DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	CONSTRUCTION		E SURVEY PLETED
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	NG _			
		345155	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	05	5/23/2017
					30 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHAB	BILITATION CENTER		A	ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F	000			
	A complaint investiga from 5/16/17 through jeopardy was identifie						
	(J) CFR 483.12 at tag F	223 at a scope and severity 226 at a scope and severity					
	(J) CFR 483.70 at tag F (J)	490 at a scope and severity					
	The tags F 223 and Substandard Quality						
		began on 5/11/17 and was An extended survey was					
F 223	from the facility and was amended.	al information was obtained the CA for F 223 and F 490 ROM	F	223			6/26/17
SS=J	ABUSE/INVOLUNTA			-			
	neglect, misappropria and exploitation as do includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to					
4 (á a	483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						06/14/2017

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/27/2017 M APPROVED D. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345155	B. WING _				C / 23/2017		
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
				230 EAST PRESNELL STREET					
RANDOLP	H HEALTH AND REHAB	ILITATION CENTER		Α	SHEBORO, NC 27203				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 223	by: Based on record revi resident and physicia to protect 2 (Resident residents from abuse cognitively impaired, and staff being sexual who was cognitively i cognitively intact, was #2. Immediate jeopardy b Resident #2 when he Resident #1. It was w #1 did not remove Re situation. Immediate 5/18/17 when an acco was provided. The fac compliance at a lowe (isolated with no actu more than minimal ha jeopardy) for example ensure all staff memb interventions put in pl Findings included: 1. Resident #2 was a 4/14/17 with multiple Intellectual Disability, ventriculo peritoneal o substance abuse. He Preadmission Screen (PASRR) level II. Rei an assisted living faci	is not met as evidenced ew, observation and staff, n interview, the facility failed ts # 2 & # 7) of 2 sampled . Resident #2, who was was witnessed by residents illy abused by Resident #1, ntact. Resident #7, who was s verbally abused by Nurse began on 5/11/17 for was sexually abused by vitnessed by NA #1 and NA esident # 2 from the jeopardy was removed on eptable credible allegation cility remains out of r scope and severity of D al harm with potential for arm that is not immediate e #2, Resident #7 and to bers are in-serviced and ace are effective. dmitted to the facility on diagnoses including hydrocephalus status post (VP) shunt and Poly was assessed as ing Resident Review sident #2 was discharged to lity on 5/12/17.	F2	223	Preparation and/or execution of this F of Correction does not constitute admission by the provider of the truth facts alleged or the conclusions set for in the statement of deficiencies. This join of correction is prepared and/or solely because it is required by the provision the Federal & State Law. 1. 5/11/17 Resident #1 and Resident were immediately separated and Resi #1 was placed on One on One Supervision. Resident #1 and Resident were interviewed separately by Social Services Director on 5/11/17 immedia following the event and both residents indicated the incident that occurred has been consensual. Police were notified immediately by the Charge Nurse and came to the facility at 8:30pm 5/11/17 interview Resident #1 and Resident # Resident #1 and Resident #2 reported that a consensual kiss occurred and denied other physical contact. Police determined and communicated to Administrator that no crime had been committed. Resident #2 was assesses the Charge Nurse on 5/11/17 following event, according to Charge Nurse Assessment was within normal limits was not documented in medical recor The Physician of Resident #1 and Resident #2 was notified by the Administrator. Resident #2 was place 15 minute checks by the charge nurse	of rth plan of #2 dent ht #2 tely ad to 2. d by g the put d. d on			
		ion Minimum Data Set ated 4/20/17 indicated that			with emotional support provided by th Social Services Director until discharg				

