STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING ______ B. WING ______	C 11/30/2018

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CAROLINA CARE HEALTH AND REHABILITATION	**111 HARRILSON STREET CHERRYVILLE, NC 28021**

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F 000	INITIAL COMMENTS A complaint survey was conducted from 11/28/18 through 11/30/18. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.12 at tag F607 at a scope and severity J Tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/28/18 and was removed on 11/30/18. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews and staff and Nurse Practitioner (NP) interviews it was determined that the facility failed to protect a resident's right to be free of sexual	F 600	F600 Free from Abuse and Neglect CFR(s):483.12(a)(1) 483.12 Freedom from Abuse, Neglect,	12/21/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/18/2018

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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abuse for 2 of 3 (Residents #2 and #3) residents reviewed for abuse. Resident #2, a cognitively impaired resident, was observed having oral sex with Resident #1. Resident #3, a cognitively impaired resident, was observed to have her breast squeezed by Resident #1. Residents #2 and #3 were assessed at the facility and found to have no physical injuries.

Immediate Jeopardy began on 10/28/18 when Resident #1 rolled Resident #2 in her wheel chair to her room and the residents were observed by staff having oral sex. Immediate Jeopardy began on 11/28/18 for Resident #3 when Resident #1 rolled her in her wheel chair to his room and he was observed by staff to squeeze her breast. Immediate Jeopardy was removed on 11/30/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training.

The findings included:

1. Resident #1 was admitted to the facility on 11/08/11 with diagnosis including unspecified dementia without behavioral disturbance, bipolar disturbance and major depressive disorder.

Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/12/18 revealed he scored a 13 on the brief interview of mental status (BIMS) indicating that he had no cognition impairments. No inappropriate behaviors were noted during the assessment period. He required

F 600

and Exploitation
Disclaimer Clause:
Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law.
On October 28, 2018, nurse removed resident #1 from resident #2s room. Nurse completed head to toe assessment to ensure no physical harm. Resident #2 was monitored by staff to be free from contact from resident # 1. Family for Resident # 2 notified of incident. Police called and notified of incident. Family took resident #1 home for the night.
On October 29, 2018 Administrator started resident on one to one supervision for 24 hours, after family returned resident to facility. After 24 hours, facility then started 15-minute checks ongoing on resident # 1s location. Social worker/designee in serviced all facility on action plan to monitor resident #1 regarding being around female residents. Administrator issued 30-day discharge notice to resident # 1 for being a danger to himself and others as well as resident level of care no longer requires Skilled Nursing Care. Social Worker began seeking ALF placement for resident #1
On October 30, 2018 Female residents on hall where Resident # 2 resided were interviewed by Social Worker or designee for any signs of abuse. None were reported.

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F 600	Continued From page 2 set up help only with walking in corridor. The resident was also as assessed as having no limitations with range of motion. Review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/14/16 and was reviewed by staff on 9/06/18: "Mr. (Resident #1's last name) was previously reported by staff and then his own self admission of inappropriate touching of female residents. He has signed a behavioral contract that he will not engage in such behavior or risk discharge." The goal was for Resident #1 will not exhibit socially inappropriate/disruptive behavior. Care plan approaches included; "Assess whether the behavior endangers the resident and/or others. Intervene if necessary", "If Mr. (Resident #1) begins to become socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate/disruptive behaviors when around others." Further review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/24/16 and was most recently reviewed by staff on 9/06/18: "Mr. (Resident #1's last name) took a female resident who had significant physical limitation outside of facility when he had been told that until this issues was decided by ADMINISTRATION he was not to take any female outside of facility." The goal was for Resident #1 not to harm others secondary to inappropriate behavior. A care plan approach included; "Staff will do an adjustment to his previous behavioral contract and all parties will sign."	F 600	On November 5, 2018 Social Worker/ designee in serviced staff on facility abuse policy regarding sexual abuse and resident□s right to be free from abuse. On November 8, 2018 Discharge appeal was held at 1:00pm. On December 1, 2018, appeal decision received by facility. On November 28, 2018, nurse removed resident #3 from resident # 1's room. Nurse completed head to toe assessment to ensure no physical harm. Resident 3 was monitored by staff to be free from contact from resident # 1. Family for Resident # 3 notified of incident on November 28, 2018. Police called and notified of incident on November 28, 2018. Administrator amended plan to 1:1 supervision for resident # 1 until ALF placement is secured. Administrator initiated immediate discharge of resident #1 to family. Social Worker to seek placement in ALF. Social Worker/ designee in serviced all staff on November 28-30, 2018 on facility abuse policy regarding sexual abuse and resident right to be free from any abuse at all times. On December 5, 2018 Rehab Director in serviced all rehab staff regarding resident # 1 being around or pushing female residents in wheelchair On November 29, 2018 Social worker/ appointed designee's and interviewed all interviewable female residents throughout facility. On November 30, 2018, all non-interviewable residents were assessed head to toe by Director of	

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Review of Resident #1's behavioral contact that was signed by Resident #1, his Power of Attorney and facility staff members on 10/26/16 specified the following; "I (Resident #1's name) understand that my previous behavioral agreement signed 4/15/16 remains in effect as long as I am a resident here. That agreement was that I understood that if I touched any female in an inappropriate manner that I would be discharged from Carolina Care Center. Today I understand that I am signing an addendum to that agreement. I agree that I will not take any female resident outside of facility. I understand that I am free to socialize with other residents in public areas inside the facility with their consent. I understand that I can attend supervised out of facility events with other residents. I understand that inappropriate touching of females and taking females outside of facility without administration consent could result in discharge from Carolina Care Center."

a. Review of Resident #1's progress notes revealed a nursing note dated 10/28/18 at 5:33 PM, written by Nurse #1 which stated, "CNA (certified nursing assistant) reported resident feeling on another female residents breasts (Resident #2) and then whispered in her ear and took her to her room. Nurse went to room and female resident was sitting up in wheelchair in front of bathroom with head moving back and forth and resident was standing in front of her with his zipper open, penis out and residents penis was in her mouth. When I asked them what they were doing she states, 'I'm just doing what all other adults do.' He didn't say anything but 'yeah.' Asked resident to leave room at this time. Educated resident he was not allowed to go back down to her room and that he had violated his

F 600

Nursing or designee.

Administrator or designee began randomly interviewing 4 residents 5 times per week for any potential abuse and reporting to include if resident has ever experienced abuse at facility for 1 month then 3 days per week for 1 month then 1 time per week for 1 month and 2 times per month for 3 months. Administrator updated QAPI Committee to change of 1:1 and reviewed findings for any further corrections.

Administrator conducted in service for department managers on importance of reporting and completing 24/5-day report timely 12-14-18. All Licensed Nursing staff will be in-serviced on reporting abuse within 2 hours 12-21-18.

Administrator or designee will monitor 4 staff members 5 days a week for one month, then 4 staff members 3 days a week for 1 month, then 4 staff members 1 time a week for one month, then 4 staff members 2 times a month for 3 months. Administrator or designee will review Allegation log sheet daily for 3 weeks and weekly thereafter for 3 months. Copies of reportable allegations will be given to Regional Manager or designee to review for timeliness.

Reports will be reviewed in monthly QAPI meeting monthly for 6 months. IDT team will make any necessary changes to monitoring as needed during monthly QAPI.

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behavior contract. Resident walked out of room at this time and went to his room."

Review of Resident #2's medical record revealed she was admitted to the facility on 06/05/17. Resident #2 diagnoses which included; dementia without behavioral disturbance, major depressive disorder, anxiety disorder and female sexual arousal disorder.

