STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		5/5/16

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

Electronically Signed | 05/02/2016

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to thoroughly investigate and submit 24 hour and 5 working reports to the Health Care Personnel Registry for 1 of 3 sampled residents for abuse (Resident #1). The findings included: Resident #1 was admitted to the facility on 02/09/16 with diagnoses of paraplegia and depression and was discharged home on 03/21/16. Review of the admission Minimum Data Set dated 02/16/16 revealed Resident #1 was cognitively intact and had no behaviors or rejection of care during the lookback period. Review of the facility grievance form dated 03/14/16 revealed Resident #1 filed a grievance against Nurse Aide #1 (NA) for being disrespectful to her during care. Resident #1 stated NA#1 came into her room to help her to get into bed and NA #2, who was not supposed to be her room, was hiding in the bathroom and came out to help NA #1 transfer her to bed and they started talking about her and laughing at her. Resident #1 further stated in the grievance that NA #1 was rough with her, pulled her shirt collar to get her into bed and broke something on her electric wheelchair. The grievance revealed the Assistant Director of Nursing (ADON) had Resident #1, her family members and NA #1 come into her office to discuss the incident on 03/14/16. The ADON reported the discussion became very heated and she stopped it. The resolution was for NA #1 to no longer provide	F 225	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 225 INVESTIGATE / REPORT ALLEGATIONS / INDIVIDUALS Corrective Action: Resident #1 On April 13, 2016, the facility initiated and faxed a 24 hour initial report to the Health Care Personnel Registry Section of the North Carolina Department of Health and Human Services, regarding resident #1 (S.G.)□s grievance filed on 3-14-16. The DON, ADON and Social Worker initiated and conducted another investigation into that grievance and then reviewed findings with the Administrator. On April 18, 2016, a follow up 5 working day report was submitted to the Health Care Personnel Registry Section of DHHS. On April 20, 2016, the Administrator was contacted Athena Foreman, HCP Investigator who advised the Department has determined that an investigation will not be conducted	

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F 225	Continued From page 2 care for Resident #1. The grievance further revealed that later in the evening on 03/14/16 Resident #1 was in the hall and told the other NAs she didn't want NA #1 to bring her dinner tray because she might spit in it. Review of the nurse's notes from 02/09/16 through 03/21/16 revealed Resident #1 had no negative behaviors or rejection of care. Review of the Director of Nursing (DON) investigation folder for Resident #1 for incidents on 03/14/16 and 03/16/16 revealed on 03/16/16 the ADON documented NA #1 was passing trays on the 100 hall and took Resident #1's tray into her room and sat it on her over bed table. The documentation stated NA#1 hit Resident #1's hand with the tray and hurt her hand, then ripped the phone cord out of the wall and broke her phone. Resident #1 stated NA#1 harassed her and she called the police and wanted to press charges. The report stated the police came and NA #1 was sent home until further investigation. There was no follow up investigation documentation in the folder for the 03/14/16 incident or the 03/16/16. Review of the facility 24 hour and 5 day reports to the Health Care Personnel Registry (HCPR) for 03/01/16 through 04/12/16 revealed no reports filed for Resident #1 for the incidents of 03/14/16 or 03/16/16. An interview was attempted on 04/12/16 at 1:00 PM with Resident #1, all available phone numbers had been disconnected. During an interview conducted on 04/12/16 at 1:20 PM NA #1 stated she worked the 100 hall on	F 225	in this case. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. All grievances filed within the last three months were reviewed to identify a possible abuse or neglect. If identified as a possible abuse or neglect, files were checked to ensure that a complete investigation was conducted and if required, a 24 hour / 5day report was completed and submitted. This was completed by the Director of Nursing, Social Worker and Administrator as of 5/2/2016. Systemic Changes: As of 5/5/2016 all staff (including contract service staff) were re-educated / in-serviced by the Administrator regarding the facility□s policy on abuse. Topics included, but not limited to: " If a staff member witnesses potential abuse or neglect, the staff member□s first responsibility is to remove the resident from potential harms way. " If a patient, family, visitor or staff member reports that possible / potential abuse or neglect has occurred, the Administrator and or the Director of Nursing must be notified immediately. " If a grievance (written or verbal) stating possible / potential abuse or neglect has occurred, then a complete investigation will be conducted. This investigation should include statements	