Facility ID: 923001

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 06/27/2017 ORM APPROVED 3 NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTIO		(X3)	DATE SURVEY COMPLETED
		345155	B. WING				C 05/23/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREETADDRES	SS, CITY, STATE, ZIP CODE		
				230 EAST PRES	SNELL STREET		
RANDOLP	H HEALTH AND REHAB	BILITATION CENTER		ASHEBORO, I	NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHC SS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	cognition related to B status (BIMS) score of includes Mental Reta disorder, encephalop verbalize needs. Had home setting but can receiving skilled thera which are not of new family." Resident #2's care pl reviewed. One of the "(name of Resident # function and impaired to MR, Anxiety disord polysubstance abuse Resident #2 "will be a needs on a daily basi injury related to cogn review date." The ap self at each interaction speaking and make en distractions and to try givers as much as por confusion. List of abuse investig (March 2017 to present the Administrator. The folders containing wri- residents and staff. T staff and residents was the two incidents was	hition. The Care Area adicated "triggered for rief Interview for mental of 08/15. Diagnoses rdation (MR), anxiety athy, and epilepsy. Able to d prior placement in group not return. Currently apy. Displays behaviors onset. Has support from an dated 4/26/17 was e care plan problems was 2) has impaired cognitive d thought processes related ler, cognitive impairment, e and epilepsy." The goal was able to communicate basic is and have minimal risk of itive impairment through the uproaches included to identify on, face resident when eye contact, reduce any to provide consistent care ossible in order to decrease ations since the last survey ent time) was requested from here were 2 incidents were ere alleging abuse. One of a for Resident #2. The staff d that Resident #2 was	F2	5/12/17. S completed BIMS (Co Resident : to ALF. Re change fre #1 is resp Party. Re education and Admin understar offered up Resident : Emergence evaluation was diagr Infection a Emergence Resident : leave of a immediate Supervisite establishe no longer Resident : Administra staff or an Resident : from last a reporting #7 by Adm Director. I this facility 2. Audit o Services I	Social Services Director d a Health Questionnaire ognitive Assessment) on #2 on 5/12/17 prior to di esident #2 with BIM of 8 om prior assessment. Re ponsible his own Responsident #1 was provided a by the Social Services nistrator on safe sex, with ding that privacy would bon request for friends/v #1 was transported to cy Room for Psych and 1 n on the night of 5/11/17 nosed with a Urinary Tra and discharged at 10:23 cy Room with a friend 5/ #1 returned to the facility absence on 5/16/17 and ely placed on One on Or on until Interdisciplinary ed a re-evaluation. Reside resides in facility as of 6 #7 was interviewed by ator and denies any abut by other resident in any of #7 BIM is 15 with no cha assessment. Abuse and education provided to R ninistrator and Social Se Nurse #2 no longer emp y.	e and ischarge 8 with no esident hsible Director th the be risitors. Medical were he ct am from (12/17. y from was ne team dent #1 5/12/17. Ise by capacity. ange abuse resident ervices loyed at	
	Resident #1 was adm	nitted to the facility on			s of current residents wit 3-15, this audit included		

Facility ID: 923001

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
					С
		345155	B. WING		05/23/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
RANDOLF	PH HEALTH AND REHAE	BILITATION CENTER		230 EAST PRESNELL STREET	
				ASHEBORO, NC 27203	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLE
F 223	Continued From page	e 3	F 22	3	
	12/22/16. His diagno	osis included a disease that		one interviews by questioning ea	ach
		al contact. His quarterly		resident to determine any other	
		ted 5/5/17 indicated that he		who have been approached in a	
	had intact cognition.			inappropriate manner by any oth	ier
				resident/staff or made to feel	
		s notes were reviewed. The		uncomfortable. Responsible Par	
		at 9:07 PM revealed "at		Guardians of residents with BIM	
		M this nurse was called to		were contacted regarding abuse	
		ig area because Resident #1 nt #2 inappropriately. When I		abuse reporting by Social Servic Director. Audits were completed	
	-	rea I noted Resident #1		5/18/17 with no new allegations	
		back into Resident #2's		time. All staff to include agency,	
		sident #1 that he needed to		interviewed by Administrator and	Staff
	•	ing right now. Resident #1		Development Coordinator on 5/1	
	then replied "I can jei	rk him off he likes it." I told		regarding abuse an abuse repor	ting. No
	him he can't do that i	n the open for all to see.		negative outcomes identified at t	his time.
		sidents and family members			
		After I started talking to		3. 5/17/17 -5/18/17 In-services	
		e sure his penis was in his		to nursing and non nursing staff	
		anging out I realized he may		Administrator and Staff Develop	
		was going on. At that time e's a grower not a shower." I		Coordinator on Abuse Prohibition	
	-	Resident #2 may not		include Elder Justice Act, what to resident displays aggressive beh	
		aid " I'm going to suck his		and actions to be taken if abuse	
		ht I'm getting me some d		observed and or suspected, repo	
		rect the conversation by		resident assessment. Staff Deve	-
	-	hat was he doing and he		Coordinator provided in-service	-
	-	ated "We mad at each other		nursing and non-nursing weeker	nd and
		aide brought Resident #2		part-time staff via phone. Nursin	-
	-	and took him to the social		nursing staff not permitted to wo	
		sistant asked Resident #1		service completed. Facility to mo	
		nd he stated "Molesting this		review all new grievances in mo	-
	-	1 then came inside and said out loud "it's nothing you all		meeting to ensure proper follow identify any possible alleged abu	-
		et me some of that d and		Compliance rounds completed d	
		We immediately began 1 on		Administrator and Social Service	
		1 to monitor his behavior. At		to provide in-services on sexuali	
		strator and Director of		intimate relationships in long terr	-
		contacted. At 7:30 PM, I		settings. To be completed by 6/2	

