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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	**2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted on 1/10/19. The survey team exited the facility on 1/10/19 and further information was obtained on 1/11/19. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J The tag F600 constituted Substandard Quality of Care. Noncompliance began on 8/23/18. The facility came back in compliance effective 8/30/18. A surveyor entered the facility on 1/14/19 to conduct an extended survey. The survey exit date was changed to 1/14/19.	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 record review, staff interviews, and	F 600	Past noncompliance: no plan of	1/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/25/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 1 detective interview the facility failed to protect a resident's right to be free of sexual abuse for one of three residents (Resident #2). Resident # 1 was observed by staff to touch Resident # 2 in her perineal area and confessed to police that he had touched Resident # 2, who was a severely cognitively impaired resident. Resident # 1 was deemed by police to be sufficiently oriented to the extent that his confession was credible evidence he had assaulted Resident # 2. The findings included: Record review revealed Resident # 1 was admitted to the skilled part of the facility on 6/26/18 after previously residing in the facility's assisted living unit. The resident had diagnosis of vascular dementia, muscle weakness, and difficulty walking. Review of Resident # 1's admission minimum data set (MDS) assessment, dated 7/5/18, revealed the resident was assessed to have a BIMs (brief interview for mental status) score of 11 which indicated moderately impaired cognition. The resident was also assessed to have no mood or behavior problems, to need extensive assistance with transfers, and to use a wheelchair for mobility. Review of Resident # 1's admission care plan, dated 7/6/18, revealed staff noted the resident had a problem with social isolation. Review of NA (Nurse Aide) documentation revealed from 6/26/18 to 8/22/18, the resident had no wandering or any other behaviors. Review of nursing notes revealed the following information. Prior to the date of 8/21/18, there	F 600	correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	**2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303**

(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 600	Continued From page 2	F 600		

were no nursing entries noting inappropriate sexual behavior since the resident's initial admission to the skilled facility on 06/26/18. On 8/21/18 at 6:57 AM Nurse # 1 entered a nursing entry which read, "CNA (certified nurse aide) reported she observed resident standing in doorway being sexually inappropriate X2 (two times) this shift." Further review of nursing notes revealed from 8/21/18 to 8/23/18 at 7:00 AM, there were no further documented episodes of sexually inappropriate behaviors noted.

Nurse # 1 was interviewed on 1/10/19 at 12:30 PM and again on 1/11/19 at 7:00 AM. According to Nurse # 1, Resident # 1 was in his room on 8/21/18. Resident # 1's room was diagonally across the hall from Resident # 2's room. Nurse # 1 stated on 8/21/18 Resident # 2 had a full time facility staff member sitting with her because she had recently sustained a fall and was confused. Nurse # 1 stated that Resident # 2's sitter had reported to Nurse # 1 that she had observed Resident # 1 looking across the hall into Resident # 2's room while masturbating in his room. Nurse # 1 stated she recalled the sitter stating that Resident # 1's vision was directed at her (the sitter), and not at the resident while engaging in this activity. According to Nurse # 1, the resident did not wander and typically stayed in or around his room. According to Nurse # 1, Resident 2 had multiple staff members sitting with her and she did not recall which sitter had reported this.

Record review revealed documented evidence of 15 minute checks on Resident # 1 starting 8/21/18 at 4:30 AM. There was no notation who initiated the checks. For every 15 minute increments, "yes" was circled that the resident had a safety check through the date of 8/23/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 3	F 600		

1:00 PM.

Review of the resident's care plan revealed on 8/21/18 the following problem was added to the care plan: (Resident) displays socially inappropriate/sexual behavior in public. Beneath this care plan problem the following notations were written by the facility social worker (SW). On 8/21/18 the SW noted, "Resident was seen masturbating on the hall looking at a female resident. This happened at night 8/20-21/18." On 8/22/18 the SW noted, "Resident repeated the same behavior the night of 8/21-22/18." Care plan interventions included the following: Activities staff to visit with resident and provide diversional activities; observe and document resident behavior; Do not argue with resident; Elicit family input for best approaches to resident; Praise resident for demonstrating desired behavior; Talk with resident in calm voice when behavior is disruptive; Remove resident from public area when behavior is disruptive and unacceptable; Encourage family/responsible party to visit with resident; Every 15 minute checks; Care plan meeting with IDT (interdisciplinary team) to discuss behaviors.