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F 225	Continued From page 3 03/16/16 and it was her job to pass supper trays to the residents that ate in their rooms. She stated she took Resident #1's supper tray into her room and set it on her over bed table. She stated she asked Resident #1 if she wanted her to open her tray and set it up and she told her no. NA #1 stated she left Resident #1's room at that point. NA #1 stated Resident #1 was on the phone when she took her tray into her room but stated she did not pull the phone cord out of the wall nor did she drop her cell phone on the floor. NA #1 stated she did not recall bumping Resident #1's hand when she sat her tray down and Resident #1 did not complain of pain at any time she was in the room. NA #1 stated Nurse #1 came to her shortly after she delivered Resident #1's supper tray and asked her what had happened between her and Resident #1. NA #1 stated Nurse #1 told her Resident #1 was very upset and had called the police because NA #1 had hurt her hand/arm and broke her cell phone. NA #1 stated the Unit Manager interviewed her about what had happened and the police came and interviewed her as well. She stated she wrote a statement for the Unit Manager and was sent home for the rest of her shift. NA #1 stated she was never interviewed by the ADON or the DON when she returned to work 2 days later. During an interview conducted on 04/12/16 at 3:57 PM the evening House Supervisor stated he was called to the 100 hall by Nurse #1. He stated she informed him there had been an incident between Resident #1 and NA #1 where Resident #1 had accused NA #1 of hitting her arm with the supper tray and breaking her cell phone. He stated he assessed Resident #1 and found no concerns with injuries or range of motion to her arm and interviewed her about the incident. The	F 225	from all witnesses, the accused and the accuser. " The Abuse and Prohibition policy for how to complete an investigation and reporting abuse / neglect allegations to the NC DHHS HCPR Section. This includes completion and submission of 24 hour and 5 day report. " Investigation files will be kept by the Administrator. All staff who were not inserviced / re-educated as of 5/5/16 on the facility'□s Abuse and Prohibition policy will not be allowed to work until they have been re-educated / inserviced. This information has been integrated into the facility□'s standard orientation training for all newly hired staff. Monitoring: The Director of Nursing and Facility Social Worker will monitor this issue using the QA Survey Tool that will review all grievances submitted to ensure that proper investigations have been completed and that a 24 hour and 5 day reports are submitted if applicable. Any identified issues will be immediately reported to the Administrator or Director or Nursing for appropriate action. This will be done on a daily basis if an allegation of abuse or neglect is reported and then documented on the QA Survey Tool. All grievances are reviewed daily for potential allegations of abuse or neglect. This will be documented daily for 2 weeks, then	

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F 225	Continued From page 4 House Supervisor stated Resident #1 wanted to go to the hospital due to arm pain and she had called the police to come to the facility. He stated he then interviewed NA #1 and had her write a statement. The House Supervisor stated the police and the Emergency Management System (EMS) arrived at the facility and assessed and questioned Resident #1 and the police questioned NA #1. He stated Resident #1 did not go out to the hospital and when the police finished questioning NA #1 he sent her home due to the abuse allegation until the investigation could be completed by the ADON and the DON. He stated he called the ADON and the DON to inform them of the incident. The House Supervisor further stated that later on in the evening Resident #1 came to him and asked for transportation to be called to take her to the police station because she wanted to press charges. He stated he called the DON and was instructed to tell Resident #1 transportation would not come out that late but they could call early the next morning. During an interview conducted on 04/12/16 at 4:21 PM Nurse #1 stated a NA informed her on 03/16/16 that Resident #1 was very upset at NA #1. Nurse #1 stated she went to see Resident #1 and she was very upset and stated NA #1 had hit her arm when she put her supper tray down on the table and she had pulled the phone cord out of the wall while she was talking to her family. Nurse #1 stated Resident #1 also told her NA #1 had broken her cell phone. Nurse #1 stated she immediately called the ADON to inform her of the incident and was told NA #1 could not provide direct care to Resident #1 but she had not been told she could not deliver meal trays to her. Nurse #1 stated she was not aware NA #1 was not to	F 225	weekly for 1 month and then monthly until resolved by Quality Assurance Committee, however, this will continue to be an ongoing process. Reports will be presented to the weekly QA committee by the Administrator, DON or designee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, Wound Care Nurse, MDS Coordinator, RN Unit Managers, Support Nurse, Therapy Director, HIM, Dietary Manager and the Administrator. Date of Compliance: May 5, 2016	

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F 225	Continued From page 5	F 225		

provide care to Resident #1. Nurse #1 stated she called the House Supervisor and he came to the 100 hall and took over the investigation. Nurse #1 stated she was never interviewed by the ADON or the DON about the incident.

