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	345464	A. BUILDING _____ B. WING _____	C 04/13/2012

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OAK GROVE HEALTH CARE CENTER	518 OLD US HWY 221 RUTHERFORDTON, NC 28139

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F 000	INITIAL COMMENTS Immediate jeopardy began on 4/7/12 when staff failed to notify the facility administration and law enforcement when an employee brought a gun in a holster carrying in and out of resident rooms on 4 of 4 resident halls. The administrator was notified of the immediate jeopardy on 4/12/12. Immediate jeopardy was removed on 4/13/12 when the facility proviced and implemented an acceptable credible allegation of compliance.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility staff failed to protect residents on four (4) of four (4) hallways by not notifying facility administration and law enforcement of a staff member who was carrying a firearm in the facility. Immediate Jeopardy began on 4/7/12 when Transporter #1 was observed by nursing staff while he carried a gun in the facility. Immediate jeopardy was removed on 4/13/12 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual	F 323	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. F-323 4/30/2012 1. Transporter #1 is no longer employed by the facility. Facility Residents along with Licensed Nurses #1, #2 & #3 and Nursing Assistants #1, #2, #3, & #4 suffered no harm or injury from Transporter #1. A 24 hour initial report was filed with the North Carolina Department of Health and Human Services Division of Health Service Regulation-Healthcare Personnel Registry on 4-12-12 followed by a . 5 day report of the facility investigation on 4-16-12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Fred V. Colton — TITLE: Administrator — (X6) DATE: 5/1/2012

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 323	Continued From page 1 harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place. The findings are: A review of a facility document titled "Facility Employee Handbook" with a revised date of 12/06 indicated in part "Zero Violence." "The Facility prohibits any workplace conduct that could be interpreted as threatening, confrontational, offensive or violent. This expectation applies to employees, visitors, residents, resident's family members, vendors, suppliers and other parties with whom you have business contact. Some specific examples of behavior that will not be tolerated include: Possession of weapons or firearms, including those licensed to carry concealed weapons, on Facility premises or in personal or Facility vehicles, or while performing in any job related capacity." The Employee Handbook also had a cover page titled "Employee Handbook Acknowledgement Form," with an area for date and employee signature and a statement at the bottom of the page "This receipt must be placed in the personnel file." A review of the personnel file for Transporter #1 revealed he was hired on 3/21/12 in a part-time position for four (4) hours each day Monday through Friday to transport residents from their rooms to physical therapy. The file also contained the document "Employee Handbook Acknowledgement Form" and was signed and dated 3/21/12 by Transporter #1. A review of a facility document titled "Employee	F 323	2. All residents, staff and visitors have the potential to be affected, so staff interviews were conducted on 4-12-12 at 7:00 PM with staff on duty by the Facility Administrator and Regional Human Resources Director to ask of any knowledge regarding firearms and/or weapons brought on to the facility premises. There were no other reports of firearms in the facility. Administrator/Human Resources Coordinator re-educated all full-time, part-time and PRN employees on the "Zero Violence" policy which includes that "Possession of weapons or firearms, including those licensed to carry concealed weapons, on facility premises or in personal vehicles, or while performing in any job related capacity is prohibited and will not be tolerated." Also, the Administrator/Human Resources Coordinator/Director of Clinical Services further educated all full-time, part-time and PRN employees that if they observe, or are made aware of or have been subjected to firearms and/or weapons on the facility premises, they should immediately dial 911and then immediately inform the	4/30/2012

