

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to immediately notify 3 of 3 cognitive impaired residents family members (Resident #1,</p>	F 157	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by this facility of	5/16/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/15/2014

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: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	Continued From page 1 #2 and #3) of an incident in which a confused and cognitively impaired resident (Resident #4) was reported to have sexually inappropriate behavior towards the residents by touching their breasts. The findings included: Resident #1 was admitted on 2/18/2014 with diagnoses including Alzheimer ' s, Dementia with Behaviors, Diabetes, Hypertension, Macular Degeneration, Glaucoma, Gout and Esophageal Reflux. A review of the most recent Minimum Data Set (MDS) dated 3/18/2014 revealed Resident #1 had severely impaired cognition, required extensive assistance with mobility and transfers and needed limited assistance with walking and locomotion. An interview was conducted on 4/29/14 at 3:32 PM with the unit manager for the secure memory unit (where Resident #1 resided). During this interview, the unit manager reported that there was a recent incident in which a male resident was observed with sexually inappropriate behaviors. The unit manager reported that about 2 weeks ago, when she came on duty the morning of 4/17/2014, it was reported to her that Resident #4 (admitted the day before) had wandered into three different female residents ' room and fondled the residents ' breast. The unit manager indicated she contacted the director of nurses (DON), the administrator and the executive director. Further discussion revealed that she, the nurse on duty during the incident, the DON, the administrator and executive director all meet that morning to discuss the incidents. When asked about notification to families regarding the incident the unit manager replied " I was told by the executive director that she would take care of it. " The unit manager indicated that families for residents on this unit were notified	F 157	the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. Prefix Tag: F157 It is the intent of this facility to inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	<p>Continued From page 2</p> <p>when ever anything out of the ordinary occurred. An interview was conducted with a Nurse Aid (NA), who reported routinely working with Resident #1 on 4/29/2014 at 3:42 PM. During this interview, the NA reported that on the late evening hours before midnight on 4/16/2014, he witnessed Resident #4 to go into Resident #1 ' s room. He stated that he followed behind Resident #4 into the room of Resident #1. He stated that he observed Resident #4 standing over Resident #1 who was in bed. He stated Resident #4 had his hands inside of Resident #1 ' s jacket, but on top of the pajamas with his hands on the breast of Resident #1. The NA stated that Resident #1 was observed to tell Resident #4 to " stop, get out of here " . The NA reported that he reported the incident to his supervisor and had a telephone conversation about the incident on 4/17/2014 with the Executive Director, the Director of Nursing and the Administrator.</p> <p>An interview was conducted with the Nursing Home Administrator, the Director of Nursing (DON), Executive Director and Administrator in training on 4/29/2014 and began at 4:37 PM. During his interview the Administrator sated that on the morning of the 4/17/2014, he met with the Night shift Nurse supervisor, the DON and the Executive Director. He stated that the meeting was pertaining to Resident #4 ' s sexually inappropriate behaviors on the night of 4/16/2014 and early morning hours on 4/17/2014. The Director of Nursing stated that she was told by her nurse supervisor that Resident #4 was observed to go into Resident #1 ' s room by a Nurse Aid. She stated they spoke to the Nurse Aid who observed the incident via telephone on 4/17/2014. The DON additionally stated that the NA stated Resident #4 ' s hands were under the jacket, but on top of the pajamas of Resident #1.</p>	F 157	<p>existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 0483.12(a).</p> <p>It is also the intent of this facility to promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in 0483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>It is also the intent of this facility to record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>1) CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS TO HAVE BEEN AFFECTED BY THE ALLEGED DEFICIENT PRACTICE. This facility notified family members of the three identified cognitively impaired residents on April 21, 2014 and documented the notification in the resident's clinical records.</p> <p>2)CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE. Twenty-four hour repors and incident reports for the last 30 days were reviewed</p>		

