STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0484	A. BUILDING: _____ B. WING _____	C 02/20/2019

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L 050	.2210(B) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (b) A facility shall ensure that the Division of Health Service Regulation is notified within 24 hours of the facility's becoming aware of any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1). This Rule is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to notify the Division of Health Service Regulation within 24 hours after they became aware of an allegation of resident abuse for 1 of 3 residents sampled for abuse (Resident #1). The findings included: Resident #1 was admitted to the facility on 07/16/18 with diagnoses that included Alzheimer's Disease, dementia, cognitive communication deficit and others. Review of a facility policy titled: Abuse/Neglect Prohibition Policy dated 11/20/17 read in part, "Reports of alleged incidents of abuse, neglect, exploitation, involuntary seclusion, and misappropriation of residents property should be reported to the Administrator immediately and other appropriate proper licensing and regulations enforcement agencies as follows: Abuse-no later than 2 hours following the allegation, Serious bodily injury- no later than 2 hours following the allegation, No abuse- no later than 24 hours	L 050	Plan of Correction for: Licensure Citation 10A-13D.2210(b) A Facility shall ensure that the Division of Health Service Regulation is notified within 24 hours of the facility becoming aware of any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1). As soon as the DON and Administrator were informed of the allegation by the Nursing Assistant and Resident Care Coordinator, the accused employee was suspended from access to the facility until the completion of the investigation. As soon as the DON and Administrator were informed of the allegation the incident was reported to DHSR within 17 hours, and to the Asheville Police Department on 2/5/19 within 90 minutes. Immediately following the DON and Administrator being informed of the allegation, the resident involved was assessed by an RN on 2/5/19. The resident was noted to have no visible injuries and behavior monitoring was	3/15/19

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L 050	Continued From page 1 following the allegation, and No serious bodily injury- no later than 24 hours following the allegation. " Review of an Initial Allegation Report dated 02/05/19 read in part, the Director of Nursing (DON) was notified by the Nurse Care Coordinator (NCC) that Nursing Assistant (NA) #1 witnessed NA #2 place her hand in a rapid manner to residents' arm, then when Resident #1 was verbally loud, NA #2 placed a gloved hand over her mouth and told her to "shush". Review of an Investigation Report dated 02/11/19 read in part, NA #1 stated a couple of weeks ago NA #2 was assisting her to place Resident #1 in bed. NA #1 stated that she was at the foot of the bed and NA #2 was at the head of the bed and she heard a slap and she asked NA #2 why did you do that and NA #2 replied "it was reflex and Resident #1 was scratching me." NA #1 stated at another time she and NA #2 were placing Resident #1 to bed using the lift and Resident #1 began to scream and NA #2 placed a gloved hand over Resident #1's mouth to keep from waking up the other residents. The summary of the facility investigation read in part, the facility spoke with 3 nurses and 6 NAs that had worked with NA #2 during the past 6 months. The interviews concluded that no abuse had ever been witnessed except by NA #1. NA #1 stated that she feared retaliation from NA #2 for reporting the abuse. The corrective action read in part, NA #2 denied ever laying hands on or hitting, slapping, or smacking any resident. NA #2 also denied placing a gloved hand over Resident #1's mouth. The report indicated that the facility had substantiated the abuse and terminated NA #2.	L 050	begun with no indication of any change in the resident□s behavior. Following the investigation, the employees who failed to report in a timely manner were counseled for their actions. To ensure no other residents were affected, a review of allegations of abuse and neglect from the previous 12 months indicated that each allegation was reported timely to Administration by facility staff and was reported to DHSR within 24 hours as required. Additionally, in each case where reasonable suspicion of a crime existed, the Asheville police department was notified within 2 hours of determining a reasonable suspicion of a crime. To ensure all Staff members were retrained on proper reporting and protection of residents, On 2/7/19, Administrator David Moore personally informed each Dept. Director of the incident and reasserted our policy of immediate reporting of any allegations of abuse, neglect or further suspicion of a crime. On 2/7/19 and 2/8/19 Dept. managers from every department discussed with their employees the policy and regulations on immediately reporting allegations of abuse and neglect to a supervisor. On 2/27/19 Admin David Moore informed all staff in writing, reminding them of their personal responsibility for prompt and immediate reporting of any allegation or suspicion of abuse in order to protect the residents from further abuse. Daily conversations continued through 3/1/19 with staff	