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F 323	Continued From page 2 Coaching Plan - Level 2" revealed "On Saturday 4/7/12 at 7:00 PM Transporter #1 brought in a pistol into the facility. The gun was unloaded and in a case but he did show it around." An employee statement indicated Transporter #1 "stated he was just visiting the facility and had just purchased the gun. He didn't realize he could not bring in the weapon because it was unloaded and had never been fired. He also stated the facility did not have a sign restricting firearms." The document dated 4/9/12 and signed by the Administrator revealed a violation of possession of weapons, dangerous device or substance on company property by Transporter #1 and he was suspended on 4/9/12 "until notified." A "brief description of violation and investigation" revealed Transporter #1 was responsible for transferring residents to and from therapy. His work days were Monday through Friday. During an interview on 4/11/12 at 12:20 PM the Human Resources Director stated Transporter #1 worked Monday through Friday each week and was last clocked in to work on Friday 4/6/12. She explained she was not aware of any policies and procedures regarding staff response if someone brought a gun into the facility but verified the employee handbook clearly stated firearms were not allowed in the facility. During an interview on 4/12/12 at 6:40 AM Licensed Nurse (LN) #1 stated she worked on Friday night 4/6/12 and Transporter #1 was in the facility and told her he would be working third shift on weekends as a security guard. She further stated he made various comments that only women worked in the facility and they had all	F 323	2. Cont. Administrator and/or Director of Clinical Services. Human Resources Director will review the "Zero Violence" policy with all new hires during the orientation period. Social Worker interviewed all residents to ensure that they feel safe while residing in the facility and there were no concerns. A Resident Council meeting was conducted in which the Assistant Activities Director discussed the facility's "Zero Violence" policy with the residents. Facility Administrator mailed letters to Residents' families, to ensure that they are familiar with the facility's "Zero Violence" policy. Signage was posted on all exterior facility doors to alert visitors that weapons/firearms are not permitted on the facility premises. A copy of the facility's "Zero Violence" policy was placed in the facility's employee break room. Corporate Human Resources Coordinator re-educated the facility Administrator and the facility Human Resources Director on the process of background checks for potential new hires.	

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F 323	Continued From page 3 those medications and he was going to keep them safe. She explained she did not think they needed a security guard because they had never had one before but she didn't ask anyone in administration about it. During an interview on 4/11/12 at 10:55 AM with NA #2 she stated she worked from 2:00 PM until 8:00 PM on Saturday 4/7/12. She explained she first saw Transporter #1 in the facility between 5:00 PM and 6:00 PM. She stated he walked up to the nurse's station and she saw the grip of a small gun sticking out of a pocket of his pants. She explained she did not know if the gun was loaded because she did not ask him. She further stated Transporter #1 told her he had a permit to carry it and he had permission from the Administrator to have it. NA #2 explained nursing staff took his word for it that he had permission to have the gun and they did not call the police or Administrator or Director of Nurses. She stated she saw Transporter #1 walk up and down each of the resident hallways, in and out of resident rooms and he talked with residents and asked them how they were doing. She further stated Transporter #1 took the charge keys (master keys) out of a desk drawer at the nurse's station and carried them in his pocket Saturday evening. She explained the keys opened and locked the outside doors to the facility and opened the medication room. During an interview on 4/11/12 at 3:48 PM with NA #3 she stated she worked Saturday 4/7/12 and Sunday 4/8/12 from 2:00 PM until 10:00 PM. She explained Transporter # walked up and down the resident's hallways with a gun in a holster on his right side around 6:30 PM or 7:00 PM on	F 323	3. Administrator/Human Resources Director will conduct Quality Improvement (QI) monitoring of the facility's "Zero Violence" policy by interviewing a sample of 6 staff members 3 x weekly for 3 months and then 1 x weekly for 9 months. Social Worker/Director of Clinical Services will conduct QI monitoring to ensure that the residents feel safe in the facility by interviewing a sample of 6 residents 3 x weekly for 3 months and then 1 x weekly for 9 months. 4. Administrator/Human Resources Director/Social Worker/Director of Clinical Services will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	4/30/2012 4/30/2012

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Saturday 4/7/12. She stated she did not know if the gun was loaded because she did not ask. She further stated she saw him go in the resident's rooms and come back out. She explained he told her he was a security guard for the facility at night. She stated she had not been informed by anyone in administration they had security and they had never seen a security guard in the facility before that night. NA #3 explained she thought something had happened so he was there for a reason. She stated she knew there was a facility policy that firearms weren't allowed. She further stated she was not aware of anyone calling administration about Transporter #1 and the gun on Saturday 4/7/12.

A review of a handwritten document titled "Grievance from 3rd Shift" and dated 4/7/12 revealed Transporter #1 "was carrying a gun on premises, nurse asked him to lock it up because it's a safety issue. Sat in car at 2 AM, at 3:15 AM car gone, was not here (Don't know if he was still on the clock). Left for 2 hours on a "fire" call. Made comment he can do whatever and the Administrator will not get rid of him. Kept going in resident's room with gun in holster on side, while families were here. He said if we had issues with the gun to take it up with the Administrator. Nurse said to have Administrator or Unit Manager call but he was not going to carry the gun."