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	<p>Continued From page 3</p> <p>When asked where Resident #4 ' s hands were on Resident #1 ' s body, the DON stated that she was not sure and that she " just assumed the stomach area " .</p> <p>When asked if they notified the family, the Administrator stated yes, and reviewed his note with this surveyor where he told a son on 4/22/14. The Administrator was unable to state which son of Resident #1 he talked to on 4/22/2014. The Administrator stated the police department showed up on 4/21/2014 with concerns about the incident and stated the family of Resident #1 wanted to have the resident sent to the Emergency Room (ER) for evaluation. He stated they sent her out (after the police told him the family wanted Resident #1 to go to the ER) and then notified the family of the incident. The notification was on 4/22/2014.</p> <p>When questioned as to why they did not notify the family of Resident #1 prior to 4/22/2014, the Executive Director stated that they wanted to make sure the staffs were not " over exaggerating " and further stated they wanted to be sure they had accurate information before they notified families.</p> <p>A review of the medical chart on 4/29/14 for Resident #1 revealed there was no documentation on 4/16 or 4/17, 2014 regarding the family being notified of resident #4 ' s touching resident #1 ' s breast.</p> <p>Continued review of the nurse ' s notes for Resident #1 revealed a notation on 4/22/2014 that stated the resident returned from a local hospital Emergency Room (ER). The note did not indicate what the ER visit was for</p> <p>An additional general noted dated 4/22/2014 by the Nursing Home Administrator, revealed he met with a son of Resident #1 and explained that Resident #1 was being monitored for sins and</p>	F 157	<p>to ensure family members were contacted if incidents had occurred to include resident to resident incidents. All family members were found to have been contacted.</p> <p>3)MEASURES TO BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT OCCUR.</p> <p>The facility's policies regarding Change in a Resident's Condition or Status was updated to include notifying family members of resident to resident incidents and documentation of the notification in the resident's clinical record. Incident reports including resident to resident altercations are reviewed daily in stand up meetings. The incident reports include a section for notation that the family member has been contacted. Nursing (RN's and LPN's) staff, were educated on change in policy regarding change in resident's condition or status by Director of Nursing, Assistant Director of Nursing, and Staff Development. The facility's in service program was updated to specifically address resident to resident incident reporting, notification, and documentation requirements.</p> <p>4)FACILITY'S PLAN TO MONITOR ITS PERFORMANCE SO SOLUTIONS ARE SUSTAINED, EVALUATED FOR EFFECTIVENESS, AND INTEGRATED INTO THE FACILITY'S QAPI PROCESS. These measures will be monitored by the Nursing Home Administrator through the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	<p>Continued From page 4</p> <p>symptoms of " mental distress " . The note did not indicate why Resident #1 was being monitored for " mental distress " . There was no mention of the incident in Resident #1 ' s record to include any report or documentation about notification to family members of the incident, prior to 4/22/2014.</p> <p>2. Resident # 2 was originally admitted on 9/5/13 and re-admitted on 11/14/13. Current diagnoses include Alzheimer ' s and Dementia with behavior disturbances. A review of the most current quarterly Minimum Data Set (MDS) dated 2/20/14 revealed residents cognitive skills were severely impaired. Further review of the MDS revealed the resident required extensive assistance for bed mobility and activities of daily living. An interview was conducted on 4/29/14 at 3:32pm with the unit manager for the secure memory unit. During this interview, the unit manager reported that there was a recent incident in which a male resident was observed with sexually inappropriate behaviors. The unit manager reported that about 2 weeks ago, when she came on duty the morning of 4/17/2014, it was reported to her that Resident #4 (admitted the day before) had wandered into three different female residents ' room and fondled the residents ' breast. The unit manager indicated she contacted the director of nurses (DON), the administrator and the executive director. Further discussion revealed that she, the nurse on duty during the incident, the DON, the administrator and executive director all meet that morning to discuss the incidents. When asked about notification to families regarding the incident the</p>	F 157	<p>QAPI process for a minimum of 6 months. The Nursing Home Administrator reviews all incident reports and ensures that it is completed including family member notification and clinical record documentation. The QAPI committee which includes the Adminstrator, Director of Nursing, Assistant Director of Nursing, Unit Nurse Managers, Therapy Representative, and Social Worker will monitor for effectiveness. The QAPI committee will make further recommendations to adjust measures as needed. The administrator is responsible to see that QAPI recommendations are acted upon in a timely manner.</p> <p>5)COMPLETION DATE 5/16/2014</p>		

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	<p>Continued From page 5</p> <p>unit manager replied " I was told by the executive director that she would take care of it. " The unit manager indicated that families for residents on this unit were notified when ever anything out of the ordinary occurred.</p> <p>An interview was conducted with the Nursing Home Administrator, the Director of Nursing (DON), Executive Director and Administrator in training on 4/29/2014 and began at 4:37PM. During this interview the Administrator sated that on the morning of 4/17/2014, he met with the Night shift Nurse supervisor, the unit manager, the DON and the Executive Director. He stated that the meeting was pertaining to Resident #4 ' s sexually inappropriate behaviors on the night of 4/16/2014 and early morning hours on 4/17/2014. . During this interview the DON went to get the notes and staff written statement so she could provide accurate information. The DON indicated the staff reported that a staff member had witnessed Resident #4 touching the breast of Resident #2 during the 3:00pm - 11:00pm shift. The DON indicated the staff placed Resident #4 on 1-1 observation/care after the incident and called her to report incident. Further discuss revealed that the DON, and the administrator wanted to be sure they had accurate information before they notified families. Staff members provided written statements to the administrative staff on 4/22/14 regarding resident #4 ' s behavior on 4/16-17, 2014. The DON read the staff statements during the interview. The families of the female residents involved were notified at that time. The administrator indicated that on 4/21/14 he received a visit from members of the local police force regarding the sexual behavior of resident #4.</p> <p>A review of the medical chart on 4/29/14 for</p>	F 157			