Review of the resident's record revealed no nursing entry documenting the incident which the SW had noted occurred on the night from 7:00 PM on 8/21/18 to 7:00 AM on 8/22/18. Nurse # 3 made an entry on 8/22/18 at 1:44 AM noting the resident had no behaviors on her shift.

Nurse # 3 was interviewed on 1/11/19 at 8:35 AM and confirmed she was the nurse who had cared for the resident on the night shift from 7:00 PM on 8/21/18 to 7:00 AM on 8/22/18. She reported she did not ever witness Resident # 1 to have any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	**2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303**

(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 600	Continued From page 4	F 600		

inappropriate sexual behaviors towards other residents. The resident generally was in his room and she had only noted him in his doorway on a couple of occasions. She had not observed or was not aware of any wandering behaviors by Resident # 1. Nurse # 3 also stated she had heard the resident would masturbate in his room, but not in front of others. She had not witnessed this herself, and no nurse aide had reported inappropriate behaviors to her.

Interview with the facility SW on 1/10/19 at 1:48 PM revealed Resident # 1 had no previous history of sexually inappropriate behavior before 8/21/18 and she had not been aware of any sexually inappropriate behavior prior to 8/21/18. She did not recall being told that the resident was directing his vision or attentions across the hall to any particular resident/visitor while masturbating in his doorway. It was the SW's understanding that the resident had masturbated within public view on two nights although the nurses had documented it had occurred on one night. The SW explained she met with the resident and his family on 8/22/18 and informed the resident that he needed to close his door if engaging in sexual behavior. The SW stated Resident # 1 voiced understanding and agreement. According to the SW the resident did not exhibit any behavior which would indicate he would assault another resident. The SW noted a referral was made for psychiatric evaluation on 8/22/18 for a future date.

Record review revealed on 8/23/18 at 9:43 AM Nurse # 1 made another nursing entry into Resident # 1's record. The entry read, "Late entry for 8/23/18 at 7 am. CNA came and reported resident (Resident #1) was in female resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 5	F 600		

(Resident #2) room with his hand touching female private areas. This nurse went to female residents room and removed (Resident # 1) from area and returned him to his room. Administrator notified and CNA was placed by resident door for 1:1."

According to the facility's five day investigative report to the state agency, dated 8/29/18, a care conference was held with Resident # 1's responsible party (RP); the administrator, the SVU (Special Victim's Unit) detective, and a registered nurse at approximately 10:45 AM on 8/23/18. The SVU detective informed the RP that Resident # 1 had confessed to molestation and it had been determined that he was competent to have given the confession. The SVU detective provided Resident # 1's RP with two options: they could take the resident home, or the resident would be taken to jail. According to the report, the RP was unable to care for Resident # 1, and at 1:00 PM Resident # 1 was discharged to jail.

Detective # 1 was interviewed on 1/11/19 at 9:25 AM and reported the following. She talked to Resident # 1 on the morning of the incident, 8/23/18, within his room and asked, "Do you know why I am here?" Resident # 1 responded, "Yes," and Detective # 1 asked, "Why?" Resident # 1 then responded, "Because I molested someone." Detective # 1 then inquired, "Who?" Resident # 1 then pointed across the hall to Resident # 2's room. Detective # 1 then asked Resident #1 what happened, and Resident # 1 said that Resident #2 had her door open, was naked, and was "asking for him to come over." He confessed to going over and touching the resident on her stomach and her back. Detective # 1 reported that the resident appeared to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 6	F 600		

cognizant to what he was confessing, and his confession in conjunction with the witnessing NA's account (NA # 1) gave her reason to take him to the police station. At the police station, Detective # 1 reported she questioned him again and Resident # 1 was consistent in the details of his confession.

Review of Resident # 2's record revealed she had a history of a stroke, was severely cognitively impaired, needed extensive assistance with her activities of daily living, and had been admitted on 6/18/18. According to the record the resident was undergoing a fourteen day MDS readmission assessment when the incident occurred on 8/23/18. This assessment was finalized on 8/29/18 and coded Resident # 1 with a BIMS score of 6; indicating the resident had severely impaired cognition.

A review of Resident # 2's nursing notes revealed the resident was assessed by Nurse # 1 for injury following the 7:00 AM incident of 8/23/18. Nurse # 1 noted within the nursing entry that a male resident had been seen "touching her (Resident # 1's) private areas." Nurse # 1 noted Resident # 2 had no bleeding, bruising, or injury.