During an interview on 4/12/12 at 10:00 AM with NA #4 she stated she worked Saturday 4/7/12 from 10:00 PM until 6:00 AM and saw Transporter #1 with the gun. She explained she saw him from 11:00 PM until midnight as he walked down each of the hallways and walked in and out of resident rooms. She further explained

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Transporter #1 had no purpose to walk in and out of resident rooms and she was not sure why he did it. She stated at approximately 12:15 AM Transporter #1 walked up to the nurse's station with the gun in his hand and told her he had a concealed weapons permit to carry it. She explained he was wearing dark pants "with a lot of pockets like the police wear." She stated she did not know if the gun was loaded because it didn't matter if it was or wasn't because she was afraid of it. NA #4 stated Transporter #1 told her he had told the Administrator he was going to do security from 10:00 PM until 6:00 AM on the weekends and it was okay for him to carry the gun in the facility. She further stated the licensed nurses told him he needed to lock the gun up but he didn't. She explained Transporter #1 told her she didn't understand because there were people who did crazy things and there were drugs in the facility. She further explained he walked away and she did not see him again until she saw him sitting in his vehicle at between 2:15 AM and 3:00 AM. She stated "we kept our eye on the residents and facility for our safety" and we made sure every door and window was locked and the alarms were all on. She explained after Transporter #1 left the facility nursing staff looked for the employee handbook to verify there were no guns allowed in the facility. She stated they wrote by hand the document "Grievance from 3rd Shift" and left a copy under the Administrator's door, on the Director of Nurses' desk and on the Unit Manager's desk. She verified she did not call the Police, Administrator, Director of Nurses or Unit Manager during her shift on 4/7/12 through 4/8/12. She stated there was also a Manager on Duty on the weekends but they did not call them when Transporter #1 had the gun in

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the facility. NA#4 explained she did not receive any concerns from residents or family members about Transporter #1 or the gun.

During an interview on 4/12/12 at 5:07 PM with NA #5 she stated she worked Saturday night 4/7/12 from 6:00 PM until 6:00 AM. She explained Transporter #1 walked around with a gun on his hip and told her he was security for the night. She verified she volunteered and wrote the document by hand titled "Grievance from 3rd Shift" because she and her co-workers were concerned that Transporter #1 had a gun in the facility. She stated she told him she felt unsafe and he told her nobody would take the gun from him. She further stated she did not know if the gun was loaded because she didn't ask. She explained she saw him as he walked in an out of resident's rooms and he answered call lights. She stated she did not hear any concerns from residents or family members while Transporter #1 had the gun in the facility. She further explained she was not aware that any staff called the police or anyone in administration to report Transporter #1 had a gun in the facility.

During an interview on 4/12/12 at 11:04 AM the Business Office Manager verified she was the Manager on Duty on Saturday 4/7/12 and was on call for a twenty-four hour period until Sunday morning 4/8/12. She stated she did not receive any calls from staff reporting Transporter #1 was in the facility with a gun.

On 4/12/12 at 12:47 PM surveyor left a message for Transporter #1 to return call
. Transporter #1 did not return the phone call.

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During an interview on 4/12/12 at 12:54 PM with LN #2 she stated she worked Saturday night 4/7/12 from 7:00 PM until 7:00 AM. She explained Transporter #1 was dressed in dark pants and had a gun in a holster on his right hip. She further explained after she got her shift report she started her medication pass and was in a resident's room giving medication when somebody came up behind her and scared her. She stated it was Transporter #1 and he did not knock on the resident's door before entering the resident's room. She explained he told her he had to go on a "fire call" and would be back in a couple of hours and he was doing security in the facility. She stated Transporter #1 came back to the facility later that evening when she went outside to take a break and she saw him with a flashlight walking around the facility property, was shining the light into the woods and inside and around the outside of two (2) storage buildings behind the facility. She explained he walked over to a table where she was sitting and sat down and stated "you all just don't understand what kind of neighborhood we're in and what if somebody breaks a window." She stated he further said "what if somebody breaks into a medication cart" and "all I need is this" and held his right fist up into the air. LN #2 explained she went back into the facility and was sitting at the nurse's station with other nursing staff when Transporter #1 walked up and said he had a gun and pointed to it on his right hip. She further explained he said he was doing security because the Administrator wanted him to do that. She stated she told him it didn't matter if he was doing security but he couldn't have a gun in the facility. She further stated he said he had all the equipment he needed to do security but he finally admitted the

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Administrator did not know he had a gun in the facility. She explained she told him he had to lock the gun up and he walked down the hallway with it toward the administrative offices and she did not see the gun again. She stated she wished she had called 911 but didn't because Transporter #1 finally took the gun away. She also stated she did not call the Administrator, Director of Nurses or Unit Manager and she was not aware that any staff called anyone in Administration when Transporter #1 had the gun in the facility.