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L 050	Continued From page 2 An observation of Resident #1 was made on 02/19/19 at 11:52 AM. Resident #1 was sitting up in her wheelchair in a private dining feeding herself lunch. She was alert and verbal but was unable to answer any questions. Resident #1 was pleasant and babbled while smiling at the staff that was assisting her. No visible red marks or bruising were noted to either hand or forearm. An interview was conducted with NA #1 on 02/20/19 at 11:45 AM. NA #1 confirmed that on 01/27/19 she and NA #2 were working night shift and were in Resident #1's room putting her to bed. She added that she was at Resident #1's feet and NA #2 was at Resident #1's head. NA #1 stated that while she was removing Resident #1's shoes she heard a very loud slap and she immediately looked at NA #2 and said, "what happened" and NA #2 replied that she had slapped Resident #1 on the left forearm because she was scratching her on the chest. NA #1 stated that she told NA #2 to leave the room and she covered Resident #1 up with a blanket and left the room and stated to NA #2 that she had put her in a bad position. NA #1 added that a couple of days later on 02/02/19 she and NA #2 were again working together and were putting Resident #1 to bed with the mechanical lift and while in the lift Resident #1 began to scream. NA #1 stated that NA #2 placed her gloved hand over Resident #1's mouth to keep her from screaming and waking up other residents. NA #1 confirmed that she had not reported these events to the DON because it was night shift and the DON was not at the facility. She added that there was a nursing supervisor in the facility when the events occurred, but she wanted to report them directly to the DON. NA #1 stated that on 01/31/19 she had reached out to the NCC and made her aware of the slap that occurred on 01/27/19 and the	L 050	members in huddles and shift meetings on the importance of proper reporting.All newly hired staff members continue to be trained on reporting requirements on their first day of employment during their campus-wide orientation. New employees in every department are trained on abuse and neglect reporting during departmental orientation. Furthermore, all employees are trained annually at a minimum on abuse and neglect reporting requirements and procedures. To ensure ongoing compliance, a QAPI plan was created 2/14/19. As of 2/22/19, each Department Director has added abuse and neglect reporting to their scheduled departmental meetings for the next 6 months, and will report this to the Monthly QAPI meeting until the August QAPI meeting or until the QAPI team determines substantial compliance has been achieved. Each subsequent allegation of abuse / neglect will be reviewed by the DON, Admin and LE Director to ensure proper reporting and protection of the resident occurred. Any employees noted to be in violation of this policy, will be counseled. These reviews will be reported to the QAPI subcommittee until substantial compliance has been achieved.	

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L 050	Continued From page 3	L 050		

NCC instructed her to report it to the DON and stated she would also attempt to speak to the DON. NA #1 stated that since the investigation she had been reeducated and learned that she had to immediately report any abuse to the nurse, supervisor, or facility management and could not wait several days before telling someone what occurred. She added that she should have reported when NA #2 slapped Resident #1 on 01/27/19 to the nursing supervisor that was on duty.

An interview was conducted with the NCC on 02/19/19 at 12:27 PM. The NCC stated that on 01/31/19 NA #1 had contacted her via private messenger on social media and stated that she needed to talk to her. The NCC stated that she called NA #1 and was informed that on the last shift that she had worked with NA #2, NA #2 had slapped Resident #1 on the hand but could not recall which hand. The NCC stated that NA #1 did not want to get anyone in trouble but felt like she had an obligation to report it. The NCC stated that she told NA #1 that she needed to report the issue to the DON or Administrator. The NCC stated that she had sent a text message to the DON on 01/31/19 that stated she needed to talk to her. She added that she was off work for a few days and was unable to speak to the DON until 02/05/19 and that was when she reported the incident that NA #1 had shared with her on 01/31/19. The NCC stated she assumed that NA #1 would get in touch with the DON and report the issue. She added that as a manager she should have followed up and ensured that the abuse allegation was reported to the DON and/or Administrator immediately after she found out on 01/31/19.

An interview was conducted with NA #2 on

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L 050	Continued From page 4	L 050		

02/19/19 at 4:50 PM. NA #2 confirmed that she had been terminated from her employment at the facility on 02/07/19 for an allegation of abuse. NA #2 stated that she has never slapped or hit any resident including Resident #1 and she never placed a gloved hand over Resident #1's mouth to keep her from screaming. NA #2 stated the allegations were untrue and she would never hit or slap a resident. She added that she had abuse training at the facility and had been taught that if she witnessed or heard any abuse she should report it immediately to the facility management staff.

