the table. NA #3 described it like scolding a child, NA #3 further stated that Resident #1 had no reaction except mumbling. NA #3 stated that she felt like NA #1 had abused Resident #1. NA #3 stated she had reported the incident to Nurse #1 and had wrote a statement about the incident as instructed by Nurse #1. Review of "Staff Statement for Incident/Accident" written by NA #3 stated that she witnessed NA #1 slam Resident #1's hand and told her to stop patting her. Another family member also witnessed the way she was talking to the resident and stated that it was inappropriate. Signed by NA #3 and dated 02/20/16. Interview with NA #2 on 03/02/16 at 4:13 PM revealed that she was present in the dining room on 02/20/16 assisting with supper and witnessed NA #1 get very irritated with Resident #1, who	F 226		

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F 226	Continued From page 45	F 226		

was patting her leg, and NA #1 grabbed her hand and slammed it into Resident #1's lap grazing the table and heard NA #1 state to Resident #1 "stop F**king patting my leg." NA #2 stated that what she witnessed between NA #1 and Resident #1 was both physical and verbal abuse because they had just had mandatory training on abuse and were educated on the different types of abuse and included examples of each type. NA #2 stated she had reported the incident to the Nurse Supervisor. No written statement by NA #2 about this incident was available

Interview with Visitor #1 on 03/04/16 at 9:53 AM revealed that she was a sitter for another resident at that facility. Visitor #1 stated that on 02/20/16 in the dining room at supper time she witnessed Resident #1 rubbing NA #1's leg and NA #1 got so mad at Resident #1 she took her arm and forced it down onto her lap. Visitor #1 stated that NA #1 was very angry and got almost nose to nose with Resident #1 and stated "I told you to stop that" and "keep your hand to yourself." Visitor #1 further stated that she witnessed NA #1 grab the wrist of Resident #1 and shove it into her lap at least 3 times while she was in the dining room tending to the resident she worked for. Visitor #1 stated that she had reported the incident to a nurse and that later that evening the Nurse Supervisor came and thanked her for reporting the incident. No written statement by Visitor #1 about this incident was available.

Interview with Nurse #1 on 03/02/16 at 3:20 PM revealed that NA #3 reported the incident with NA #1 and Resident #1 in the dining room on 02/20/16 at approximately 6:30 PM. Nurse #1 stated the Nurse supervisor was already aware. Nurse #1 thanked NA #3 for reporting the incident to him and instructed NA #3 to write a statement about what she witnessed. Nurse #1 further

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F 226	Continued From page 46 stated that he did nothing further because he took it for granted the Nurse Supervisor was taking care of the situation. No written statement by Nurse #1 about this incident was available. Interview with Nurse Supervisor on 03/02/16 at 2:34 PM revealed that NA #2 reported to him that NA #1 was being verbally aggressive and very hateful to Resident #1. Nurse Supervisor stated he went to the dining room and asked to speak with NA #1 and asked what was going on. NA #1 stated that Resident #1 was rubbing her leg near her private area and NA #1 stated that she had pushed Resident #1's hand away and told her not to do that. Nurse supervisor stated he asked NA #1 if she was being verbally aggressive and NA #1 stated "NO" and so Nurse Supervisor asked NA #1 if maybe the tone of her voice could be perceived as verbally aggressive and NA #1 replied "maybe." Nurse supervisor again stated that he had reassigned NA #1 to the 400 secure memory care unit for the remainder of her shift. Nurse Supervisor confirmed that he had not spoken to the director of nursing (DON) but had sent an email notifying him of the incidents that happened on 02/20/16. Nurse Supervisor further stated that his only other action besides talking to NA #1 was to reassign her to another unit for the remainder of her shift. No written statement by Nurse Supervisor about this incident was available. Review of email dated 02/21/16 at 7:15 PM from Nurse Supervisor to DON read in part that a visitor had witnessed NA #1 being rude to Resident #1 and shoving her arm when Resident #1 would pat NA #1 on the leg. "When I questioned NA #1 about it she became upset, defensive, and with an aggressive attitude." Nurse Supervisor talked to NA #1 under the camera in the 100 medication unit so the DON	F 226		