Review of Resident #2's quarterly MDS dated 10/18/18 revealed she had a BIMS (Brief Interview for Mental Status) score of 8 (which indicated moderately impaired cognition), required supervision with set up help only with locomotion on the unit, required extensive assistance with one person physical assistance with transfers and used a wheelchair as a mobility device.

Review of Resident #2's care plan revealed the following "Problem" was initiated on 10/16/18: "Decision making: (Resident #2's first name) has difficulty making her own safe/appropriate decisions, long and short term memory deficit is noted." The goal specified, "(Resident #2's first name) will suffer no loss of dignity due to memory loss." Approaches included; "Assist to reminisce and redirect as much as possible to decrease further decline in cognition."

Review of Resident #2's progress notes revealed a nursing note, written by Nurse #1, on 10/28/18 at 5:18 PM which specified the following; "CNA (certified nursing assistant) reported another resident feeling on residents breasts and then whispered in her ear and took her to her room. Nurse went to room and resident was sitting up in wheelchair in front of bathroom with head moving

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back and forth and the other resident standing in front of her with his zipper open, penis out and residents penis was in her mouth. When I asked them what they were doing she states, 'I'm just doing what all other adults do.' Asked other resident to leave room at that time. She states, 'I wanted to do it and then grabbed his arm and was telling him to come back to her bed later.' Explained to resident he was not allowed to go back down to her room. Removed other resident at this time. Sitting up in her room NAD (no apparent distress)." The note also specified Resident #2's family was made aware.

Review of the facility's "Investigation Report" signed by the Director of Nurses (DON) revealed Resident #1 was alert and oriented in all spheres with a BIMS of 13 with no short term or long term memory problems. Resident #2 was assessed as having a BIMS of 8 with short term and long term memory problems. The investigation specified that Resident #1 was interviewed by the police on 10/28/18 and he admitted to being in female resident's room and having inappropriate contact with resident. The investigation report specified Resident #2 was unable to remember the incident when interviewed by the police.

Observations and an interview with Resident #1 on 11/28/18 at 3:55 PM revealed he was able to ambulate independently and was able to verbally answer questions. During the interview with Resident #1 he stated he remembered he had inappropriate contact with a female resident a month or so ago, but denied inappropriately touching of any female residents since this incident which occurred a month ago.

Observations of Resident #2 on 11/28/18 at 4:15

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PM revealed she was seated in her wheel chair and was pleasantly confused. Resident #2 did not recall what day it was or what she ate for lunch that day. Resident #2 also did not recall any incidents of inappropriate behaviors being exhibited by male residents or staff members towards her.

Interview with the facility's Social Worker (SW) on 11/30/18 at 12:40 PM revealed Resident #1 was alert and oriented and could consent to engage in sexual activity, but Resident #2 was cognitively impaired and was unable to consent to sexual activity.

Review of an Investigation-employee statement written by Nurse Aide (NA) #1 dated and signed 10/28/18 stated NA #1 saw Resident #1 bending over Resident #2 and touching Resident #2's breasts in the hallway and started rolling to her room in her wheelchair and immediately reported it to her supervisor.

During interview on 11/30/18 at 12:05 PM with NA #1 she stated on 10/28/18 she observed Resident #1 rolling Resident #2 in her wheelchair in the hallway. She specified that she was seeing the residents from behind, so she could not see if Resident #1 was touching Resident #2's breasts, but his hand was draped over her shoulder. She stated she did not verbally tell Resident #1 to stop rolling Resident #2 in her wheel chair because they were too far ahead of her, but she followed them and found them together in Resident #2's room. NA #1 stated she could hear the residents from the room's open doorway and it sounded like they were having oral sex. NA #1 stated she peeked in the doorway and she could not directly see what they were doing because they were

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F 600	Continued From page 7 around the corner in the room, but from what she could hear it sounded like they were engaged in oral sex. NA #1 stated she was so shocked from what she heard and could see that she did not say anything to the residents or attempt to stop them, but immediately went to report it to the Unit Manager (Nurse #1). NA #1 stated the Unit Manager (Nurse #1) quickly responded to her request to check on Resident #1 and Resident #2. NA #1 stated she was now aware that she should have immediately interrupted and stopped Resident #1 and Resident #2, separated the residents and then reported their activity to the Unit Manager. During an interview on 11/30/18 at 3:32 PM with Nurse #1 (Unit Manager) she stated that during the evening of 10/28/18 NA #1 asked her to go to Resident #2's room because she saw Resident #1 touching Resident #2's breasts in the hallway and they were now in Resident #2's room. Nurse #1 stated she went to the room, knocked on the room's opened door and when she entered Resident #2's room she observed Resident #1's and Resident #2 engaged in oral sex. Nurse #1 stated she observed Resident #1's penis in Resident #2's mouth. Nurse #1 stated she asked the residents what they were doing and they stopped. Nurse #1 stated she told Resident #1 to go to his room and she immediately reported this to the Director of Nursing (DON) and administrator. Interview with the facility's DON on 11/28/18 at 4:35 PM revealed during the evening of 10/28/18 Nurse #1 called her and informed her that Resident #1 and Resident #2 were observed having oral sex in Resident #2's room. The DON stated Resident #1 had previously exhibited	F 600		

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inappropriate touching of a female resident and he was aware of his actions. So, the facility placed Resident #1 on 1 on 1 direct staff observation for 24 hours to monitor his behaviors in an effort to protect Resident #2 and other residents. The DON specified the facility started an abuse investigation and the local police department was notified about the incident.

Interview with the DON on 11/29/18 at 4:30 PM revealed staff are trained if they see abuse in any form they are to keep the resident safe, ask the abuser to leave and not leave the resident alone. The DON stated NA #1 should have immediately stopped Resident #1 and Resident #2 on 10/28/18 when the residents were alone in a room together and NA #1 thought they were engaged in sexual activity.

Review of the police incident/investigation report revealed the police responded in reference to a report of a sexual assault at the facility on 10/28/18 at 6:21 PM. The report specified; "Suspect engaged in a sex act with victim" and listed Resident #2 as the victim.

During interview with the Administrator on 11/29/18 at 8:40 AM she stated when she was informed of Resident #1 and Resident #2's being observed engaged in oral sex in Resident #2's room on 10/28/18 she immediately came to the facility. The administrator stated the police were notified of the incident during the evening of 10/28/18 and an officer came to the facility to investigate. The administrator stated Resident #1's family was notified and they took him home for the night. Upon his return to the facility on 10/29/18 the resident was placed on 1 on 1 direct staff to resident monitoring for the first 24 hours

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and then was placed on 15 minute staff checks to monitor the resident's behaviors.

During another interview with the administrator on 11/29/18 at 4:05 PM, the administrator stated, on 10/28/18 NA #1 should have stopped Resident #1 and Resident #2 when she heard the residents together in Resident #2's room and she thought they were having inappropriate relations instead of going to report what she thought the residents were doing to Nurse #1. The administrator stated, Resident #1 should not be allowed to roll resident's in their wheel chairs and if he was observed doing this staff should stop him. She stated Resident #1's inappropriate behaviors had been shared with department managers at morning stand up meetings which are attended by department managers. The administrator stated her expectation was for the department managers to share any concerns, such as Resident #1's inappropriate behaviors of touching female residents and rolling other residents in their wheel chairs, with the employees in their department to protect the residents in the facility. The administrator stated Resident #1 would remain on 1 on 1 direct staff monitoring until he is discharged from the facility to an assisted living facility.

b. Review of Resident #1's progress notes revealed a social service note dated 11/28/18 at 12:15 PM which specified, "Resident family notified of incident with female resident (Resident #3) at approximately 9:55 am. Family was told this was grounds for immediate discharge and that he needed to be picked up today. Daughter states she is at work, but she would call his sister. At approximately 12:15 PM, resident was interviewed regarding incident. He was notified

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that this is reportable to the state, the police were called, and this was grounds for immediate discharge. Resident states understanding. RP (responsible party) was also notified that it was reported and that the police were called."