During an interview on 4/13/12 at 12:11 PM with LN #3 she stated she worked every weekend and worked on Saturday 4/7/12 from 7:00 PM until 7:00 AM. She explained when she got to work Transporter #1 was already in the facility. She stated she did not see him at first and someone told her he was a security guard that night. She further stated she did not think much about it at first because "we've had a couple of things get gone lately." She explained she saw Transporter #1 at the nurse's station between 7:30 PM and 8:00 PM and told him, "I heard you have a gun" and he said "yes I do." She stated she did not ask if the gun was loaded because she didn't want to know and she didn't hear if any staff said the gun was loaded or unloaded. She further stated Transporter #1 got a little attitude when she questioned him about the gun. He told her he had the proper paperwork and if she had a problem with it to take it up with the Administrator. She explained Transporter #1 left the facility for a couple of hours because he told them he was going on a "fire call" and while he was gone the nursing staff did a search of the policy book and found there were to be no weapons on the

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premises. LN #3 stated when Transporter #1 came back to the facility between 10:00 PM to 11:00 PM the nursing staff confronted him about the gun and "I was a little bit afraid of him." She further stated she did not think he would pull the gun out but he did make a comment, "I don't really need a gun, all I need is this right here and held up his fist" She explained Transporter #1 took the gun away after 11:00 PM but she was not sure where he put it. She stated came back to the nurses station and said he put it up, went outside to his car and he was gone after 2:00 AM. LN #3 further stated she worked on Sunday 4/8/12 from 7:00 PM to 7:00 AM and Transporter #1 was there when she arrived at the facility. She explained NA #1 had been confronted by Transporter #1 and was in tears. She stated she went to check on NA #1 in the conference room and a law enforcement officer was standing in the room and she believed he had a sheriffs' badge on his shirt sleeve. She explained she went back to the nurses station and approximately 30 minutes later NA #1 came to the nurses station and Transporter #1 left the facility. She stated she did not see Transporter #1 with a gun on Sunday 4/8/12. LN #3 stated she was not aware that any staff had called anyone in administration on Saturday 4/7/12 about the gun. She explained if Transporter #1 had not taken the gun away they would have called the Administrator. She further explained there was no reason he should have had a gun in the building and she thought the staff were shocked that he had a gun and was showing it to anyone who would look at it. She explained the staff were not comfortable at all that Transporter #1 had a gun and he was a little frightening at times. She stated she was concerned if a resident had gotten out of control

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Transporter #1 might have shot someone. She explained they had residents who were confused and she was worried that a resident might get the gun because Transporter #1 had the gun tucked in his pants with a black holster around it and the handle was sticking out. She stated she had not been told by anyone in administration they would have a security guard but took Transporter #1's word for it that the Administrator had approved for him to be there as a security guard.

During an interview on 4/11/12 at 10:14 AM Nursing Assistant (NA) #1 stated she did not work on Saturday 4/7/12 but worked the 7:00 AM to 7:00 PM shift on Sunday 4/8/12. She explained when she got to work NA #2 told her Transporter #1 had a gun in the facility on Saturday 4/7/12 and he was showing it to the nursing staff in the nursing station. She stated NA #2 also told her Transporter #1 walked around the facility with the gun in his hand and told them he would use it if he had to. She explained NA #2 told her they didn't think about calling the police because Transporter #1 told them the Administrator said it was okay to have the gun in the facility. NA #1 further explained NA #2 told her Transporter #1 took the charge keys out of the desk at the nursing station and carried them around Saturday night. She stated the keys opened various doors in the building including the medication room but not the narcotic cabinet. NA #1 further stated she called the facility Administrator on Sunday evening because she was concerned about the gun, was afraid and requested for her fiancée to stay in the building until she finished her shift. She further explained after she talked with the Administrator, Transporter #1 told her fiancée he had to leave and the police arrived shortly

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thereafter. She stated the police told Transporter #1 it was not permissible for him to have a gun on the premises and if he had a gun he would be arrested and then the police left the facility.