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F 226	Continued From page 47 could observe her body language an attitude. I moved her to the 400 secure memory care unit for the remainder of her shift. Interview with the DON on 03/02/16 at 3:37 PM revealed that he was made aware of the incident on 02/20/16 via email from Nurse Supervisor that he received on 02/22/16 when he arrived at work. NA #1 told DON that Resident #1 was putting her hand on NA #1's leg and NA #1 was placing it back on Resident #1. The DON confirmed that there was no investigation completed on the incident with Resident #1 and had not been reported to the North Carolina Health Care Personnel Registry via the initial 24 hour report or the 5 working day report. The DON further stated he had not talked to the sitter/visitor that was present in the dining room that day because he had no contact information for that sitter/visitor, and the DON confirmed that he had not spoken to the other NAs that were working that evening. The DON stated that if abuse had been reported to Nurse Supervisor the expectation is that Nurse Supervisor would contact the DON or the administrator immediately. Interview with the Administrator on 03/03/16 at 12:08 PM revealed that she was notified by the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The Administrator confirmed that the DON had not reported the incident with NA #1 and Resident #1 to the Health Care Personnel Registry and had not completed a full investigation. The Administrator also stated that if a NA had witnessed the incident on 02/20/16 at supper in the dining room then an investigation should have been completed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON and/or administrator. The administrator	F 226		

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F 226	Continued From page 48 went on to say that staff is expected to complete a full investigation that included interviews with all staff involved. The administrator stated that nurse supervisor was fully capable of starting the investigation which should have included the immediate suspension of NA #1. The administrator further stated nurse supervisor should have immediately notified the DON so a thorough investigation could be completed and the incidents reported to the Health Care Personnel Registry via the initial 24 hour report and the 5 working day report as stated in the facility policy. The Administrator stated, after conversations with the DON yesterday, he felt like he should have done something so he filled out and faxed the 24 hour initial report to the Health Care Personnel Registry.. 3. Resident #2 was admitted to the facility on 10/17/15 with diagnoses that included diabetes mellitus, hypertension, Alzheimer's disease, and dementia. Review of the most recent comprehensive admission minimum data set (MDS) dated 10/26/15 revealed that Resident #2 was severely cognitively impaired and no behaviors were identified. The MDS also indicated that Resident #2 required extensive assistance with ADLs. Interview with NA #2 on 03/02/16 at 5:09 PM revealed that on 02/20/16 at approximately 5:00 PM Resident #2 was in the dining room waiting for supper and had become anxious and uncooperative and tried to leave the dining room. NA #2 stated that she took Resident #2 to see a family member who also resided at the facility to see if that would calm Resident #2 down. NA #2 stated that after Resident #2 had visited with the family member for a few minutes he had calmed down and NA #2 was able to return Resident #2 to the dining room. NA #2 further stated that when	F 226		

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F 226	Continued From page 49 she returned Resident #2 to the dining room NA #1 asked NA #2 "what is his issue?" NA #2 stated to NA #1 that Resident #2 had delusions that his daughter had been killed. NA #2 stated that NA #1 then approached Resident #2 and got down in his face and stated "that was a stupid reason to hit me and you had no reason to act like way" in a very aggressive and threatening tone. NA #2 also stated that NA #1 was very hateful in the way NA #1 spoke to Resident #2 that evening in the dining room. NA #2 stated she reported this to the Nurse Supervisor at approximately 5:15 PM. Interview with the Nurse supervisor on 03/02/16 at 2:34 PM revealed that on 2/20/16 at approximately 5:15 PM NA #2 reported to him that NA #1 had been very hateful to Resident #2 and was talking very loudly, more loudly than she should have been to Resident #2 in the dining room. Nurse Supervisor confirmed that he had not spoken to the DON but had sent an email notifying him of the incidents that happened on 02/20/16. Nurse Supervisor further stated that his only other action besides talking to NA #1 was to reassign her to another unit for the remainder of her shift. No written statement by Nurse Supervisor about this incident was available. Interview with DON on 03/02/16 at 3:37 PM stated that he was not made aware of the incident until Monday 02/22/16 when he arrived at work and read the email from Nurse Supervisor. The DON confirmed that there was no investigation completed on Resident #2 and the incident was not reported to the North Carolina Health Care Personnel Registry via the 24 hour initial report and 5 working day report. The DON also stated he had not spoken to the NAs that were working that evening about the incident and had not obtained statements from them regarding the incident. The DON further stated that he trusted	F 226		