Review of Resident #3's medical record revealed she was admitted on 5/31/16. Resident #3 had diagnoses which included; major depressive disorder, anxiety disorder and difficulty walking.

Review of Resident #3's Annual MDS dated 10/05/18 revealed she had a BIMS (Brief Interview for Mental Status) score of 7 (which indicated severely impaired cognition), the activity of walking in room and corridor did not occur, she utilized a wheel chair as a mobility device and required supervision with one person physical assistance with locomotion on and off the unit.

Review of Resident #3's progress notes revealed a social services note dated 11/28/18 at 2:17 PM which specified. "Resident interviewed regarding incident with male resident this morning. Resident was notified that we reported to state and the police were called. Resident agreed to speak with police when they came. RP (responsible party) was notified of incident and also made aware that it was reported to state and police came to speak with resident. RP appreciative of notification at this time."

Review of the facility's initial allegation report revealed on 11/28/18 at 9:45 AM a male resident (Resident #1) pushed female resident (Resident #3) in his room and Licensed Nurse went directly behind them and (Resident #1) was bending over female resident sitting in wheel chair fondling her breast. Nurse immediately removed female

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resident from situation.

Review of the facility's investigation revealed an interview the Social Worker conducted with Resident #3 on 11/28/18 which revealed the following; "Resident states the she was in her room, male resident came to her room and wanted to show her a picture in his room. Male resident pushes her in her wheelchair to his room. At this time, (Resident #3's name) states the male resident asked if he could kiss her, and she gave him permission to kiss her on the forehead. Male resident kissed her on the forehead, and nurse came in and pushed her out of the room. At this time, she remembers going to BINGO but does not recall who pushed her there."

Observations of Resident #3 on 11/29/18 at 10:24 AM revealed she was seated in her wheel chair and was pleasantly confused. Interview with Resident #3 at this time revealed she did not recall any incidents where a male resident had acted or touched her inappropriately.

Review of the facility's investigation revealed an interview the facility's Social Worker conducted with Resident #1 on 11/28/18 which revealed the following; "Resident states that female resident showed interest in seeing the Christmas tree in his room, so he went to get her out of her room and pushed her to his room and states that 'nothing else happened'. Nurse (Nurse #2's first name) walked in and said (Resident #3's first name) in exasperated tone, and nurse went to (DON's first name) (DON) office and Mr. (Resident #1's last name) went to BINGO alone. When asked, Mr. (Resident #1's last name) states that he did not touch female resident in

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anyway."

Observations and an interview with Resident #1 on 11/28/18 at 3:55 PM revealed he was able to ambulate independently and was able to verbally answer questions. During the interview with Resident #1 he stated he remembered he had inappropriate contact with a female resident a month or so ago, but denied inappropriately touching of any female residents since this incident which occurred a month ago. Resident #1 did admit to pushing a female resident in her wheel chair from her room to his room during the morning of 11/28/18, but stated that he did not touch the female resident inappropriately while the female resident was in his room.

On 11/30/18 at 2:40 PM an interview was conducted with the facility's Social Worker (SW), who interviewed Residents #1 and Resident #3 as part of the facility's investigation. The SW stated Resident #1 was alert and oriented and could consent to engage in sexual activity, but Resident #3 was cognitively impaired and was unable to consent to sexual activity. The SW stated that when she interviewed Resident #1 he denied touching Resident #3 inappropriately on 11/28/18, but admitted to pushing Resident #3 in her wheel chair into his room on 11/28/18. The SW stated the facility was in the process of finding placement for Resident #1 at an assisted living facility.

Review of the facility's investigation revealed a written statement from Nurse #2 which specified, "Informed by therapist she noticed (Resident #1's name) pushing a female resident into his room. Went immediately to room. Door was open and noted (Resident #1's name) standing on the left

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F 600	Continued From page 13 side of female resident's wheel-chair leaning over her. Walked in and noted hand fondling her right breast. Asked (Resident #1) what he was doing. He jerked his hand away quickly and stepped back away from woman. Stated 'we were getting ready to go to Bingo.' (Resident #1's name) reached over picked banana up and gave to this nurse and stated 'here this is for you.' Instructed both residents they were not to be in the room and immediately afterward removed female resident from room. Reported to DON (Director of Nursing)." Interview with Nurse #2 on 11/29/18 at 11:30 AM revealed on 11/28/18 Therapy staff #1 reported to her that Resident #1 had rolled Resident #3 into his room. Nurse #2 stated she immediately responded and when she entered Resident #1's room Resident #1 was standing to the side of Resident #3's wheel chair and was straightening a blanket that was on Resident #3's lap. Nurse #2 stated she then observed Resident #1 use his left hand to squeeze Resident #3's right breast twice. Nurse #3 stated she then asked Resident #1 what he was doing and he immediately stepped away from Resident #3 and he said they were getting ready for bingo. Nurse #2 stated Resident #1 then picked up a banana and gave it to her. Nurse #2 stated she informed the residents that they should not be in the room together and she removed Resident #3 from Resident #1's room and reported the incident to the DON. Review of the facility's investigation revealed a written statement from Therapy staff #1 which specified, on 11/28/18 at 9:15 am she was passing by room #215 which was occupied by Resident #3 and Resident #5 and Resident #1 was standing inside the room with both residents	F 600		

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in the room. The statement specified therapy staff #1 reported to nursing on the hall to make aware of situation and later returned to the room and asked Resident #1 if he was there to take resident to BINGO. Resident #1 stated "yes" and the staff member remained in the room until Resident #1 pushed Resident #3 out of room toward the 100 hall. The statement specified; "When I checked to see if that the resident (Resident #1's name) was headed in the right direction toward BINGO, resident was not, resident (Resident #1 name) pushed resident (Resident #3's name) into his room. I then reported to staff with staff removing resident (Resident #3's name) from residents (Resident #1's name) room."

Interview with Therapy staff #1 on 11/29/18 at 11:55 AM revealed she did not see Resident #1 act inappropriately, but thought it was odd for a male resident to be in the room occupied by two female residents, so she reported it to the nursing staff. Therapy staff #1 stated she was unaware Resident #1 had a history of touching female residents inappropriately and that he was being monitored every 15 minutes by staff for an incident of inappropriate behaviors with a female resident (Resident #2) on 10/28/18. Therapy staff #1 stated she also was not aware Resident #1 should not be pushing other residents in their wheelchairs.

An interview with the Nurse Practitioner (NP) on 11/29/18 at 2:10 PM revealed Resident #1 was alert and oriented and was aware of his actions. The NP stated following the 10/30/18 incident where Resident #1 and Resident #2 were observed having inappropriate contact Resident #1 he was placed on 1:1 staff to resident

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monitoring for a 24 hour period and following the initial 24 hour period he was then placed on 15 minute checks by staff to monitor his behaviors. The NP stated she was involved with the decision to place Resident #1 on 15 minute staff monitoring and was in agreement with this decision. The NP stated since Resident #1 had a second occurrence of having inappropriate contact with another female resident (Resident #3) on 11/28/18 he was placed back on 1:1 staff monitoring which would continue until he was discharged to an assisted living facility because Resident #1 no longer required skilled level care.