During an interview on 4/11/12 at 1:30 PM the Director of Nurses stated she was not informed that Transporter #1 was in the facility with a gun until Sunday afternoon 4/8/12 at approximately 8:30 PM. She explained she received a call from LN #3 about the incident and she asked if the Administrator had been notified and was told staff had called him earlier on Sunday evening. She stated it was her expectation staff should have asked Transporter #1 to leave the facility immediately and they should have contacted law enforcement. She also explained the facility had a manager on duty assigned for a twenty-four hour period on Saturday and Sunday and they were expected to report any concerns to the Administrator. She stated she was not aware if the manager on duty had been notified. She further stated she thought Transporter #1 took it upon himself to perform the role of security guard without correct guidance and he should have been removed from the facility.

During an interview on 4/11/12 at 2:12 PM the Administrator stated Transporter #1 was hired as a rehabilitation transport person and before he was hired he did work as a volunteer. He stated he received a phone call from NA #1 on Sunday evening 4/8/12 at approximately 6:00 PM. He explained NA #1 told him she didn't feel comfortable with Transporter #1 and was afraid and wanted her boyfriend who was at the facility to stay there with her. He explained Transporter

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#1 got upset with the boyfriend because he didn't like where the boyfriend was standing and called the Administrator and during this call Transporter #1 admitted he brought a gun into the facility on Saturday 4/7/12. He further stated Transporter #1 told him he had called a friend at the police department and the officer was presently at the facility. The Administrator stated he talked to the police officer and told Transporter #1 to go home. He explained Transporter #1 came to his office on Monday morning 4/9/12 and said he wasn't aware he couldn't have a gun in the facility. The Administrator verified he did not receive any phone calls from the facility staff on Saturday 4/7/12 but it was his expectation staff should have immediately called the police and Administrator.

The Administrator was informed of Immediate Jeopardy on 4/12/12 at 4:10 PM.
The facility provided a credible allegation of compliance which included:

Allegation of Substantial Compliance
1. Area police officer responded to a call from the facility on Sunday, April 8, 2012 at approximately 6:30 PM. The call was initiated by Transporter #1 in regards to a verbal confrontation with a guest in the facility. During the course of the officer ' s visit, Nursing Assistant #1 reported to the responding officer that Transporter #1 allegedly had a gun on the facility premises on the evening of Saturday, April 7, 2012. The officer spoke with the facility Administrator via telephone and as a result of this conversation, Transporter #1 was asked by the facility Administrator to leave the facility on Sunday, April 8, 2012 at approximately 6:45 PM. Transporter #1 was instructed to report to the

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facility Administrator's office on Monday, April 9, 2012 at 9:00 A.M., was suspended and subsequently terminated from employment.

2. As of Thursday, April 12, 2012 at 7:00 PM, the facility Administrator and Regional Human Resources Director have interviewed all staff on duty on Thursday, April 12, 2012 at 7:00 PM to ask of any knowledge regarding firearms and/or weapons brought on to the facility premises. No other reports of firearms in the facility have been made as of this time, Thursday, April 12, 2012 at 7:00 PM. Facility Administrator and Regional Human Resources Director reiterated during the course of staff interviews that if there is a report of firearms and/or weapons on the facility premises, employee will immediately dial 911 and then notify the facility Administrator and/or Director of Clinical Services. In addition, a posting of the "Zero Violence" policy has been placed in the employee break room on Thursday, April 12, 2012 at 7:30 PM.

3. The following steps were taken:
a. Administrator/Human Resources Coordinator initiated re-education to full-time, part-time and PRN employees on Wednesday, April 11, 2012 at approximately 1:00 PM on "Zero Violence" policy which includes that "Possession of weapons or firearms, including those licensed to carry concealed weapons, on facility premises or in personal or facility vehicles, or while performing in any job related capacity" is prohibited and will not be tolerated. In-service will be completed by Friday, April 13, 2012 by 9 AM. After 9 AM on Friday, April 13, 2012, employees who have not completed the in-service will not be permitted to work until the education is completed.