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	<p>Continued From page 6</p> <p>Resident #2 revealed there was no documentation on 4/16 or 4/17, 2014 regarding the family being notified of resident #4 ' s touching resident #2 ' s breast.</p> <p>A review of the medical chart on 4/29/14 for Resident #2 revealed a series of nurse ' s notes dated 4/22/14 which referred to the incident that had occurred 7 days prior. The first note was at 10:35am. The note documented an attempt to notify family of reported touching of breasts by another male resident. It also stated other female residents were being interviewed and that the male resident was in the facility for approximately 12 hours with 1-1 care before being discharged from the facility. The next note at 1:38pm documented family member had been informed of the incident. The next note at 2:35pm indicated the resident was " alert and responsive. Confused due to dementia. Quite affect smiling. No signs & symptoms of mental distress. " The next note at 2:36pm documented a phone call to ----- (person ' s name) with Department of Social Services to inform him of the " occurrence as described in previous note left message on voice mail. " Resident taken to emergency room by facility for a physical exam. The next note at 7:41pm documented the residents return to the facility and that the physical exam was negative.</p> <p>3. Resident #3 was admitted to the facility on 2/6/14. Current diagnoses included Alzheimer ' s and dementia with behavior disturbances. A review of the admission minimum data set (MDS) dated 2/12/14 revealed the residents cognitive skills were severely impaired. Further review of the MDS revealed the resident required limited assistance for bed mobility.</p> <p>An interview was conducted on 4/29/14 at</p>	F 157			

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	<p>Continued From page 7</p> <p>3:32pm with the unit manager for the secure memory unit. During this interview, the unit manager reported that there was a recent incident in which a male resident was observed with sexually inappropriate behaviors. The unit manager reported that about 2 weeks ago, when she came on duty the morning of 4/17/2014, it was reported to her that Resident #4 (admitted the day before) had wandered into three different female residents ' room and fondled the residents ' breast. The unit manager indicated she contacted the director of nurses (DON), the administrator and the executive director. Further discussion revealed that she, the nurse on duty during the incident, the DON, the administrator and executive director all meet that morning to discuss the incidents. When asked about notification to families regarding the incident the unit manager replied " I was told by the executive director that she would take care of it. " The unit manager indicated that families for residents on this unit were notified when ever anything out of the ordinary occurred.</p> <p>An interview was conducted with the Nursing Home Administrator, the Director of Nursing (DON), Executive Director and Administrator in training on 4/29/2014 and began at 4:37PM. During this interview the Administrator sated that on the morning of 4/17/2014, he met with the Night shift Nurse supervisor, the unit manager, the DON and the Executive Director. He stated that the meeting was pertaining to Resident #4 ' s sexually inappropriate behaviors on the night of 4/16/2014 and early morning hours on 4/17/2014. . During this interview the DON the DON went to get the notes and staff written statement so she could provide accurate information. The DON indicated the staff reported that a staff member</p>	F 157			

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2014
NAME OF PROVIDER OR SUPPLIER ABERNETHY LAURELS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 LEONARD AVENUE NEWTON, NC 28658		
(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 157	<p>Continued From page 8</p> <p>had witnessed Resident #4 touching the breast of Resident #3 during the 3:00pm - 11:00pm shift. The DON indicated the staff placed Resident #4 on 1-1 observation/care after the incident and called her to report incident. Further discuss revealed that the DON and the administrator wanted to be sure they had accurate information before they notified the families. Staff members provided written statements to the administrative staff on 4/22/14 regarding resident #4 ' s behavior on 4/16-17, 2014. The DON read the staff statements during the interview. The families of the female residents involved were notified at that time. The administrator indicated that on 4/21/14 he received a visit from members of the local police force regarding the sexual behavior of resident #4.</p> <p>A review of the medical chart on 4/29/14 for Resident #3 revealed there was no documentation on 4/16 or 4/17, 2014 regarding the family being notified of resident #4 ' s touching resident #3 ' s breast.</p> <p>The only documentation available in Resident #3 ' s medical record was dated 4/22/14. The general note was dated 4/22/14 at 10:36am and signed by the administrator. The note stated the family member had been called to report " touching of breasts by a male resident " to resident #3. It was explained that this was witnessed by staff. It took place between the doorway between the hall and her room. Resident was immediately separated. " Your ----- (resident) does not ' t recall the event and seems happy. We are monitoring for any signs of mental anguish and currently we are not seeing any signs of distress or mental anguish. "</p>	F 157			