Interview with the Director of Nursing (DON) on 11/28/18 at 4:35 PM revealed Resident #1 should not be allowed to push any resident in their wheelchairs. The DON stated Resident #1 had previously exhibited inappropriate touching of a female resident and he was aware of his actions. The DON stated if staff observed Resident #1 pushing another resident in their wheel chair the staff member should instruct him to stop pushing the resident and report the behavior to a nurse.

Interview with the administrator on 11/29/18 at 8:40 AM revealed on 11/28/18 Resident #1 was placed back on 1:1 staff monitoring after he rolled Resident #3 in her wheel chair into his room and was observed by a nurse to touch the female resident's breast.

During another interview with the administrator on 11/29/18 at 4:05 PM, the administrator stated Resident #1 should not be allowed to roll resident's in their wheel chairs and if he was observed doing this staff should stop him. She stated Resident #1's inappropriate behaviors had been shared with department managers at

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F 600	Continued From page 16 morning stand up meetings which are attended by department managers. The administrator stated her expectation was for the department managers to share any concerns, such as Resident #1's inappropriate behaviors of touching female residents and rolling other residents in their wheel chairs, with the employees in their department to protect the residents in the facility. The administrator stated Resident #1 would remain on 1 on 1 direct staff monitoring until he is discharged from the facility to an assisted living facility. On 11/30/18 at 8:32 AM the administrator was informed of the Immediate Jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 11/30/18 at 8:40 PM. The facility's credible allegation of IJ removal indicated: Carolina Care Health and Rehabilitation Credible Allegation of Immediate Jeopardy removal For the purpose of this allegation Carolina Care Health and Rehabilitation (CCHR) is not in substantial compliance with the regulation set forth, this plan of correction constitutes CCHR credible allegation of Immediate Jeopardy removal. On October 28, 2018 Resident # 1 took resident # 2 to her room and resident # 2 performed oral sex on resident # 1. Nurse # 1 removed resident #1 from resident # 2's room. Nurse completed head to toe assessment to ensure no physical harm. Resident # 2 will be monitored by staff to be free from contact from resident # 1. Family for Resident # 2 notified of incident on October 28, 2018. Police called and notified of incident on	F 600		

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F 600	Continued From page 17 October 28, 2019 in regards to resident # 2. Resident # 2 will be protected from abuse. On November 28, 2018 resident # 1 was seen with resident # 3 touching her breast. Nurse #2 removed resident #3 from resident #1's room. Nurse completed head to toe assessment to ensure no physical harm. Resident # 3 will be monitored by staff to be free from contact from resident # 1. Family for Resident # 3 notified of incident on November 28, 2018. Police called and notified of incident on October 28, 2019 in regards to resident # 3. Resident # 3 will be protected from abuse. Facility identified other residents to be at risk as all female residents due to the nature of the allegation. Social worker/ appointed designee's interviewed all interviewable female residents throughout facility as of November 29, 2019. All non interviewable residents will be monitored by nursing staff to ensure they are free from abuse. All non interviewable residents will be assessed head to toe by Director of Nursing or designee by November 30, 2018. Family took resident #1 home for the night to avoid further incident. Upon return to the facility on 0otober 29, 2018 Administrator started resident on one to one supervision for 24 hours. Facility then started 15 minute checks ongoing on resident # 1 whereabouts. Social worker/designee in serviced all facility staff on October 29, 2018 on action plan to monitor resident #1 in regards to being around female residents. Social Worker/ designee in serviced staff on November 30, 2018 on facility abuse policy in regards to sexual abuse and resident right to be free from any abuse at all times.	F 600		

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Administrator issued 30 day discharge notice to resident # 1 on October 29, 2018 in regards to being a danger to himself and others as well as resident level of care no longer requires Skilled Nursing Care . Family appealed. Discharge notice appeal held on November 8, 2018 with decision still pending. Social Worker will attempt to find safe location for transfer. Effective November 28, 2018 Administrator amended plan to 1:1 supervision for resident # 1. Administrator will ensure that a staff member is assigned to resident # 1 at all times until other placement is secured. Nursing will monitor residents daily to ensure they are free from abuse. Rehab Director in serviced all rehab staff in regards to resident # 1 being around or pushing female residents in wheelchair. Administrator or designee will randomly question 4 female residents 5 times per week for any potential abuse and reporting to include if resident has ever experienced abuse at facility for 1 month then 3 days per week for 1 month then 1 time per week for 1 month and 2 times per month for 3 months.

Administrator reviewed findings to QAPI committee on November 30, 2018 for any further corrections. Social working will update Administrator and QAPI committee of any contacts for placement. CCHR will continue to review action plan and make any necessary adjustments until placement of accused resident is obtained. Administrator updated QAPI Committee to change of 1:1 supervision on November 30, 2018.

Facility will remove Immediate Jeopardy as of November 30, 2018.

The facility's credible allegation of IJ removal was

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F 600	Continued From page 19 verified on 11/30/18 at 9:05 PM. Observations revealed Resident #1 had 1 on 1 direct staff monitoring in place and no inappropriate resident or staff behaviors were observed in the facility, Interviews with residents revealed that they felt safe in the facility, interviews with facility staff revealed they had received inservice training on resident abuse and were aware they should immediately stop any form of resident abuse they observe, separate the residents involved to protect the residents and then report the abuse, review of facility documentation revealed resident skin audits were completed as specified on the credible allegation which revealed no suspicious bruising or injuries and review of resident interviews conducted by staff revealed residents felt safe at the facility and had not been mistreated.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews, staff and Nurse Practitioner (NP) interviews the facility failed to implement the	F 607	F607 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) 483.12(b) The facility must develop and	12/21/18

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F 607	Continued From page 20 facility's abuse policies to protect and prevent resident to resident sexual abuse for 2 of 3 sampled residents reviewed for abuse. Resident #2, a cognitively impaired resident, was observed having oral sex with Resident #1. Resident #3, a cognitively impaired resident, was observed to have her breast squeezed by Resident #1. Residents #2 and #3 were assessed at the facility and found to have no physical injuries. The facility also failed to implement its policy for reporting abuse by not reporting an incident of resident to resident sexual abuse to the state agency within two hours for 1 of 3 sampled residents reviewed for abuse (Resident #2). Immediate Jeopardy began on 10/28/18 when staff observed Resident #1 roll Resident #2 in her wheel chair to her room and the residents were observed by staff having oral sex in her room which was not immediately stopped by the staff member. Immediate Jeopardy began on 11/28/18 for Resident #3 when staff observed Resident #1 rolling her in her wheel chair to his room and he was observed by staff to squeeze her breast. Immediate Jeopardy was removed on 11/30/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. Example #2 was cited at a scope and severity of a "D" where a plan of correction is required. The findings included: 1. Review of the facility's "Abuse Prevention	F 607	implement written policies and procedures that: 483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, 483.12(b)(2) Establish policies and procedures to investigate any such allegations, and 483.12(b)(3) Include training as required at paragraph 483.95 On October 28, 2018, nurse removed resident #1 from resident #2s room. Nurse completed head to toe assessment to ensure no physical harm. Resident #2 was monitored by staff to be free from contact from resident # 1. Family for Resident # 2 notified of incident. Police called and notified of incident. Family took resident #1 home for the night. On October 29, 2018 Administrator started resident on one to one supervision for 24 hours, after family returned resident to facility. After 24 hours, facility then started 15-minute checks ongoing on resident # 1s location. Social worker/designee in serviced all facility on action plan to monitor resident #1 regarding being around female residents. Administrator issued 30-day discharge notice to resident # 1 for being a danger to himself and others as well as resident level of care no longer requires Skilled Nursing Care. Social Worker began seeking ALF placement for resident #1 On October 30, 2018 Female residents on hall where Resident # 2 resided were interviewed by Social Worker or designee	