During an interview, which was conducted with NA # 8 on 1/11/19 at 10:07 AM, the NA reported the following. She had been a facility caregiver for Resident # 2 during August, 2018, and Resident # 2 would at times take off her gown due to confusion. NA # 8 would see that Resident # 1 was watching Resident # 2 from his room, which was diagonally across the hall, and therefore NA #8 would close Resident # 2's door for privacy and place the gown back on her. NA # 8 reported she never saw Resident # 1 enter Resident # 2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 7 room. NA # 8 stated she did report this to a nurse, but did not recall a specific nurse to whom she had spoken. NA # 7 was interviewed on 1/11/19 at 9:03 AM. NA # 7 had been a one on one sitter on some of the evening shifts for Resident # 2 during the time period of 8/15/18 to 8/21/18 due to fall precaution measures the facility was taking with Resident # 2. NA # 7 reported as she sat with Resident # 2, there were never any times Resident # 1 tried to enter Resident # 2's room, and she never witnessed him to have any inappropriate behaviors. NA # 1 was interviewed on 1/10/19 at 11:30 AM. NA # 1 confirmed she had witnessed Resident # 1 touch Resident # 2 in a private area on 8/23/18. NA #1 stated she had been walking down the hall around 7:00 AM on 8/23/18 before shift change report when she glanced in Resident # 2's room and saw Resident # 1 was in Resident # 2's room. When she entered the room, she found Resident # 1 was seated in his wheelchair beside of Resident # 2. Resident # 1's gown was on and her disposable brief was pulled down to her thigh area. Resident # 1 had his hand in Resident #2's private area and was moving his hand back and forth. NA # 1 immediately said, "No stop, don't do that," and pulled Resident # 1's wheelchair away from the resident and back to the doorway. She ran to get the nurse, who was at the desk. It took her "about 4 seconds" to get Nurse # 1. Nurse # 1 immediately came to the room, and informed Resident # 1 he was not to be in the room and should not be touching Resident # 2. Nurse # 1 directed staff that Resident # 1 be placed back in his room. Nurse # 1 placed a staff member outside of Resident # 1's door. According to NA #	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 8	F 600		

1, Resident # 2 was taking deep breaths as if she was upset but did not verbalize anything. Following the incident, she was not bathed, but she was dressed.

During the interview conducted with Nurse # 1 on 1/10/19 at 12:30 PM, Nurse # 1 reported the following details. Prior to the incident of 8/23/18 at 7:00 AM, she had just observed Resident # 1 in his room and in his bed approximately five to ten minutes earlier. NA # 1 alerted her at 7:00 AM on 8/23/18 that she needed to "come right now" with her. She immediately went to Resident # 2's room where Resident #1 was sitting in his wheelchair at the doorway. At that point Resident # 1 had been pulled away from the resident, and therefore she did not witness Resident # 1 touching Resident # 2. Nurse #1 noted she appointed a staff member to be 1 on 1 with Resident # 1 in his room. Resident # 2 was assessed and found to be nervous, but otherwise okay. Once she made sure Resident # 1 was being monitored full time, and Resident # 2 was without injury she immediately called the Administrator. When she assessed Resident # 2, she did not find any signs of physical injury. Nurse # 1 reported Resident # 2 appeared "very nervous" which was not like her normal status. According to Nurse # 1, Resident # 1 had gotten himself out of bed on the morning of 8/23/18 without staff assistance.

NA # 6 was interviewed on 1/11/19 at 6:50 AM. NA # 6 routinely cared for Resident # 1 on the night shift. NA # 6 stated Resident # 6 would generally be asleep at the beginning of the shift, and would get himself up in the morning before she left at 7:00 AM. At times she would find him in the hallway outside his room and in front of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 9	F 600		

residents' rooms across from his or beside him. At times he would look in, but there would never be any times he would enter others rooms. NA # 6 reported he did not wander to other parts of the facility, and she never knew him to have any sexually inappropriate behaviors or any other type of inappropriate behaviors. When she saw him looking into others rooms, she redirected him back to his room and he went back to his room.

NA # 3 was interviewed on 1/10/19 at 2:16 PM. NA # 3 routinely cared for Resident # 1 on the dayshift. NA # 3 reported Resident # 1 always acted "like a gentleman" and she had never known him to have sexually inappropriate behaviors, other types of behavior problems, or wandering behavior.