During an interview on 04/12/16 at 4:51 PM NA #3 stated she cared for Resident #1 on the 3:00 PM to 11:00 PM on 03/16/16. NA #3 stated she was helped in the dining room during supper and when she returned to the hall NA #2 told her Resident #1 was very upset. NA #3 stated she went in to check on Resident #1 and she had never seen her that upset. She stated Resident #1 was normally very pleasant and happy. NA #3 stated Resident #1 told her NA #1 had brought her supper tray in and hit her arm with it, pulled the phone cord out of the wall and broke her cell phone and that she was going to sue the facility and she had called the police. NA #3 stated no one had interviewed her about the incident and she was not interviewed by the police when they came.

During an interview conducted on 04/13/16 at 1:59 PM the ADON stated she was informed Resident #1 wanted to see her on 03/14/16. She stated when she spoke to Resident #1 she revealed NA #1 had harassed her. The ADON stated she asked Resident #1 and NA #1 to come to her office so they could discuss the issue together. She stated Resident #1 brought her family with her and the discussion became very heated between Resident #1, her family and NA #1 so the she stopped the discussion and made the resolution that NA #1 would no longer provide care to Resident #1. The ADON stated all parties were in agreement. The ADON stated she did not let the nursing staff on the 100 hall know NA #1

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F 225	Continued From page 6 could not provide care for Resident #1. The ADON stated she was called on 03/16/16 by Nurse #1 and the House Supervisor and informed of the allegation that NA #1 had hit Resident #1's arm with the supper tray, pulled the phone cord out of the wall and broke her cell phone and that the House Supervisor had sent NA #1 home. She stated she did not feel the need to come into the facility due to NA #1 being sent home and she was not involved in the investigation. During an interview conducted on 04/13/16 at 2:21 PM the DON stated she received a call from the House Supervisor on 03/16/16 to inform her of Resident #1's allegation that NA #1 had hit her with the supper tray and hurt her arm, pulled the phone cord out of the wall and broke her cell phone. She stated she did not go into the facility that evening because she felt the House Supervisor had handled the situation appropriately by assessing the resident and taking statements from Resident #1 and the NA #1 and sending NA #1 home due to the allegation. The DON stated she spoke to Resident #1 on 03/17/16 and she no longer wished to press charges against NA #1. The DON stated she also spoke to Resident #1's roommate but she had not seen what had happened the night before. The DON stated she was involved with another investigation at the time and did interview any other staff or NA #1 about the incident on 03/16/16 and did not follow up on the incident according to the facility policy. She further stated she should have filed a 24 hour and 5 day report to HCPR due to the allegation of abuse by Resident #1.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		5/5/16

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F 226	Continued From page 7 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 review and staff interviews the facility failed to implement their abuse policy and procedures to thoroughly investigate an allegation of staff to resident abuse and submit 24 hour and 5 working day reports to the Health Care Personnel Registry for 1 of 3 residents reviewed for abuse (Resident #1) The findings included: Review of the facility's policy titled "Abuse Prohibition" with a revised date of 09/2013 revealed in part under Reportable Incidents that any allegations (regardless of whether the allegations are substantiated) against any personnel, including injuries of unknown origin that appear to involve the conduct of abuse, neglect, misappropriating property of the patient or the facility, committing fraud against a patient or facility or diverting drugs belonging to the patient or facility, must be reported to the Health Care Personnel Registry (HCPR) via the 24 hour and 5 day report. Resident #1 was admitted to the facility on 02/09/16 with diagnoses of paraplegia and depression and was discharged home on 03/21/16.	F 226	F 226 DEVELOP / IMPLEMENT ABUSE / NEGLECT, ETC. POLICIES Corrective Action: Resident #1 On April 13, 2016, the facility initiated and faxed a 24 hour initial report to the Health Care Personnel Registry Section of the North Carolina Department of Health and Human Services, regarding resident #1 (S.G.)□s grievance filed on 3-14-16. The DON, ADON and Social Worker initiated and conducted another investigation into that grievance and then reviewed findings with the Administrator. On April 18, 2016, a follow up 5 working day report was submitted to the Health Care Personnel Registry Section of DHHS. On April 20, 2016, the Administrator was contacted Athena Foreman, HCP Investigator who advised the Department has determined that an investigation will not be conducted in this case. Identification of other residents who may be involved with this practice:	