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F 607	Continued From page 21 Program" policy statement, which was dated revised August 2006, revealed the following: "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal property and involuntary seclusion." The "Policy Interpretation and Implementation" specified the following: "1. Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual." Review of the facility's policy statement for "Preventing Resident Abuse", which was revised April 2014, revealed the following: "Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse." The policy's "Interpretation and Implementation" specified; 1. The facility's goal is to achieve and maintain an abuse-free environment. 2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following: "j. Assessing, care planning and monitoring residents with needs and behaviors that may lead to conflict or neglect; k. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues; ..." Resident #1 was admitted to the facility on 11/08/11 with diagnosis including unspecified dementia without behavioral disturbance, bipolar disturbance and major depressive disorder.	F 607	for any signs of abuse. None were reported. On November 5, 2018 Social Worker/ designee in serviced staff on facility abuse policy regarding sexual abuse and resident□s right to be free from abuse. On November 8, 2018 Discharge appeal was held at 1:00pm. On December 1, 2018, appeal decision received by facility. On November 28, 2018, nurse removed resident #3 from resident # 1's room. Nurse completed head to toe assessment to ensure no physical harm. Resident 3 was monitored by staff to be free from contact from resident # 1. Family for Resident # 3 notified of incident on November 28, 2018. Police called and notified of incident on November 28, 2018. Administrator amended plan to 1:1 supervision for resident # 1 until ALF placement is secured. Administrator initiated immediate discharge of resident #1 to family. Social Worker to seek placement in ALF. Social Worker/ designee in serviced all staff on November 28-30, 2018 on facility abuse policy regarding sexual abuse and resident right to be free from any abuse at all times. On December 5, 2018 Rehab Director began educating all rehab staff regarding resident # 1 being around or pushing female residents in wheelchair. On November 29, 2018 Social worker/ appointed designee's and interviewed all interviewable female residents throughout	

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Continued From page 22

Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/12/18 revealed he scored a 13 on the brief interview of mental status (BIMS) indicating that he had no cognition impairments. No inappropriate behaviors were noted during the assessment period. He required set up help only with walking in corridor. The resident was also as assessed as having no limitations with range of motion.

Review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/14/16 and was reviewed by staff on 9/06/18: "Mr. (Resident #1's last name) was previously reported by staff and then his own self admission of inappropriate touching of female residents. He has signed a behavioral contract that he will not engage in such behavior or risk discharge." The goal was for Resident #1 will not exhibit socially inappropriate/disruptive behavior. Care plan approaches included; "Assess whether the behavior endangers the resident and/or others. Intervene if necessary", "If Mr. (Resident #1) begins to become socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate/disruptive behaviors when around others."

Further review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/24/16 and was most recently reviewed by staff on 9/06/18: "Mr. (Resident #1's last name) took a female resident who had significant physical limitation outside of facility when he had been told that until this issues was decided by ADMINISTRATION he was not to take any female outside of facility." The goal was for

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facility for any signs of abuse. None were reported.

On November 30, 2018, all non-interviewable residents were assessed head to toe by Director of Nursing or designee fpr signs of abuse. None noted.

On December 3, 2018, Administrator issued 30 day discharge notice to Resident #1.

Administrator or designee began randomly interviewing 4 residents 5 times per week for any potential abuse and reporting to include if resident has ever experienced abuse at facility for 1 month then 3 days per week for 1 month then 1 time per week for 1 month and 2 times per month for 3 months. Administrator updated QAPI Committee to change of 1:1 and reviewed findings for any further corrections.

Administrator conducted in service for department managers on importance of reporting and completing 24/5-day report timely 12-14-18. All Licensed Nursing staff will be in-serviced on reporting abuse within 2 hours 12-21-18.

Administrator or designee began randomly monitoring staff for awareness of abuse and neglect by interviewing 4 staff members 5 days a week for one month, then 4 staff members 3 days a week for 1 month, then 4 staff members 1

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F 607	Continued From page 23 Resident #1 not to harm others secondary to inappropriate behavior. A care plan approach included; "Staff will do an adjustment to his previous behavioral contract and all parties will sign." Review of Resident #1's behavioral contact that was signed by Resident #1, his Power of Attorney and facility staff members on 10/26/16 specified the following; "I (Resident #1's name) understand that my previous behavioral agreement signed 4/15/16 remains in effect as long as I am a resident here. That agreement was that I understood that if I touched any female in an inappropriate manner that I would be discharged from Carolina Care Center. Today I understand that I am signing an addendum to that agreement. I agree that I will not take any female resident outside of facility. I understand that I am free to socialize with other residents in public areas inside the facility with their consent. I understand that I can attend supervised out of facility events with other residents. I understand that inappropriate touching of females and taking females outside of facility without administration consent could result in discharge from Carolina Care Center." a. Review of Resident #1's progress notes revealed a nursing note dated 10/28/18 at 5:33 PM, written by Nurse #1 which stated, "CNA (certified nursing assistant) reported resident feeling on another female residents breasts (Resident #2) and then whispered in her ear and took her to her room. Nurse went to room and female resident was sitting up in wheelchair in front of bathroom with head moving back and forth and resident was standing in front of her with his zipper open, penis out and residents	F 607	time a week for one month, then 4 staff members 2 times a month for 3 months Administrator or designee will review Allegation log sheet daily for 3 weeks and weekly thereafter for 3 months. Copies of reportable allegations will be given to Regional Manager or designee to review for timeliness. Reports will be reviewed in monthly QAPI meeting monthly for 6 months. IDT team will make any necessary changes to monitoring as needed during monthly QAPI.	

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penis was in her mouth. When I asked them what they were doing she states, 'I'm just doing what all other adults do.' He didn't say anything but 'yeah.' Asked resident to leave room at this time. Educated resident he was not allowed to go back down to her room and that he had violated his behavior contract. Resident walked out of room at this time and went to his room."

Review of Resident #2's medical record revealed she was admitted to the facility on 06/05/17. Resident #2 diagnoses which included; dementia without behavioral disturbance, major depressive disorder, anxiety disorder and female sexual arousal disorder.

Review of Resident #2's quarterly MDS dated 10/18/18 revealed she had a BIMS (Brief Interview for Mental Status) score of 8 (which indicated moderately impaired cognition), required supervision with set up help only with locomotion on the unit, required extensive assistance with one person physical assistance with transfers and used a wheelchair as a mobility device.

Review of Resident #2's care plan revealed the following "Problem" was initiated on 10/16/18: "Decision making: (Resident #2's first name) has difficulty making her own safe/appropriate decisions, long and short term memory deficit is noted." The goal specified, "(Resident #2's first name) will suffer no loss of dignity due to memory loss." Approaches included; "Assist to reminisce and redirect as much as possible to decrease further decline in cognition."