MA (Medication Aide) # 3 was interviewed on 1/11/19 at 8:52 AM. MA # 3 stated she had cared for the resident while he resided on the assisted living unit of the facility and prior to his transfer to the skilled unit. MA # 3 stated the resident had no inappropriate behaviors or wandering, and was always appropriate.

According to facility documentation after the incident occurred, the following transpired on the date of 8/23/18 at the following times:
The Administrator was notified-"approximately" at 7:21 AM
The Administrator arrived at the facility-7:30 AM
Police notified-"approximately" 7:45 AM
Resident # 1 and Resident # 2's responsible parties were notified-8:00 AM
Police arrived at the facility to conduct an investigation-8:05 AM
Resident # 2's responsible party (RP) arrived at the facility-8:30 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 10	F 600		

Resident # 2 was assessed from head to toe with her RP present -9:10 AM by a facility nurse
The special victims unit (SVU) detectives arrived at the facility-9:20 AM
The residents' physicians were notified-8:50 AM
Psychiatry services were notified of an immediate need for psychological assessment for Resident # 2-9:15 AM
Regional Ombudsman notified at 10:30 AM

A 24 hour report, noting that the facility was investigating an incident of suspected resident abuse, was submitted to the state agency on 8/23/18.

Record review revealed on 8/29/18 a five day investigative report was completed and submitted to the state agency. The facility substantiated Resident # 2 had been sexually assaulted by Resident # 1.

Interview with the Acting Administrator on 1/10/19 at 5:50 PM revealed the current Administrator was on extended leave at the present time. According to the Acting Administrator, who was a corporate employee, she had been aware of the incident when it had occurred on 8/23/18. According to the Acting Administrator, Resident # 1 had not displayed any signs of sexually inappropriate behavior towards residents prior to the 8/23/18 incident. The Acting Administrator stated the facility did their investigation and conducted their own internal plan of correction (POC) to assure no future occurrences. The Acting Administrator stated she would follow up with the Administrator, who was on leave, and locate the documentation of their POC (Plan of Correction).
The Acting Administrator presented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 11	F 600		

documented evidence on 1/11/19 at 3:54 PM that following the incident of 8/23/18, the facility took corrective measures to assure there would be no further assault. The facility presented the following plan of correction that had been completed on 8/30/18