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F 226	Continued From page 8 Review of the admission Minimum Data Set dated 02/16/16 revealed Resident #1 was cognitively intact and had no behaviors or rejection of care during the lookback period. Review of the facility grievance form dated 03/14/16 revealed Resident #1 filed a grievance against Nurse Aide #1 (NA) for being disrespectful to her during care. Resident #1 stated NA#1 came into her room to help her to get into bed and NA #2, who was not supposed to be in her room because Resident #1 had requested that NA#2 not be allowed to work with her, was in her room and helped NA #1 transfer her to bed and they started talking about her and laughing at her. Resident #1 further stated in the grievance that NA #1 was rough with her, pulled her shirt collar to get her into bed and broke something on her electric wheelchair. The grievance revealed the Assistant Director of Nursing (ADON) had Resident #1, her family members and NA #1 come into her office to discuss the incident on 03/14/16. The ADON reported the discussion became very heated and she stopped it. The resolution was for NA #1 to no longer provide care for Resident #1. The grievance further revealed that later in the evening on 03/14/16 Resident #1 was in the hall and told the other NAs she didn't want NA #1 to bring her dinner tray because she might spit in it. Review of the nurse's notes from 02/09/16 through 03/21/16 revealed Resident #1 had no negative behaviors or rejection of care. Review of the Director of Nursing (DON) investigation folder for Resident #1 for incidents on 03/14/16 and 03/16/16 revealed on 03/16/16 the ADON documented NA #1 was passing trays	F 226	All residents have the potential to be affected by this practice. All grievances filed within the last three months were reviewed to identify a possible abuse or neglect. If identified as a possible abuse or neglect, files were checked to ensure that a complete investigation was conducted and if required, a 24 hour / 5day report was completed and submitted. This was completed by the Director of Nursing, Social Worker and Administrator as of 5/2/2016. Systemic Changes: As of 5/5/2016 all staff (including contract service staff) were re-educated / in-serviced by the Administrator specifically regarding the facility□s policy and procedures on Abuse Prohibition and Abuse Prevention Guidelines. Topics included, but not limited to: " If a staff member witnesses potential abuse or neglect, the staff member□s first responsibility is to remove the resident from potential harms way. " If a patient, family, visitor or staff member reports that possible / potential abuse or neglect has occurred, the Administrator and or the Director of Nursing must be notified immediately. " If a grievance (written or verbal) stating possible / potential abuse or neglect has occurred, then a complete investigation will be conducted. This investigation should include statements from all witnesses, the accused and the accuser. " The Abuse and Prohibition policy for	

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F 226	Continued From page 9 on the 100 hall and took Resident #1's tray into her room and sat it on her over bed table. The documentation stated NA#1 hit Resident #1's hand with the tray and hurt her hand, then ripped the phone cord out of the wall and broke her phone. Resident #1 stated NA#1 harassed her and she called the police and wanted to press charges. The report stated the police came and NA #1 was sent home until further investigation. There was no follow up investigation documentation in the folder for the 03/14/16 incident or the 03/16/16. Review of the facility 24 hour and 5 day reports to the Health Care Personnel Registry (HCPR) for 03/01/16 through 04/12/16 revealed no reports filed for Resident #1 for the incidents of 03/14/16 or 03/16/16. During an interview conducted on 04/12/16 at 12:20 PM NA#2 stated she helped NA #1 get Resident #1 back into bed on 03/16/16. She stated NA #1 was not rough with Resident #1 and they did not talk, laugh or giggle about Resident #1 when transferring her to bed. During an interview conducted on 04/12/16 at 1:20 PM NA #1 stated she worked the 100 hall on 03/16/16 and it was her job to pass supper trays to the residents that ate in their rooms. She stated she took Resident #1's supper tray into her room and set it on her over bed table. She stated she asked Resident #1 if she wanted her to open her tray and set it up and she told her no. NA #1 stated she left Resident #1's room at that point. NA #1 stated Resident #1 was on the phone when she took her tray into her room but stated she did not pull the phone cord out of the wall nor did she drop her cell phone on the floor. NA #1	F 226	how to complete an investigation and reporting abuse / neglect allegations to the NC DHHS HCPR Section. This includes completion and submission of 24 hour and 5 day report. " Investigation files will be kept by the Administrator. All staff who were not inserviced / re-educated as of 5/5/16 on the facility□'s Abuse and Prohibition policy will not be allowed to work until they have been re-educated / inserviced. This information has been integrated into the facility'□s standard orientation training for all newly hired staff. Monitoring: The Director of Nursing and Facility Social Worker will monitor this issue using the QA Survey Tool that will review all grievances submitted to ensure that proper investigations have been completed and that a 24 hour and 5 day reports are submitted if applicable. Any identified issues will be immediately reported to the Administrator or Director or Nursing for appropriate action. This will be done on a daily basis if an allegation of abuse or neglect is reported and then documented on the QA Survey Tool. All grievances are reviewed daily for potential allegations of abuse or neglect. This will be documented daily for 2 weeks, then weekly for 1 month and then monthly until resolved by Quality Assurance Committee, however, this will continue to	