Review of Resident #2's progress notes revealed a nursing note, written by Nurse #1, on 10/28/18

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at 5:18 PM which specified the following; "CNA (certified nursing assistant) reported another resident feeling on residents breasts and then whispered in her ear and took her to her room. Nurse went to room and resident was sitting up in wheelchair in front of bathroom with head moving back and forth and the other resident standing in front of her with his zipper open, penis out and residents penis was in her mouth. When I asked them what they were doing she states, 'I'm just doing what all other adults do.' Asked other resident to leave room at that time. She states, 'I wanted to do it and then grabbed his arm and was telling him to come back to her bed later.' Explained to resident he was not allowed to go back down to her room. Removed other resident at this time. Sitting up in her room NAD (no apparent distress)." The note also specified Resident #2's family was made aware.

Review of the facility's "Investigation Report" signed by the Director of Nurses (DON) revealed Resident #1 was alert and oriented in all spheres with a BIMS of 13 with no short term or long term memory problems. Resident #2 was assessed as having a BIMS of 8 with short term and long term memory problems. The investigation specified that Resident #1 was interviewed by the police on 10/28/18 and he admitted to being in female resident's room and having inappropriate contact with resident. The investigation report specified Resident #2 was unable to remember the incident when interviewed by the police.

Observations and an interview with Resident #1 on 11/28/18 at 3:55 PM revealed he was able to ambulate independently and was able to verbally answer questions. During the interview with Resident #1 he stated he remembered he had

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inappropriate contact with a female resident a month or so ago, but denied inappropriately touching of any female residents since this incident which occurred a month ago.

Observations of Resident #2 on 11/28/18 at 4:15 PM revealed she was seated in her wheel chair and was pleasantly confused. Resident #2 did not recall what day it was or what she ate for lunch that day. Resident #2 also did not recall any incidents of inappropriate behaviors being exhibited by male residents or staff members towards her.

Interview with the facility's Social Worker (SW) on 11/30/18 at 12:40 PM revealed Resident #1 was alert and oriented and could consent to engage in sexual activity, but Resident #2 was cognitively impaired and was unable to consent to sexual activity.

Review of an Investigation-employee statement written by Nurse Aide (NA) #1 dated and signed 10/28/18 stated NA #1 saw Resident #1 bending over Resident #2 and touching Resident #2's breasts in the hallway and started rolling to her room in her wheelchair and immediately reported it to her supervisor.

During interview on 11/30/18 at 12:05 PM with NA #1 she stated on 10/28/18 she observed Resident #1 rolling Resident #2 in her wheelchair in the hallway. She specified that she was seeing the residents from behind, so she could not see if Resident #1 was touching Resident #2's breasts, but his hand was draped over her shoulder. She stated she did not verbally tell Resident #1 to stop rolling Resident #2 in her wheel chair because they were too far ahead of her, but she followed

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them and found them together in Resident #2's room. NA #1 stated she could hear the residents from the room's open doorway and it sounded like they were having oral sex. NA #1 stated she peeked in the doorway and she could not directly see what they were doing because they were around the corner in the room, but from what she could hear it sounded like they were engaged in oral sex. NA #1 stated she was so shocked from what she heard and could see that she did not say anything to the residents or attempt to stop them, but immediately went to report it to the Unit Manager (Nurse #1). NA #1 stated the Unit Manager (Nurse #1) quickly responded to her request to check on Resident #1 and Resident #2. NA #1 stated she was now aware that she should have immediately interrupted and stopped Resident #1 and Resident #2, separated the residents and then reported their activity to the Unit Manager.

During an interview on 11/30/18 at 3:32 PM with Nurse #1 (Unit Manager) she stated that during the evening of 10/28/18 NA #1 asked her to go to Resident #2's room because she saw Resident #1 touching Resident #2's breasts in the hallway and they were now in Resident #2's room. Nurse #1 stated she went to the room, knocked on the room's opened door and when she entered Resident #2's room she observed Resident #1's and Resident #2 engaged in oral sex. Nurse #1 stated she observed Resident #1's penis in Resident #2's mouth. Nurse #1 stated she asked the residents what they were doing and they stopped. Nurse #1 stated she told Resident #1 to go to his room and she immediately reported this to the Director of Nursing (DON) and administrator.

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Interview with the facility's DON on 11/28/18 at 4:35 PM revealed during the evening of 10/28/18 Nurse #1 called her and informed her that Resident #1 and Resident #2 were observed having oral sex in Resident #2's room. The DON stated Resident #1 had previously exhibited inappropriate touching of a female resident and he was aware of his actions. So, the facility placed Resident #1 on 1 on 1 direct staff observation for 24 hours to monitor his behaviors in an effort to protect Resident #2 and other residents. The DON specified the facility started an abuse investigation and notified the local police department about the incident.

Review of the police incident/investigation report revealed the police responded in reference to a report of a sexual assault at the facility on 10/28/18 at 6:21 PM. The report specified; "Suspect engaged in a sex act with victim" and listed Resident #2 as the victim.

During interview with the Administrator on 11/29/18 at 8:40 AM she stated when she was informed of Resident #1 and Resident #2's being observed engaged in oral sex in Resident #2's room on 10/28/18 she immediately came to the facility. The administrator stated the police were notified of the incident during the evening of 10/28/18 and an officer came to the facility to investigate. The administrator stated Resident #1's family was notified and they took him home for the night. Upon his return to the facility on 10/29/18 the resident was placed on 1 on 1 direct staff to resident monitoring for the first 24 hours and then was placed on 15 minute staff checks to monitor the resident's behaviors.

During another interview with the administrator on

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F 607	Continued From page 29 11/29/18 at 4:05 PM, the administrator stated, on 10/28/18 NA #1 should have stopped Resident #1 and Resident #2 when she heard the residents together in Resident #2's room and she thought they were having inappropriate relations instead of going to report what she thought the residents were doing to Nurse #1. The administrator stated, Resident #1 should not be allowed to roll resident's in their wheel chairs and if he was observed doing this staff should stop him. She stated Resident #1's inappropriate behaviors had been shared with department managers at morning stand up meetings which are attended by department managers. The administrator stated her expectation was for the department managers to share any concerns, such as Resident #1's inappropriate behaviors of touching female residents and rolling other residents in their wheel chairs, with the employees in their department to protect the residents in the facility. The administrator stated Resident #1 would remain on 1 on 1 direct staff monitoring until he is discharged from the facility to an assisted living facility. b. Review of Resident #1's progress notes revealed a social service note dated 11/28/18 at 12:15 PM which specified, "Resident family notified of incident with female resident (Resident #3) at approximately 9:55 am. Family was told this was grounds for immediate discharge and that he needed to be picked up today. Daughter states she is at work, but she would call his sister. At approximately 12:15 PM, resident was interviewed regarding incident. He was notified that this is reportable to the state, the police were called, and this was grounds for immediate discharge. Resident states understanding. RP (responsible party) was also notified that it was	F 607		

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reported and that the police were called."

Review of Resident #3's medical record revealed she was admitted on 5/31/16. Resident #3 had diagnoses which included; major depressive disorder, anxiety disorder and difficulty walking.

Review of Resident #3's Annual MDS dated 10/05/18 revealed she had a BIMS (Brief Interview for Mental Status) score of 7 (which indicated severely impaired cognition), the activity of walking in room and corridor did not occur, she utilized a wheel chair as a mobility device and required supervision with one person physical assistance with locomotion on and off the unit.

Review of Resident #3's progress notes revealed a social services note dated 11/28/18 at 2:17 PM which specified. "Resident interviewed regarding incident with male resident this morning. Resident was notified that we reported to state and the police were called. Resident agreed to speak with police when they came. RP (responsible party) was notified of incident and also made aware that it was reported to state and police came to speak with resident. RP appreciative of notification at this time."