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F 323	Continued From page 14 b. Administrator/Human Resources Coordinator/Director of Clinical Services further educated full-time, part-time and PRN employees on Wednesday, April 11, 2012 at approximately 1:00 PM that if they observe, or are made aware of or have been subjected to firearms and/or weapons on the facility premises, they should immediately dial 911 and then immediately inform the Administrator and/or Director of Clinical Services. In-service will be completed by Friday, April 13, 2012 by 9 AM. After 9 AM on Friday, April 13, 2012, employees who have not completed the in-service will not be permitted to work until the education is completed. c. Any violations of the "Zero Violence" policy will be thoroughly investigated and where warranted disciplinary action taken, up to and including immediate termination of the offending employees. If non-employees are involved, full-time, part-time and PRN employees should immediately dial 911 and then inform the Administrator and/or Director of Clinical Services. In certain matters having criminal implications, violations may be reported to the police or other law enforcement personnel. d. Employees will not be retaliated against for making good faith reports under this policy. e. A 24 hour initial report was filed with the North Carolina Department of Health and Human Services Division of Health Service Regulation-Healthcare Personnel Registry on Thursday, April 12, 2012 at approximately 9:00 AM. A 5 day report to follow upon completion of facility investigation. f. Social Worker initiated interviews on Wednesday, April 12, 2012 at approximately 2:00 PM with 57 interviewable residents to ensure that they feel safe while residing in the facility. The	F 323		

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resident interviews were completed on Thursday, April 12, 2012 at approximately 11:00 AM. The results indicated that the residents feel safe while residing in the facility. The Administrator investigated one non-related concern which was resolved with a grievance on Wednesday, April 11, 2012.

g. Assistant Activity Director informed residents during resident council meeting of the "Zero Violence" policy as it relates to firearms on the facility premises on Thursday, April 12, 2012 at approximately 10:00 AM. He advised residents that the facility strives to ensure residents are always safe and that should they have any concerns related to their safety, they can notify any member of the staff.

h. Residents' families to be reminded via mail of the "Zero Violence" policy. Letters will be mailed out by Friday, April 13, 2012 by 12:00 PM.

i. Signage was posted on all exterior facility doors on Wednesday, April 11, 2012 at approximately 8:00 PM to alert visitors that weapons/firearms are not permitted on the premises.

j. Corporate Human Resources Director re-educated Administrator and facility Human Resources Coordinator on Thursday, April 12, 2012 at approximately 4:00 PM on background check results for potential hires. Administrator and facility Human Resources Coordinator fully understand that the Corporate Human Resources Director must be notified prior to hire for any backgrounds revealing more than a minor traffic violation.

4. The following steps have been taken and monitoring will be ongoing:

a. Administrator/Human Resources

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F 323	Continued From page 16 Coordinator/Director of Clinical Services will conduct Quality Improvement (QI) monitoring of the "Zero Violence" policy as it relates to firearms on the premises of the facility. He/She will interview 6 staff members (equating to approximately 18% of the total employee population per week) about the "Zero Violence" policy as it relates to firearms on the facility premises and to whom and when to report any instances. QI monitoring initiated on Wednesday, April 11 at approximately 4:00 PM and will continue to be conducted 3 x weekly for 3 months and 1 x weekly for 9 months. b. Social Worker/Director of Clinical Services will interview residents to ensure that they feel safe while residing in the facility. She will interview 6 residents (equating to 30 % of the total resident population per week). QI monitoring initiated on Wednesday, April 11 at approximately 2:00 PM and will continue to be conducted 3 x weekly for 3 months and 1 x weekly for 9 months. c. Administrator/Human Resources Director/Social Worker/Director of Clinical Services will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision. The next meeting will be on Friday, April 13, 2012 at 9:00 AM. Immediate Jeopardy was removed on 4/13/12 at 3:20 PM with interviews of nursing assistants, licensed nursing staff and administrative staff who worked as Managers on Duty confirmed they received inservice training on 4/11/12, 4/12/12 and 4/13/12 prior to reporting on duty regarding the "Zero Violence" policy.	F 323		

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F 323	Continued From page 17 Interviews with nursing assistants, licensed nurses and administrative staff who worked as Managers on Duty revealed awareness of expectations of the "Zero Violence" policy they would immediately call 911, then the facility Administrator and/or Director of Nurses if there was a report or observation of anyone with a firearm or weapon in the facility. Interviews with residents and family members revealed they were pleased with the "Zero Violence" policy and they had not had and concerns about violations of the policy. Review of the inservice documents and sign in sheets confirmed the inservice training had been done on 4/11/12, 4/12/12 and 4/13/12 and signage was verified on all exterior facility doors to alert visitors that weapons/firearms were not permitted on the premises.	F 323		