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ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

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F 226	Continued From page 10 stated she did not recall bumping Resident #1's hand when she sat her tray down and Resident #1 did not complain of pain at any time she was in the room. NA #1 stated Nurse #1 came to her shortly after she delivered Resident #1's supper tray and asked her what had happened between her and Resident #1. NA #1 stated Nurse #1 told her Resident #1 was very upset and had called the police because NA #1 had hurt her hand/arm and broke her cell phone. NA #1 stated the Unit Manager interviewed her about what had happened and the police came and interviewed her as well. She stated she wrote a statement for the Unit Manager and was sent home for the rest of her shift. NA #1 stated she was never interviewed by the ADON or the DON when she returned to work 2 days later. During an interview conducted on 04/12/16 at 4:21 PM Nurse #1 stated a NA informed her on 03/16/16 that Resident #1 was very upset at NA #1. Nurse #1 stated she went to see Resident #1 and she was very upset and stated NA #1 had hit her arm when she put her supper tray down on the table and she had pulled the phone cord out of the wall while she was talking to her family. Nurse #1 stated Resident #1 also told her NA #1 had broken her cell phone. Nurse #1 stated she immediately called the ADON to inform her of the incident. Nurse #1 stated she called the House Supervisor and he came to the 100 hall and took over the investigation. Nurse #1 stated she was never interviewed by the ADON or the DON about the incident. During an interview conducted on 04/12/16 at 3:57 PM the evening House Supervisor stated he was called to the 100 hall by Nurse #1. He stated she informed him there had been an incident	F 226	be an ongoing process. Reports will be presented to the weekly QA committee by the Administrator, DON or designee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, Wound Care Nurse, MDS Coordinator, RN Unit Managers, Support Nurse, Therapy Director, HIM, Dietary Manager and the Administrator. Date of Compliance: May 5, 2016	

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F 226	Continued From page 11	F 226		

between Resident #1 and NA #1 where Resident #1 had accused NA #1 of hitting her arm with the supper tray and breaking her cell phone. He stated he assessed Resident #1 and found no concerns with injuries or range of motion to her arm and interviewed her about the incident. The House Supervisor stated Resident #1 wanted to go to the hospital due to arm pain and she had called the police to come to the facility. He stated he then interviewed NA #1 and had her write a statement. The House Supervisor stated the police and the Emergency Management System (EMS) arrived at the facility and assessed and questioned Resident #1 and the police questioned NA #1. He stated Resident #1 did not go out to the hospital and when the police finished questioning NA #1 he sent her home due to the abuse allegation until the investigation could be completed by the ADON and the DON. He stated he called the ADON and the DON to inform them of the incident. The House Supervisor further stated that later on in the evening Resident #1 came to him and asked for transportation to be called to take her to the police station because she wanted to press charges. He stated he called the DON and was instructed to tell Resident #1 transportation would not come out that late but they could call early the next morning.