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
1) On 8/23/18 at approximately 7:05AM Resident 1 was witnessed to be in Resident 2's room by staff CNA1. CNA1 reported Resident 2 was lying on her bed on the left side with her brief pulled down and Resident 1 was in his wheelchair next to her bed with his left hand in between her legs. CNA immediately instructed him to stop and pulled him out of the room. CNA saw nurse standing at the nurse's station and yelled for her. Nurse came and the CNA reported what she saw. Nurse ensured Resident 2 was safe and Resident 1 was being supervised by CNA1.
2) On 8/23/18 at approx. 7:21am, nurse notified Administrator of the incident. Administrator on site at 7:30am and ensured that Resident 2 was safe and secure and both residents separated. Resident 1 was immediately placed on 1:1 supervision by the Administrator. Staff instructed not to remove any articles from the room; staff dressed resident for comfort but did not bathe until further instructed by detectives. Police immediately notified approx. 7:45am. Administrator notified both responsible parties at 8:00am and both parties expressed that they will be arriving to the facility ASAP.
3) On 8/23/18 at 8:05a Fayetteville police arrived to take report and investigate the allegation. RP of Resident 2 arrived to the facility at 8:30 to support her mother throughout the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 12 process. Detectives of SVU were notified by the Fayetteville police and arrived on the scene at 9:20a to conduct a full investigation. As part of the investigation, the detective interviewed employees, Resident 2 [along with RP present due to resident not interview able], and Resident 1. Detectives obtained the necessary materials needed such as clothing, swabs, and hand/fingernail inspection. Detectives were informed that Resident 2 has a BIMS score of 6/15 and Resident 1 with a BIMS of 11/15. 4) On 8/23/18 at approx. 9:10a, a full head to toe body assessment was completed on Resident 2 by MDS Coordinator (assessing RN) with no injuries present. MD notified of incident at 8:50a by unit nurse; administrator notified by medical director expressing his concern of incident and that Resident 1 is to be discharged due to the safety and wellbeing of individuals in the facility due to his inappropriate sexual behaviors. 5) On 8/23/18 at approx. 10:30a, Ombudsman notified of the incident by the Director of Operations and a 30 day discharge notice had been issued. Guidance provided regarding discharge options. Approx. 10:45a Care conference was held with the family of Resident 1. Administrator, SVU Detective, and assessing RN in attendance. The detective informed family that Resident 1 confessed to molestation, expressing "he touched her breast, stomach, and vaginal area". Detective was able to determine that Resident 1 was fully competent of his actions, as he restated his inappropriate behavior. Detective offered family two options: take Resident 1 home or he would be obtained by law enforcement. Family unable to care for Resident 1 at home; no other options available. Copy of discharge notice provided to family. 6) On 8/23/18 approx. 11:30a, detective notified	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 13 administrator via phone that an officer will be arriving to the facility within an hour to pick up Resident 1 to take him to Cumberland County jail. Family of Resident 1 at bedside. Resident discharged to law enforcement approx. 1:00p. Medications provided to officer. 7) On 8/23/18 at approx. 3:30p Psych arrived to evaluate Resident 2; resident had no recollection of the incident and displayed no signs of mental anguish. Resident 2 was placed on acute charting and monitoring for changes in mood and behavior. RP of Resident 2 cooperative and satisfied with facility interventions and appreciative of the quick responses and reporting. RP did not wish to press charges against Resident 1. 8) On 8/24/18, staff in serviced on abuse, how to respond the media, and residents/family questions regarding the incident. Inservices conducted by administrator and facility performance improvement nurse/staff development coordinator. Other resident's on that unit interviewed for any inappropriate behaviors. The two non-verbal residents on that unit were observed by the RN MDS Coordinator. No other concerns or issues noted. After interviews it has been concluded that this was an isolated incident. 9) An initial investigation report was sent to DHHS on 8/23/18. Final investigation report was sent to DHHS on 8/29/18. A. Address how the facility will identify other residents having the potential to be affected by the same deficient practice 1) On 8/23/18, 100% of active residents with behaviors as identified by the MDS (Section E) have been reassessed by the IDT including the Administrator, MDS Coordinator, DON, and	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 14 Social Worker for the type of behaviors exhibited and for any resident with inappropriate sexual behaviors. Resident interventions to include but not limited to 15 minute Safety Checks and 1:1 monitoring; will be implemented based on individualized needs to protect the safety and well-being of the affected resident and all other residents. 2) From this audit it was determined one other male resident had the tendency towards inappropriate behavior. This resident was immediately placed on 24 hour one-on-one monitoring. That shall continue until the behavior is no longer exhibited or until the resident is no longer physically able to act upon the behavior. 3) Section E will be completed by the MDS Coordinator on all residents admitted after 8/24/18 to assess for any abnormal behaviors, sexually inappropriate behaviors, physically aggressive behaviors, etc. B. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur 1) Beginning on 8/24/18, all staff were in-serviced by the administrator or designee on CMS Phase 2 Regulations with re-education of staff duties to report immediately abnormal or disruptive behaviors, protecting the resident from abuse (Redirection is not an intervention), and monitoring the effectiveness of interventions. Abnormal or inappropriate behaviors should be documented by CNAs in the kiosk under the behavior section and the nurse will document in the nurses note. 2) Staff not in-serviced by 8/29/18 will be in serviced prior to the beginning of their next. 3) New staff will continue to be in-serviced on abuse prevention upon hire and at least annually.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 15	F 600		

4) During new admission conference, the Admission Coordinator will review the facility Abuse Prevention Program and inquire of any history of behaviors or abuse. Any history of abuse will communicated to the MDS Coordinator the same day.
5) Room Audit Rounds will be conducted by the QI nurse or designee to monitor for compliance with the Abuse Reporting requirements and to monitor for any abnormal behaviors. Findings will be immediately addressed by the IDT and appropriate follow-up care and monitoring will be implemented as deemed appropriate.
C. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
1) Beginning 8/24/18, outcomes of MDS audits (Section E) or other behavior with the potential to cause harm to residents were reviewed by the administrative team for alerts to inappropriate sexual behavior. Any resident who codes on the MDS as having the potential behavior will be discussed by the IDT to include administrator, DON, Social Work and MDS Coordinator during morning administrative meeting for development of actions or plan if needed. This will occur at a minimum of monthly X 3 months
2) Random Room Round audits will be conducted weekly x3, then monthly x2, then quarterly thereafter by performance improvement nurse/staff development nurse. Any abnormal behaviors or reports from staff of abnormal or inappropriate behaviors will be documented on the Room Round Audit form and sent to the ED/DNS for immediate intervention.