Review of the facility's initial allegation report revealed on 11/28/18 at 9:45 AM a male resident (Resident #1) pushed female resident (Resident #3) in his room and Licensed Nurse went directly behind them and (Resident #1) was bending over female resident sitting in wheel chair fondling her breast. Nurse immediately removed female resident from situation.

Review of the facility's investigation revealed an interview the Social Worker conducted with

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Resident #3 on 11/28/18 which revealed the following; "Resident states the she was in her room, male resident came to her room and wanted to show her a picture in his room. Male resident pushes her in her wheelchair to his room. At this time, (Resident #3's name) states the male resident asked if he could kiss her, and she gave him permission to kiss her on the forehead. Male resident kissed her on the forehead, and nurse came in and pushed her out of the room. At this time, she remembers going to BINGO but does not recall who pushed her there."

Observations of Resident #3 on 11/29/18 at 10:24 AM revealed she was seated in her wheel chair and was pleasantly confused. Interview with Resident #3 at this time revealed she did not recall any incidents where a male resident had acted or touched her inappropriately.

Review of the facility's investigation revealed an interview the facility's Social Worker conducted with Resident #1 on 11/28/18 which revealed the following; "Resident states that female resident showed interest in seeing the Christmas tree in his room, so he went to get her out of her room and pushed her to his room and states that 'nothing else happened'. Nurse (Nurse #2's first name) walked in and said (Resident #3's first name) in exasperated tone, and nurse went to (DON's first name) (DON) office and Mr. (Resident #1's last name) went to BINGO alone. When asked, Mr. (Resident #1's last name) states that he did not touch female resident in anyway."

Observations and an interview with Resident #1 on 11/28/18 at 3:55 PM revealed he was able to

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ambulate independently and was able to verbally answer questions. During the interview with Resident #1 he stated he remembered he had inappropriate contact with a female resident a month or so ago, but denied inappropriately touching of any female residents since this incident which occurred a month ago. Resident #1 did admit to pushing a female resident in her wheel chair from her room to his room during the morning of 11/28/18, but stated that he did not touch the female resident inappropriately while the female resident was in his room.

On 11/30/18 at 4:45 PM an interview was conducted with the facility's Social Worker (SW), who interviewed Residents #1 and Resident #3 as part of the facility's investigation. The SW stated Resident #1 was alert and oriented and could consent to engage in sexual activity, but Resident #3 was cognitively impaired and was unable to consent to sexual activity. The SW stated that when she interviewed Resident #1 he denied touching Resident #3 inappropriately on 11/28/18, but admitted to pushing Resident #3 in her wheel chair into his room on 11/28/18. The SW stated the facility was in the process of finding placement for Resident #1 at an assisted living facility.

Review of the facility's investigation revealed a written statement from Nurse #2 which specified, "Informed by therapist she noticed (Resident #1's name) pushing a female resident into his room. Went immediately to room. Door was open and noted (Resident #1's name) standing on the left side of female resident's wheel-chair leaning over her. Walked in and noted hand fondling her right breast. Asked (Resident #1) what he was doing. He jerked his hand away quickly and stepped

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back away from woman. Stated 'we were getting ready to go to Bingo.' (Resident #1's name) reached over picked banana up and gave to this nurse and stated 'here this is for you.' Instructed both residents they were not to be in the room and immediately afterward removed female resident from room. Reported to DON (Director of Nursing)."

Interview with Nurse #2 on 11/29/18 at 11:30 AM revealed on 11/28/18 Therapy staff #1 reported to her that Resident #1 had rolled Resident #3 into his room. Nurse #2 stated she immediately responded and when she entered Resident #1's room Resident #1 was standing to the side of Resident #3's wheel chair and was straightening a blanket that was on Resident #3's lap. Nurse #2 stated she then observed Resident #1 use his left hand to squeeze Resident #3's right breast twice. Nurse #3 stated she then asked Resident #1 what he was doing and he immediately stepped away from Resident #3 and he said they were getting ready for bingo. Nurse #2 stated Resident #1 then picked up a banana and gave it to her. Nurse #2 stated she informed the residents that they should not be in the room together and she removed Resident #3 from Resident #1's room and reported the incident to the DON.

Review of the facility's investigation revealed a written statement from Therapy staff #1 which specified, on 11/28/18 at 9:15 am she was passing by room #215 which was occupied by Resident #3 and Resident #5 and Resident #1 was standing inside the room with both residents in the room. The statement specified therapy staff #1 reported to nursing on the hall to make aware of situation and later returned to the room and asked Resident #1 if he was there to take

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resident to BINGO. Resident #1 stated "yes" and the staff member remained in the room until Resident #1 pushed Resident #3 out of room toward the 100 hall. The statement specified; "When I checked to see if that the resident (Resident #1's name) was headed in the right direction toward BINGO, resident was not, resident (Resident #1 name) pushed resident (Resident #3's name) into his room. I then reported to staff with staff removing resident (Resident #3's name) from residents (Resident #1's name) room."

Interview with Therapy staff #1 on 11/29/18 at 11:55 AM revealed she did not see Resident #1 act inappropriately, but thought it was odd for a male resident to be in the room occupied by two female residents, so she reported it to the nursing staff. Therapy staff #1 stated she was unaware Resident #1 had a history of touching female residents inappropriately and that he was being monitored every 15 minutes by staff for an incident of inappropriate behaviors with a female resident (Resident #2) on 10/28/18. Therapy staff #1 stated she also was not aware Resident #1 should not be pushing other residents in their wheelchairs.

An interview with the Nurse Practitioner (NP) on 11/29/18 at 2:10 PM revealed Resident #1 was alert and oriented and was aware of his actions. The NP stated following the 10/30/18 incident where Resident #1 and Resident #2 were observed having inappropriate contact Resident #1 he was placed on 1:1 staff to resident monitoring for a 24 hour period and following the initial 24 hour period he was then placed on 15 minute checks by staff to monitor his behaviors. The NP stated she was involved with the decision

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to place Resident #1 on 15 minute staff monitoring and was in agreement with this decision. The NP stated since Resident #1 had a second occurrence of having inappropriate contact with another female resident (Resident #3) on 11/28/18 he was placed back on 1:1 staff monitoring which would continue until he was discharged to an assisted living facility because Resident #1 no longer required skilled level care.

Interview with the Director of Nursing (DON) on 11/28/18 at 4:35 PM revealed Resident #1 should not be allowed to push any resident in their wheelchairs. The DON stated Resident #1 had previously exhibited inappropriate touching of a female resident and he was aware of his actions. The DON stated if staff observed Resident #1 pushing another resident in their wheel chair the staff member should instruct him to stop pushing the resident and report the behavior to a nurse.

Interview with the administrator on 11/29/18 at 8:40 AM revealed on 11/28/18 Resident #1 was placed back on 1:1 staff monitoring after he rolled Resident #3 in her wheel chair into his room and was observed by a nurse to touch the female resident's breast.