During an interview on 04/12/16 at 4:51 PM NA #3 stated she cared for Resident #1 on the 3:00 PM to 11:00 PM on 03/16/16. NA #3 stated she was helped in the dining room during supper and when she returned to the hall NA #2 told her Resident #1 was very upset. NA #3 stated she went in to check on Resident #1 and she had never seen her that upset. She stated Resident #1 was normally very pleasant and happy. NA #3

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F 226	Continued From page 12	F 226		

stated Resident #1 told her NA #1 had brought her supper tray in and hit her arm with it, pulled the phone cord out of the wall and broke her cell phone and that she was going to sue the facility and she had called the police. NA #3 stated no one had interviewed her about the incident and she was not interviewed by the police when they came.

During an interview conducted on 04/13/16 at 1:59 PM the ADON stated she was informed Resident #1 wanted to see her on 03/14/16. She stated when she spoke to Resident #1 she revealed NA #1 had harassed her. The ADON stated she asked Resident #1 and NA #1 to come to her office so they could discuss the issue together. She stated Resident #1 brought her family with her and the discussion became very heated between Resident #1, her family and NA #1 so the she stopped the discussion and made the resolution that NA #1 would no longer provide care to Resident #1. The ADON stated all parties were in agreement. The ADON stated she did not let the nursing staff on the 100 hall know NA #1 could not provide care for Resident #1. The ADON stated she was called on 03/16/16 by Nurse #1 and the House Supervisor and informed of the allegation that NA #1 had hit Resident #1 ' s arm with the supper tray, pulled the phone cord out of the wall and broke her cell phone and that the House Supervisor had sent NA #1 home. She stated she did not feel the need to come into the facility due to NA #1 being sent home and she was not involved in the investigation.

During an interview conducted on 04/13/16 at 2:21 PM the DON stated she received a call from the House Supervisor on 03/16/16 to inform her of Resident #1's allegation that NA #1 had hit her

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F 226	Continued From page 13 with the supper tray and hurt her arm, pulled the phone cord out of the wall and broke her cell phone. She stated she did not go into the facility that evening because she felt the House Supervisor had handled the situation appropriately by assessing the resident and taking statements from Resident #1 and the NA #1 and sending NA #1 home due to the allegation. The DON stated she spoke to Resident #1 on 03/17/16 and she no longer wished to press charges against NA #1. The DON stated she also spoke to Resident #1's roommate but she had not seen what had happened the night before. The DON stated she was involved with another investigation at the time and did interview any other staff or NA #1 about the incident on 03/16/16 and did not follow up on the incident according to the facility policy. She further stated she should have filed a 24 hour and 5 day report to HCPR due to the allegation of abuse by Resident #1.	F 226		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		5/5/16

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F 514	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have documentation in the resident's medical record concerning an allegation of staff to resident abuse resulting in a call to the police for 1 of 3 residents reviewed for abuse (Resident #1). The findings included: Resident #1 was admitted to the facility on 02/09/16 with diagnoses of paraplegia and depression. Review of the admission Minimum Data Set dated 02/16/16 revealed Resident #1 was cognitively intact and had no behaviors or rejection of care during the lookback period. Review of the facility grievance form dated 03/14/16 revealed Resident #1 filed a grievance against Nurse Aide #1 (NA) for being disrespectful to her during care. Resident #1 stated NA#1 came into her room to help her to get into bed and NA #2, who was not supposed to be her room, was hiding in the bathroom and came out to help NA #1 transfer her to bed and they started talking about her and laughing at her. Resident #1 further stated in the grievance that NA #1 was rough with her, pulled her shirt collar to get her into bed and broke something on her electric wheelchair. The grievance revealed the Assistant Director of Nursing (ADON) had Resident #1, her family members and NA #1 come into her office to discuss the incident on 03/14/16. The ADON reported the discussion became very heated and she stopped it. The	F 514	F 514 RESIDENT RECORDS □ COMPLETE / ACCURATE / ACCESSIBLE Corrective Action: Resident #1 On April 13, 2016, the facility initiated and faxed a 24 hour initial report to the Health Care Personnel Registry Section of the North Carolina Department of Health and Human Services, regarding resident #1 (S.G.)□s grievance filed on 3-14-16. The DON, ADON and Social Worker initiated and conducted another investigation into that grievance and then reviewed findings with the Administrator. On April 18, 2016, a follow up 5 working day report was submitted to the Health Care Personnel Registry Section of DHHS. On April 20, 2016, the Administrator was contacted Athena Foreman, HCP Investigator who advised the Department has determined that an investigation will not be conducted in this case. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. On 5/2/2016 the Director of Nursing reviewed all potential allegations of abuse or neglect that may have occurred in the last three months to	