An interview was conducted with the DON on 02/19/19 at 1:27 PM. The DON stated that on 02/05/19 the NCC came into her office and asked if I had spoken to NA #1. She stated she replied "NO" and the NCC stated that NA #1 had reported to her that NA #2 had slapped Resident #1 a few days ago while they were providing care to Resident #1. The DON stated that she immediately stopped the conversation and they called NA #1 on the phone. During the phone conversation the DON stated that NA #1 reported that NA #2 had slapped Resident #1 and placed a gloved hand over her mouth to keep her from screaming. The DON stated that they arranged for NA #1 to come to the facility the next day to give a formal statement, but they went ahead and filed the initial report to the Division of Health Service regulation, notified the police department and began the investigation. The DON reported that NA #2 was not scheduled to work again until 02/07/19 at which time she was interviewed and terminated from employment. The DON was unaware that the NA #1 had told the NCC on 01/31/19 of the abuse allegation and stated that she expected the NCC to immediately notify herself or the Administrator, so the investigation

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L 050	Continued From page 5 could have begun immediately. The DON also stated that she would expect that NA #1 would have reported the issue at the time it occurred instead of waiting a few days before reporting it to the NCC. An interview was conducted with the Administrator on 02/19/19 at 3:28 PM. The Administrator stated that on 02/05/19 he was called into the DON's office and verbally made aware that NA #1 reported that NA #2 had slapped Resident #1. The Administrator stated that the DON immediately called NA #1 and he went and filed the initial 24-hour report with the state regulatory agency. He added that the next day NA #1 came to the facility to give her statement and the facility management team divided up the investigation to complete it. Once the information had been collected they believed they had enough information to speak to NA #2 and once we had spoken to NA #2 decided to substantiate the allegation and terminate her employment with the facility. The Administrator stated that he expected NA #1 to report the incident immediately after it occurred, and he also expected the NCC to immediately report the incident when she became aware on 01/31/19 instead of waiting until 02/05/19.	L 050		
L 051	.2210(C) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (c) A facility shall investigate allegations of any act listed in G.S. 131E-256(a)(1), shall document all information pertaining to such investigation, and shall take the necessary steps to prevent further incidents while the investigation is in progress.	L 051		3/15/19

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L 051	Continued From page 6 This Rule is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to take the necessary steps to prevent further resident abuse while the investigation was in process for 1 of 3 residents sampled for abuse (Resident #1). The findings included: Resident #1 was admitted to the facility on 07/16/18 with diagnoses that included Alzheimer's Disease, dementia, cognitive communication deficit and others. Review of a facility policy titled: Abuse/Neglect Prohibition Policy dated 11/20/17 read in part, "When there is an allegation of abuse/neglect, the Health Care Administrator or Designee will ensure that the resident/residents is/are protected from any potential further abuse/neglect during the investigative process." "This will be accomplished by removal of employee from the care of the resident/residents by reassignment to another unit, suspension or termination as the allegation may warrant. If reassigned to another unit in the facility, the employee will be strictly monitored by the direct supervisor for appropriate behavior on the newly assigned unit. The direct supervisor will also ensure there is no further contact between the complainant and the accused until the investigation is complete." Review of Nursing Assistant (NA) #1's time care dated 01/01/19 through 02/23/19 revealed that she had clocked in/out on 01/27/19, 01/28/19, 01/31/19, 02/01/19, 02/02/19, 02/03/19, 02/04/19	L 051	Plan of Correction for: Licensure Citation 10A-13D.2210 (c) A facility shall investigate allegations of any act listed in G.S. 131E256(a)(1), shall document all information pertaining to such investigation, and shall take the necessary steps to prevent further incidents while the investigation is in progress. In order to ensure the resident was protected from further harm, as soon as the DON and Administrator were informed of the allegation by the Nursing assistant and Resident Care Coordinator, the accused employee was suspended from access to the facility until the completion of the investigation. Immediately following the DON and Administrator being informed of the allegation, the resident involved was assessed by an RN on 2/5/19. The resident was noted to have no visible injuries and behavior monitoring was begun with no indication of any change in the resident□s behavior. Following the results of the investigation the accused employee was terminated from employment. To ensure no other residents were affected: Facility leadership began investigating the accusation immediately, and interviewed 3 nurses and 6 CNAs who had worked with the accused. None expressed any knowledge of any abuse of	