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F 226	Continued From page 50 the Nurse supervisor because he was present at the time and had a better idea of what happened. The DON stated if any abuse was reported to Nurse Supervisor he should immediately notify the DON. The DON again confirmed this incident was not investigated and was not reported to the Health Care Personnel Registry. Interview with the Administrator on 03/03/16 at 12:08 PM revealed that she was notified by the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON and/or administrator. The administrator went on to say that staff is expected to complete a full investigation that included interviews with all staff involved. The administrator stated that nurse supervisor was fully capable of starting the investigation which should have included the immediate suspension of NA #1. The administrator further stated nurse supervisor should have immediately notified the DON so a thorough investigation could be completed and the incidents reported to the Health Care Personnel Registry via the initial 24 hour report and the 5 working day report as stated in the facility policy. The Administrator stated, after conversations with the DON yesterday, he felt like he should have done something so he filled out and faxed the 24 hour initial report to the Health Care Personnel Registry. The administrator and DON were notified on 03/03/16 at 2:30 PM of immediate jeopardy. The administrator provided acceptable credible allegation of compliance on 03/04/16 at 6:45 PM. Credible Allegation of Compliance F226	F 226		

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F 226	Continued From page 51 (1) On 12/28/15, Resident #6 had a bruise of unknown origin with no 24 hour report or 5 day working report submitted to the NC Health Care Personnel Registry and a thorough investigation was not completed. On 2/20/16 at 11:00pm, Nursing Assistant (NA) #1, who physically and/or verbally abused Residents #1 and #2 on 02/20/16, left the facility after working her entire shift. On 2/22/16 at 3:23pm, the accused NA was suspended (she had not returned to work since leaving on 2/20/16 @ 11:00pm) and was ultimately terminated from employment on 2/26/16 at 1:20pm. On 02/22/16 an investigation was initiated on the abuse of Resident #2 by the Director of Nursing which resulted in termination of NA #1 on 2/26/16 at 1:20pm. On 02/22/16 the family member of Resident #2 was involved in the investigation and was made aware of the investigation initiated on 2/22/16 as well as of the outcome of the investigation on 2/26/16 by the Director of Nursing. On 03/03/16, the Nursing Supervisor was placed on suspension pending further investigation of his role in the allegations of abuse for Residents #1 and #2, which occurred on 02/20/16, for failure to protect residents and properly report resident abuse. As of 03/04/16. The results of this investigation are pending and the Nursing Supervisor will remain on suspension until the investigation is complete. On 03/03/16 at 2:19 pm The 24 hour Health Care Personnel Registry (HCPR) abuse/neglect	F 226		

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F 226	Continued From page 52 investigation report form for Resident #1 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. On 03/03/16 at 2:19pm the 24 hour abuse/neglect investigation report form for Resident #1 was completed and faxed for further investigation of alleged abuse. On 03/03/16 at 3:20pm, Nursing Assistant (NA) #2 and Nursing Assistant (NA) #3 who failed to immediately report allegations of abuse towards Resident #1 and Resident #2 were suspended pending further investigation of their actions related to the allegations. NA #2 and NA #3 received written disciplinary actions for failure to immediately report allegations of abuse according to the Abuse/Neglect policy on 03/04/16 and will return to work as of 03/05/16. On 3/4/16 at 9:00 am, the Director of Nursing completed the NC Board of Nursing Complaint Evaluation Tool to determine reporting requirements for the Nursing Supervisor and obtained a score of 11 which indicated NC Board of Nursing consultation but no requirement for reporting. The Director of Nursing contacted the NC Board of Nursing for the required consultation on 03/04/16 at 10:00am. The Director of Nursing was given a phone appointment for further review on Monday, 3/7/16 at 1:30pm. On 03/04/16 at 5:19pm, the 24 hour Health Care Personnel Registry (HCPR) abuse/neglect investigation report form for Resident #6 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. (2)	F 226		

