STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK RD ARDEN, NC 28704

(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 223 SS=G	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, medical record review, and facility record review, the facility failed to keep one (1) of three (3) cognitively impaired residents free from abuse (Resident #1). The findings are: A policy entitled Resident Abuse and dated 03/12, provided by the facility, read in part: "No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident." Resident #1 was admitted to the facility on 01/22/09 with dementia. The latest Minimum Data Set (MDS), dated 03/27/12, revealed the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. The MDS also revealed the resident required limited to extensive assistance with most activities of daily living, including supervision with meals.	F 223	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Certified Nursing Assistant #1 was immediately suspended pending investigation. Facility Administrator and Director of Nursing immediately initiated an investigation and gathered staff and resident interviews. Resident # 1 unable to recall incident. Certified Nursing Assistant #2 along with Residents #2, #3, and #4 interviewed and corroborated series of events. Local police notified and report was made. Police investigation of incident was initiated. A 24 hour report was completed and sent to the North Carolina State Health Care Personnel Registry. Upon completion of facility investigation, Certified Nursing Assistant #1 was terminated. A 5 day report was completed and sent to the North Carolina State Health Care Personnel Registry. 2. Director of Nursing/Director of Social Services interviewed all current interviewable residents regarding abuse and neglect and no other instances were reported.	5/4/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Verna McEntire — TITLE: Administrator — (X6) DATE: 04-27-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 A 5-Working Day Report, dated 04/06/12, filed by the facility with the State Health Care Personnel Registry, was reviewed. It contained the results of the facility investigation of an alleged incident of employee to resident abuse that occurred on Saturday, 03/31/12, at 8:10 AM. The facility investigation substantiated the allegation, based on witness statements from three alert and oriented residents and from one Nursing Assistant (NA), NA #2. The investigation concluded that NA #1 assisted Resident #1 back to her table at breakfast in the main dining room and then slapped the resident on the right side of her face. Resident #1 began to cry. The report noted that NA #2 immediately reported the incident to Registered Nurse (RN) #1 and to the weekend administrative Manager on Duty (MOD). The MOD immediately contacted the Administrator and the Director of Clinical Services (DCS) by phone and instructed NA #1 to immediately leave the building until contacted by the Administrator, which she did. The report also noted that Resident #1 had pain at the time of the incident with no further injury. The report further noted that the County Department of Social Services and local law enforcement were notified with a police report filed on 03/31/12 which prompted an investigation by a detective. The employee was terminated at completion of the facility investigation. On 04/09/12 at 9:33 AM, the facility Maintenance Director who was the MOD on 03/31/12, was interviewed. He reported that on that Saturday he was approached by NA #2 who reported that NA #1 had just slapped Resident #1 and left the dining room. He stated he called the	F 223	Licensed Nursing Staff completed skin sweeps on all current residents no other unexplained skin impairments were noted. Director of Nursing/Charge Nurse interviewed all current staff regarding abuse and neglect and no other instances were reported. Director of Nursing/Charge Nurse re-educated all current staff on facility policy and procedure for abuse and neglect. Facility will continue to complete back ground checks on all newly hired employees as well as licensure checks, drug testing and checks with the Office of Inspector General. Facility will continue to complete education during orientation for new hires on facility policy and procedure for abuse and neglect. Facility will initiate education during orientation for new hires on facility policy and procedure for behavior management of residents with dementia and other related disorders. Activities Director/Director of Social Services will discuss residents' rights with residents attending monthly Residents' Council meetings.	

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F 223	Continued From page 2 Administrator who told him to send NA #1 home immediately which he did. He also called the DCS to report the incident. He stated both the Administrator and the DCS arrived at the facility within a few minutes. On 04/09/12 at 10:03 AM, the Administrator and DCS were interviewed. They reported that on 03/31/12 the MOD implemented the facility abuse policy by informing the Administrator and DCS of the alleged abuse and suspending NA #1 pending an investigation. The DCS stated that before leaving for the facility she called back and spoke to RN #1. She instructed her to do a skin sweep and body audit of Resident #1, to notify the resident's family, and to complete an incident report. The DCS stated the skin sweep and body audit revealed no bruising, red marks, or other injuries to Resident #1. The Administrator and DCS reported they arrived at the facility within a few minutes, checked on the safety and condition of Resident #1, and began their investigation. They took statements from the three alert and oriented residents and NA #2, who had all witnessed the incident. All witnesses agreed that Resident #1 had attempted to leave the breakfast table in her wheelchair and been returned to the table by NA #1 who then slapped her on the right side of her face, making the resident cry. NA #2 went to console the resident as NA #1 left the dining area. She then reported the incident to RN #1 and the MOD. The DCS further stated that the physician and the local police department were notified. An officer arrived on 03/31/12 and filed a report and a detective has continued the investigation.	F 223	3. Administrator/Director of Nursing/Director of Social Services will conduct Quality Improvement monitoring of resident abuse and neglect using a sample size of at least 6 residents 3 x weekly for 12 months. Administrator/Director of Nursing/Director of Social Services will conduct Quality Improvement monitoring of resident abuse and neglect using a sample size of at least 6 employees 3 x weekly for 12 months. 4. Administrator/Director of Nursing/Director of Social Services will report results of Quality Improvement monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	

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F 223	Continued From page 3 The Administrator and DCS made multiple attempts to contact NA #1 as part of their investigation, but she did not answer or return calls. A certified letter was sent to NA #1 who did not respond and she has since been terminated from employment. She noted that after investigation of the incident, abuse and neglect inservices for all staff were begun on 04/03/12 and completed on 04/10/12. On 04/10/12 at 3:15 PM Resident #5, who was considered alert and oriented by the facility, was interviewed. She stated that at breakfast in the dining room on 03/31/12, she was sitting at a table with Resident #1. She stated she witnessed NA #1 slap Resident #1 on the side of her head. She stated she did not see any visible injury but that Resident #1 cried momentarily. On 04/12/12 at 3:15 PM the Administrator was again interviewed. She stated all staff had been inserviced on abuse and neglect since the incident. She stated some random residents and staff had been interviewed regarding possible incidents of abuse and some random residents had been screened for injuries of unknown origin. No incidents or injuries had been found. However, the Administrator further stated that a complete audit of all residents and staff had not been performed. On 04/12/12 at 3:20 PM NA #2 was available for interview. She stated that on 03/31/12 at approximately 8:10 AM she was working in the dining room assisting residents with breakfast. She stated she witnessed Resident #1 being brought back to the table by NA #1. She stated NA #1 looked at her and said, "This is the third	F 223		

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F 223	Continued From page 4 time I've brought her back here." Then she witnessed NA #1 slap Resident #1 on the side of the head. Resident #1 started crying and NA #1 left the dining room. NA #2 stated she went to Resident #1 to comfort her, then immediately went to RN #1 and the MOD to report the incident. She stated the MOD escorted NA #2 from the building. An unsuccessful attempt was made by phone to contact NA #1 who did not return the call.	F 223		