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L 051	Continued From page 7 and on her last day of employment on 02/07/19. Review of an Initial Allegation Report dated 02/05/19 read in part, the Director of Nursing (DON) was notified by the Nurse Care Coordinator (NCC) that NA #1 witnessed NA #2 place her hand in a rapid manner to residents' arm, then when Resident #1 was verbally loud, NA #2 placed a gloved hand over her mouth and told her to "shush". Review of an Investigation Report dated 02/11/19 read in part, NA #1 stated a couple of weeks ago NA #2 was assisting her to place Resident #1 in bed. NA #1 stated that she was at the foot of the bed and NA #2 was at the head of the bed and she heard a slap and she asked NA #2 why did you do that and NA #2 replied "it was reflex and Resident #1 was scratching me." NA #1 stated at another time she and NA #2 were placing Resident #1 to bed using the lift and Resident #1 began to scream and NA #2 placed a gloved hand over Resident #1's mouth to keep from waking up the other residents. The investigation concluded that no abuse had ever been witnessed except by NA #1 The corrective action read in part, NA #2 denied ever laying hands on or hitting, slapping, or smacking any resident. NA #2 also denied placing a gloved hand over Resident #1's mouth. The report indicated that the facility had substantiated the abuse and terminated NA #2. An observation of Resident #1 was made on 02/19/19 at 11:52 AM. Resident #1 was sitting up in her wheelchair in a private dining feeding herself lunch. She was alert and verbal but was unable to answer any questions. Resident #1 was pleasant and babbled while smiling at the staff that was assisting her. No visible red marks or	L 051	a resident by the accused or any other employee. Facility leadership also interviewed 6 interviewable residents who had been had been cared for by the accused employee in the past. None of these expressed being abused by the accused, or by any staff member, and none stated any knowledge of any abuse by the accused or any other employee. A review of all allegations of abuse or neglect in the 12 months prior to this occurrence demonstrated that the facility consistently removed each identified accused employee from resident care during the investigations thereby protecting all Residents. In order to prevent re-occurrence, Policies were reviewed and are appropriate, stating When there is an allegation of abuse/neglect, the Health Care Administrator or Designee will ensure that the resident/residents is/are protected from any potential further abuse/neglect during the investigative process. This will be accomplished by removal of employee from the care of the resident/residents& The direct supervisor will also ensure there is no further contact between the complainant and the accused until the investigation is complete. On 2/7/19, Administrator David Moore reasserted personally to each department manager the facility policy of immediate reporting of any allegations of abuse or neglect as well as need to remove the accused employee from patient care during investigation of any allegation. On 2/7/19 and 2/8/19 Dept. managers from every department	

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L 051	Continued From page 8 bruising were noted to either hand or forearm. An interview was conducted with NA #1 on 02/20/19 at 11:45 AM. NA #1 confirmed that on 01/27/19 she and NA #2 were working night shift and were in Resident #1's room putting her to bed. She added that she was at Resident #1's feet and NA #2 was at Resident #1's head. NA #1 stated that while she was removing Resident #1's shoes she heard a very loud slap and she immediately looked at NA #2 and said, "what happened" and NA #2 replied that she had slapped Resident #1 on the left forearm because she was scratching her on the chest. NA #1 stated that she told NA #2 to leave the room and she covered Resident #1 up with a blanket and left the room and stated to NA #2 that she had put her in a bad position. NA #1 added that a couple of days later on 02/02/19 she and NA #2 were again working together and were putting Resident #1 to bed with the mechanical lift and while in the lift Resident #1 began to scream. NA #1 stated that NA #2 placed her gloved hand over Resident #1's mouth to keep her from screaming and waking up other residents. NA #1 confirmed that she had not reported these events to the DON because it was night shift and the DON was not at the facility. NA #1 stated that on 01/31/19 she had reached out to the Nurse Care Coordinator and made her aware of the slap that occurred on 01/27/19. An interview was conducted with the NCC on 02/19/19 at 12:27 PM. The NCC stated that on 01/31/19 NA #1 had contacted her via private messenger on social media and stated that she needed to talk to her. The NCC stated that she called NA #1 and was informed that on the last shift that she had worked with NA #2, NA #2 had slapped Resident #1 on the hand but could not	L 051	discussed with their employees the policy and regulations on immediately reporting allegations of abuse and neglect to a supervisor. On 2/27/19 Admin David Moore informed all staff in writing, reminding them of their responsibility for prompt and immediate reporting of any allegation or suspicion of abuse in order to protect the residents from further abuse. Daily conversations continued through 3/1/19 with staff members in huddles and shift meetings on the importance of proper reporting. All newly hired staff members continue to be trained on reporting requirements on their first day of employment during their campus-wide orientation. New employees in every department are trained on abuse and neglect reporting during departmental orientation. Furthermore, all employees are trained annually at a minimum on abuse and neglect reporting requirements and procedures. To ensure ongoing compliance: A QAPI plan was created 2/14/19. As of 2/22/19, each Department Director has added abuse and neglect reporting to their scheduled departmental meetings for the next 6 months, and and will report this to the Monthly QAPI meeting until the August QAPI meeting or until the QAPI team determines substantial compliance has been achieved. Each subsequent allegation of abuse / neglect will be reviewed by the DON, Admin and LE Director to ensure proper reporting and protection of the resident occurred. Any employees noted to be in violation of this policy, will be counseled disciplined.	