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F 226	Continued From page 53 Residents #1, #2, and #6 were assessed by the 100 unit Social Services Coordinator on 03/03/16 for any residual effects from the alleged physical/verbal abuse with no concerns noted. An in-service was conducted by the Administrator for all staff on duty on 03/03/16 regarding resident abuse. The in-service agenda included: 1. Revised Abuse & Neglect policy/procedure to: - Immediate removal of the resident from the abusive situation by the employee who witnesses the abuse - Immediate reporting of the abusive situation by the employee who witnesses the abuse to the direct supervisor or any other member of management currently on duty - Immediate suspension of the alleged employee by the direct supervisor or member of management - Immediate reporting of the abusive situation by the direct supervisor or member of management to the Director of Nursing or the Administrator 2. Definitions of physical and verbal abuse including tone of voice and temperament used towards any resident including scenarios of both physical and verbal abuse. 3. Definition of how to make the immediate notification of abuse allegations and the expectation that such allegations will be reported verbally. 4. Expectations for the immediate protection of any resident in which abuse/neglect are suspected. No staff member will be allowed to perform any work-related duties until the In-service has been completed.	F 226		

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F 226	Continued From page 54 On 03/04/16 all residents who are alert and oriented were interviewed by the 100 unit Social Services Coordinator and MDS Coordinators to determine if there were any reports of abuse and/or neglect with no negative responses. On 03/04/16 head to toe skin assessments were completed on all residents (including Residents #1, #2, and #6) to assess for possible signs of abuse by the Nursing Supervisors, MDS Coordinators, and Risk Management Coordinator. Skin assessments revealed no signs of potential abuse. On 03/04/16 at 5:18pm, the Administrator in-serviced the Director of Nursing on his specific role and responsibility in immediately reporting any allegations of abuse/neglect or suspicions of abuse/neglect including bruising of unknown origin and beginning the appropriate investigations in the required timeframe per policy (upon 24 hours of verbal notice). On 03/04/16 at 5:21pm, the Administrator completed the NC Board of Nursing Complaint Evaluation Tool to determine reporting requirements for the Director of Nursing based on his role in the failure to complete the required reporting and investigations of allegations of abuse for Resident #6 and obtained a score of 11 which indicated NC Board of Nursing consultation but no requirement for reporting. The Administrator contacted the NC Board of Nursing for the required consultation on 03/04/16 at 5:28pm and was made aware that the office is closed. The Director of Nursing was suspended on 03/04/16 @ 5:40pm with a pending appointment with the NC Board of Nursing for Monday 03/07/16 for further direction.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	614 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

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F 226	Continued From page 55 On 03/04/16 at 5:45pm, the Administrator in-serviced all Nursing Managers, which includes all shift supervisors, on their specific role in immediately reporting and beginning the appropriate investigation for all reported concerns of potential abuse and/or neglect including bruising of unknown origin. No nursing manager will be allowed to perform any work-related duties until this in-service has been completed. Immediate jeopardy was removed on 03/04/16 at 7:05 PM when staff interviews with nursing staff, administrative staff, and non-nursing staff confirmed that they had received in service training on the immediate reporting of the abusive situation to the direct supervisor or any other member of the management team on duty, the immediate start of a full investigation of the reported abusive situation, and the reporting to the Health Care Personnel Registry in 24 hours and the investigative findings in the 5 working day report.	F 226		