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F 514	Continued From page 15 resolution was for NA #1 to no longer provide care for Resident #1. The grievance further revealed that later in the evening on 03/14/16 Resident #1 was in the hall and told the other NAs she didn't want NA #1 to bring her dinner tray because she might spit in it. Review of the Director of Nursing (DON) investigation folder for Resident #1 for incidents on 03/14/16 and 03/16/16 revealed on 03/16/16 the ADON documented NA #1 was passing trays on the 100 hall and took Resident #1's tray into her room and sat it on her over bed table. The documentation stated NA#1 hit Resident #1's hand with the tray and hurt her hand, then ripped the phone cord out of the wall and broke her phone. Resident #1 stated NA#1 harassed her and she called the police and wanted to press charges. The report stated the police and the paramedics came to the facility and NA #1 was sent home until further investigation. There was no follow up investigation documentation in the folder for the 03/14/16 incident or the 03/16/16. Review of the nurse's notes from 03/16/16 through 03/21/16 revealed no documentation of Resident #1's allegation of physical abuse by NA #1 or an assessment of Resident #1 after the allegation was made on 03/16/16. During an interview conducted on 04/12/16 at 4:21 PM Nurse #1 stated a NA informed her on 03/16/16 that Resident #1 was very upset at NA #1. Nurse #1 stated she went to see Resident #1 and she was very upset and stated NA #1 had hit her arm when she put her supper tray down on the table and she had pulled the phone cord out of the wall while she was talking to her family. Nurse #1 stated Resident #1 also told her NA #1	F 514	validate that a nursing note was documented regarding either the physical or mental status, or change in condition of the resident if applicable. Systemic Changes: As of 5/5/2016 the Nursing Administration Team including Director of Nursing, Assistant Director of Nursing and RN Unit Managers and/or designee inserviced the full time, part time and PRN, RNs, and LPNs. Topics included, but were not limited to: " Anytime a resident, family, visitor or staff report an allegation of abuse or neglect the Administrator and/or DON must be notified immediately. " The nurse on duty should complete an assessment of the patient and document that assessment or change in condition (if any) in the progress note in the electronic health records. " Nursing will document on any significant event, change in behavior and/or any changes found from completion of a new assessment on all residents that reported a potential allegation of abuse or neglect. This information has been integrated into the facility□'s standard orientation training for all newly hired staff. Monitoring:	

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F 514	Continued From page 16 had broken her cell phone. Nurse #1 stated she immediately called the ADON to inform her of the incident and then called the House Supervisor, who came to the 100 hall and took over the investigation. Nurse #1 stated she did not write a nurse's note regarding Resident #1's allegation of physical abuse by NA #1 or that Resident #1 had been assessed by the paramedics. During an interview conducted on 04/12/16 at 3:57 PM the evening House Supervisor stated he conducted the investigation of Resident #1's allegation of physical abuse against NA #1 on 03/16/16. He stated he wrote a statement for the DON but did not write a nurse's note regarding his assessment of Resident #1 in her medical record. He stated he should have made a nurse's note regarding his physical assessment of Resident #1. During an interview conducted on 04/13/16 at 2:21 PM the DON stated she would have expected to see a nurse's note regarding the assessment of Resident #1 on 03/16/16. She stated a note should be written any time there was a change in condition or status of a resident.	F 514	The Director of Nursing, ADON, Unit Manager or designee will monitor this issue using the QA Survey Tool. All residents that have had an allegation of abuse or neglect reported will be reviewed to ensure that a progress note has been entered into the medical record with an assessment. Any identified issues will be immediately reported to the Administrator or Director or Nursing for appropriate action. This will be done on a daily basis if an allegation of abuse or neglect is reported and then documented on the QA Survey Tool. All grievances are reviewed daily for potential allegations of abuse or neglect. This will be documented daily for 2 weeks, then weekly for 1 month and then monthly until resolved by Quality Assurance Committee, however, this will continue to be an ongoing process. Reports will be presented to the weekly QA committee by the Administrator, DON or designee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Date of Compliance: May 5, 2016	