During another interview with the administrator on 11/29/18 at 4:05 PM, the administrator stated Resident #1 should not be allowed to roll resident's in their wheel chairs and if he was observed doing this staff should stop him. She stated Resident #1's inappropriate behaviors had been shared with department managers at morning stand up meetings which are attended by department managers. The administrator stated her expectation was for the department managers to share any concerns, such as

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(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 607	Continued From page 36 Resident #1's inappropriate behaviors of touching female residents and rolling other residents in their wheel chairs, with the employees in their department to protect the residents in the facility. The administrator stated Resident #1 would remain on 1 on 1 direct staff monitoring until he is discharged from the facility to an assisted living facility. On 11/30/18 at 8:32 AM the administrator was informed of the Immediate Jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 11/30/18 at 8:40 PM. The facility's credible allegation of IJ removal indicated: Carolina Care Health and Rehabilitation Credible Allegation of Immediate Jeopardy removal: For the purpose of this allegation Carolina Care Health and Rehabilitation (CCHR) is not in substantial compliance with the regulation set forth, this plan of correction constitutes CCHR credible allegation of Immediate Jeopardy removal. On October 28, 2018 Resident # 1 took resident # 2 to her room and resident # 2 performed oral sex on resident # 1. Nurse # 1 removed resident #1 from resident # 2's room. Nurse completed head to toe assessment to ensure no physical harm. Resident # 2 will be monitored by staff to be free from contact from resident # 1. Family for Resident # 2 notified of incident on October 28, 2018. Police called and notified of incident on October 28, 2019 in regards to resident # 2. Resident # 2 will be protected from abuse. On November 28, 2018 resident # 1 was seen with resident # 3 touching her breast. Nurse #2 removed resident #3 from resident #1's room.	F 607		

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F 607	Continued From page 37 Nurse completed head to toe assessment to ensure no physical harm. Resident # 3 will be monitored by staff to be free from contact from resident # 1. Family for Resident # 3 notified of incident on November 28, 2018. Police called and notified of incident on October 28, 2019 in regards to resident # 3. Resident # 3 will be protected from abuse. Facility identified other residents to be at risk as all female residents due to the nature of the allegation. Social worker/ appointed designee's interviewed all interviewable female residents throughout facility as of November 29, 2019. All non interviewable residents will be monitored by nursing staff to ensure they are free from abuse. All non interviewable residents will be assessed head to toe by Director of Nursing or designee by November 30, 2018. Family took resident #1 home for the night to avoid further incident. Upon return to the facility on 0otober 29, 2018 Administrator started resident on one to one supervision for 24 hours. Facility then started 15 minute checks ongoing on resident # 1 whereabouts. Social worker/designee in serviced all facility staff on October 29, 2018 on action plan to monitor resident #1 in regards to being around female residents. Social Worker/ designee in serviced staff on November 30, 2018 on facility abuse policy in regards to sexual abuse and resident right to be free from any abuse at all times. Administrator issued 30 day discharge notice to resident # 1 on October 29, 2018 in regards to being a danger to himself and others as well as resident level of care no longer requires Skilled Nursing Care . Family appealed. Discharge notice appeal held on November 8, 2018 with decision still pending. Social Worker will attempt to find	F 607		

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safe location for transfer. Effective November 28, 2018 Administrator amended plan to 1:1 supervision for resident # 1. Administrator will ensure that a staff member is assigned to resident # 1 at all times until other placement is secured. Nursing will monitor residents daily to ensure they are free from abuse. Rehab Director in serviced all rehab staff in regards to resident # 1 being around or pushing female residents in wheelchair. Administrator or designee will randomly question 4 female residents 5 times per week for any potential abuse and reporting to include if resident has ever experienced abuse at facility for 1 month then 3 days per week for 1 month then 1 time per week for 1 month and 2 times per month for 3 months.

Administrator reviewed findings to QAPI committee on November 30, 2018 for any further corrections. Social working will update Administrator and QAPI committee of any contacts for placement. CCHR will continue to review action plan and make any necessary adjustments until placement of accused resident is obtained. Administrator updated QAPI Committee to change of 1:1 supervision on November 30, 2018.

Facility will remove Immediate Jeopardy as of November 30, 2018.

The facility's credible allegation of IJ removal was verified on 11/30/18 at 9:05 PM. Observations revealed Resident #1 had 1 on 1 direct staff monitoring in place and no inappropriate resident or staff behaviors were observed in the facility, Interviews with residents revealed that they felt safe in the facility, interviews with facility staff revealed they had received inservice training on

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resident abuse and were aware they should immediately stop any form of resident abuse they observe, separate the residents involved to protect the residents and then report the abuse, review of facility documentation revealed resident skin audits were completed as specified on the credible allegation which revealed no suspicious bruising or injuries and review of resident interviews conducted by staff revealed residents felt safe at the facility and had not been mistreated.

2. Review of the facility's policy entitled; "Abuse Investigation and Reporting" policy, which was dated as revised July 2017, revealed the following "Policy Statement"; "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ('abuse') shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." Review of the policy's section on "Reporting" revealed the following; "2. An allegation of abuse, neglect, exploitation or mistreatment (including injuriesof unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury."

Review of Resident #1's progress notes revealed a nursing note dated 10/28/18 at 5:33 PM, written by Nurse #1 which stated, "CNA (certified nursing assistant) reported resident feeling on another female residents breasts (Resident #2) and then

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whispered in her ear and took her to her room. Nurse went to room and female resident was sitting up in wheelchair in front of bathroom with head moving back and forth and resident was standing in front of her with his zipper open, penis out and residents penis was in her mouth. When I asked them what they were doing she states, 'I'm just doing what all other adults do.' He didn't say anything but 'yeah.' Asked resident to leave room at this time. Educated resident he was not allowed to go back down to her room and that he had violated his behavior contract. Resident walked out of room at this time and went to his room."

Review of the facility's "Investigation and Report" signed by the Director of Nurses (DON) revealed Resident #1 was alert and oriented in all spheres with a BIMS of 13 with no short term or long term memory problems. Resident #2 was assessed as having a BIMS of 8 with short term and long term memory problems. The investigation specified that Resident #1 was interviewed by the police on 10/28/18 and he admitted to being in female resident's room and having inappropriate contact with resident. The investigation report specified Resident #2 was unable to remember the incident when interviewed by the police.

Interview with the facility's Social Worker (SW) on 11/30/18 at 12:40 PM revealed Resident #1 was alert and oriented and could consent to engage in sexual activity, but Resident #2 was cognitively impaired and was unable to consent to sexual activity.

During an interview on 11/30/18 at 3:32 PM with Nurse #1 (Unit Manager) she stated that during the evening of 10/28/18 NA #1 asked her to go to

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F 607	Continued From page 41 Resident #2's room because she saw Resident #1 touching Resident #2's breasts in the hallway and they were now in Resident #2's room. Nurse #1 stated she went to the room, knocked on the room's opened door and when she entered Resident #2's room she observed Resident #1's and Resident #2 engaged in oral sex. Nurse #1 stated she observed Resident #1's penis in Resident #2's mouth. Nurse #1 stated she asked the residents what they were doing and they stopped. Nurse #1 stated she told Resident #1 to go to his room and she immediately reported this to the Director of Nursing (DON) and administrator. Review of the police incident/investigation report revealed the police responded in reference to a report of a sexual assault at the facility on 10/28/18 at 6:21 PM. The report specified; "Suspect engaged in a sex act with victim" and listed Resident #2 as the victim. During interview with the Administrator on 11/29/18 at 8:40 AM she stated during the evening of 10/28/18 she was informed of Resident #1 and Resident #2's being observed engaged in oral sex in Resident #2's room and she immediately came to the facility. The administrator stated the police were notified of the incident during the evening of 10/28/18 and a police officer came to the facility to investigate. During another interview with the administrator on 11/29/18 at 4:05 PM she stated she did not report this incident of resident to resident sexual abuse, which occurred during the evening of 10/28/18, within two hours to the state survey agency. The administrator stated she did not report this incident of resident abuse to the state survey	F 607		

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F 607	Continued From page 42 agency until 10/29/18 at 4:08 PM because she thought she had 24 hours to report an incident of resident abuse if there was no physical harm to the residents involved in the incident.	F 607		