D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 16 1) Beginning 8/24/18, outcomes of MDS audits (Section E) or other behavior with the potential to cause harm to residents were reviewed by the administrative team for alerts to inappropriate sexual behavior. Any resident who codes on the MDS as having the potential behavior will be discussed by the IDT to include administrator, DON, Social Work and MDS Coordinator during morning administrative meeting for development of actions or plan if needed. This will occur at a minimum of monthly X 3 months 2) Random Room Round audits will be conducted weekly x3, then monthly x2, then quarterly thereafter by performance improvement nurse/staff development nurse. Any abnormal behaviors or reports from staff of abnormal or inappropriate behaviors will be documented on the Room Round Audit form and sent to the ED/DNS for immediate intervention. 3) Results/outcomes of the above plan will brought to the facility QA meeting quarterly for review by committee members for compliance. Any revisions to the plan will require re-inservicing of appropriate personnel. 4) Any revision to the plan will require the monitoring process to begin again at D(1) Validation Information On 1/11/19 at 5:19 PM an interview was held with the Acting Administrator regarding their plan of correction. According to the Acting Administrator the facility identified no other resident who had experienced any mistreatment from Resident # 1. They did this through interviewing and observing other residents who resided on the unit, on which Resident # 1 reportedly contained his limited wheelchair movements to. The Acting Administrator presented documented evidence that the audit of all facility resident behaviors was	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 600	Continued From page 17 completed on 8/23/18. According to the Acting Administrator, the facility's initial audit of 8/23/18 had revealed one cognitively impaired resident who made sexual comments but had no history of displaying physically sexual inappropriate behavior. Following 8/23/18, the facility had placed a 1 on 1 staff member with this cognitively impaired resident as an added assurance, and this intervention was to be continued long term. The Acting Administrator provided documentation of this. The Acting Administrator presented the facility abuse policy which noted there was zero tolerance for abuse. According to the Acting Administrator, this policy was discussed with all newly admitted residents and their families, and an inquiry was made of the family/resident upon admission of any previous abuse history. An online search was also conducted to assure all newly admitted residents were not listed on a published National Sex Offenders List. According to the Acting Administrator, the facility had no further newly admitted residents with sexually inappropriate behavior. Also according to the administrator, there were no residents who had been residing at the facility on 8/23/18 and who had developed sexually inappropriate behaviors since their initial audit. This was based on their continuing assessments and audits done per their POC. The Acting Administrator presented documented evidence of room audits which had been done per the schedule in their POC, and reported the quality assurance nurse observed during the room audits for residents with behaviors which would indicate they were at risk of abusing others or had experienced abuse; talked to staff members about resident behaviors; and talked to staff members to assure they knew about reporting abuse during the audits. The administrator presented documented evidence of	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING ______ B. WING ______	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	**2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303**

(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 600	Continued From page 18 abuse training that was conducted with staff, and which was completed on 8/30/18. The Acting Administrator presented documented evidence that their plan of correction was discussed in their October, 2018 quarterly quality assurance meeting, and it was determined their plan was working and no new cases of resident abuse had been found. During the survey, on 1/10/19 beginning at 8:55 AM observations were made on all facility halls revealing there were multiple staff members in attendance and supervising residents. Multiple interviews were held with random residents on all halls of the facility, and no mistreatment or fear of mistreatment was reported by residents. There were no residents observed to be displaying inappropriate sexual behaviors or abusive behaviors. There were no residents who were observed to be exposing themselves to public view. Multiple staff members were interviewed and reported they had received training regarding abuse, and all were knowledgeable regarding actions they should take if they suspected abuse. Interview with staff members revealed they were not aware of any abuse or mistreatment which had occurred since 8/23/18. Other cases of alleged abuse were reviewed, and revealed 1) no evidence any residents had been abused and 2) the facility followed their policy in regards to keeping residents safe, investigating other alleged cases, and reporting other alleged cases. The facility's date of compliance was validated at 8/30/18.	F 600		