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L 051	Continued From page 9 recall which hand. The NCC stated that she told NA #1 that she needed to report the issue to the DON or Administrator. She added that she was off work for a few days and was unable to speak to the DON until 02/05/19 and that was when she reported the incident that NA #1 had shared with her on 01/31/19. The NCC stated she assumed that NA #1 would get in touch with the DON and report the issue. She added that as a manager she should have followed up and ensured that the abuse allegation was reported to the DON and/or Administrator immediately after she found out on 01/31/19. An interview was conducted with NA #2 on 02/19/19 at 4:50 PM. NA #2 confirmed that she had been terminated from her employment at the facility on 02/07/19 for an allegation of abuse. She also confirmed that she had worked at the facility on the following days: 01/27/19, 01/28/19, 01/31/19, 02/01/19, 02/02/19, 02/03/19, 02/04/19 and on her last day of employment on 02/07/19. NA #2 also confirmed that she had not been suspended from employment at the facility nor has she been moved to a different unit and routinely cared for Resident #1, she stated she was scheduled off when she clocked out on 02/04/19 and was not scheduled to return until 02/07/19. NA #2 stated that she has never slapped or hit any resident including Resident #1 and she never placed a gloved hand over Resident #1's mouth to keep her from screaming. NA #2 stated the allegations were untrue and she would never hit or slap a resident. She added that she had abuse training at the facility and had been taught that if she witnessed or heard any abuse she should report it immediately to the facility management staff. An interview was conducted with the DON on	L 051	These reviews will be reported to the QAPI subcommittee until substantial compliance has been achieved.	

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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) COMPLETE DATE
L 051	Continued From page 10	L 051		

02/19/19 at 1:27 PM. The DON stated that on 02/05/19 the NCC came into her office and asked if I had spoken to NA #1. She stated she replied "NO" and the NCC stated that NA #1 had reported to her that NA #2 had slapped Resident #1 a few days ago while they were providing care to Resident #1. The DON stated that she immediately stopped the conversation and they called NA #1 on the phone. During the phone conversation the DON stated that NA #1 reported that NA #2 had slapped Resident #1 and placed a gloved hand over her mouth to keep her from screaming. The DON stated that they arranged for NA #1 to come to the facility the next day to give a formal statement. The DON reported that NA #2 was not scheduled to work again until 02/07/19 at which time she was interviewed and terminated from employment. The DON was unaware that the NA #1 had told the NCC on 01/31/19 of the abuse allegation and stated that she expected the NCC to immediately notify herself or the Administrator, so the investigation could have begun immediately, and NA #1 removed from duty to protect Resident #1 and the other residents. The DON also stated that she would expect that NA #1 would have reported the issue at the time it occurred instead of waiting a few days before reporting it to the NCC again so the residents in the facility could have been protected from any further potential abuse.

An interview was conducted with the Administrator on 02/19/19 at 3:28 PM. The Administrator stated that on 02/05/19 he was called into the DON's office and verbally made aware that NA #1 reported that NA #2 had slapped Resident #1. Once the information had been collected they believed they had enough information to speak to NA #2 and once we had spoken to NA #2 decided to substantiate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0484	A. BUILDING: _____ B. WING _____	C 02/20/2019

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L 051	Continued From page 11 allegation and terminate her employment with the facility. The Administrator stated that he expected NA #1 to report the incident immediately after it occurred, and he also expected the NCC to immediately report the incident when she became aware on 01/31/19 instead of waiting until 02/05/19 to ensure the residents were protected.	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	C 02/20/2019

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F 000	INITIAL COMMENTS No federal deficiencies were cites as a result of the complaint investigation. Event ID HF3F11.	F 000		

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

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.