Facility ID: 923001

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STATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		0.15455			С
		345155	B. WING		05/23/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET	
RANDOLP	H HEALTH AND REHAB	ILITATION CENTER		ASHEBORO, NC 27203	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET
F 223	Continued From page	۵ <i>4</i>	F 22	, r	
Γ 223	called on call physicia 7:45 PM. (Name of ph Resident #1 to be ser (ER) to have a psych party (RP) of Resident made aware of the new she understood. At 8: Police department an Officer) came to the b report. I explained to showed him the area well. At 8:30 PM, we h #2 and we asked what Resident #1 permission penis. Resident #2 st touched his penis and (times) and Resident like that (meaning gay #1 kept doing it and F Resident #1 had kisse mouth. Resident #2 a Resident #1 had kisse mouth. Resident #2 a Resident #1 around h police to tell Resident time he'll testify again didn't want Resident # we interviewed Resid Resident #2 wanted to But he had learned hi Officer) explained to F consequences of his acknowledged the fact the officer was stating nonemergency transp and transported him t	an and he returned the call at hysician) ordered for ht to the emergency room evaluation. The responsible th #1 was contacted and ew order and expressed that 00 PM, contacted county d at 8:15 PM (name of building to do the police him what happened. I also the incident happened in as both interviewed Resident at happened and if he gave on to touch him on his aid that Resident #1 had d he told him to stop 3x #1 did not. That he was not y) like Resident #1. Resident Resident #2 said that ed him 2x before in the lso said he didn't want im anymore. He wanted the st him. But right now he #1 to go to jail. At 8:45 PM ent #1 who said that o be touched and liked it. s lesson this time. (Name of Resident #1 the actions and he ct that he understood what	F 22	 Administrator/Staff Development Coordinator will continue to provid education to staff to include all new and any new agency. Administrato Social Worker, or Staff Developme Coordinator will provide education Abuse Prohibition to include Elder Act to all new hires during orientat This will be completed by date of compliance. All new admission par will include the facilities Abuse Pro Policy and Facility Grievance Polic discussed during admission proces 4. Audit tools will be used by Soci Services Director to interview 10 F Resident weekly x 6 weeks, then 5 Family/Residents weekly x 6 week determine if there are any new alle allegations. Audit tools will be used Administrator, Director of Nursing, Managers and Therapy Manager t interview 10 staff members weekly weeks, and then 5 staff members v x 6 weeks to determine if there are new alleged allegations. The Admi or Director of nursing will report an allegations of abuse to state and th proper authorities. Results will be I to QAPI monthly x 3 to assure compliance. 	w hires or, ent on Justice ion. ckets whibition cy to be ss. al family/ 5 ss to eged d by Unit o r x 6 weekly e any inistrator by new he
		se #1, author of the nurse's			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345155	B. WING				C 23/2017
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RANDOLI	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 223	notes dated 5/11/17 to Review of the EMS re- that a non- emergence to (the name of facility stated that they had co performing sexual act (Resident #2) and he for psychiatric evaluar stated that Resident # stretcher to the wheel Review of the ER not that Resident #1 press the (name of facility) fr Resident #1 stated th masturbating another was mentally disabled that "well, he (Reside until we got caught." Resident #1 denied "s ideation or hallucinati charges/convictions fr #1 was diagnosed wit (UTI) and was discha prescription for antibio Review of the Police revealed "Nurse repo had observed a male facility masturbating a (Resident #2). Nurse (Resident #2) being m mental capacity to co report further indicate Nurse interviewed the #2). He stated that the kissed him on the mo	eport dated 5/11/17 revealed y transport was dispatched y). The nurse at the facility aught Resident #1 ts on another resident was transported to the ER tion. The report further #1 was able to walk from Ichair without assistance. es dated 5/11/17 revealed ented in ER via EMS from for psychiatric evaluation. at he "was caught patient (Resident #2) that d." Resident #1 also stated nt #2) told me he liked it The notes revealed that suicidal ideation/homicidal ons. Denies any previous or sexual assault." Resident th Urinary Tract Infection rged back to facility with a otic. report dated 5/11/17 rted that some of the staff patient (Resident #1) at the	F	223	3		

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 06/27/2017 DRM APPROVED NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		ATE SURVEY DMPLETED	
		345155	B. WING			C 05/23/2017		
NAME OF P	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				2	230 EAST PRESNELL STREET			
RANDULP	PH HEALTH AND REHAB	SEITATION CENTER		4	ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 223	until staff interrupted revealed that "while in (Resident #2), he app aware of everything th to use normal reason (Resident #2) told me not want to pursue ch he did want me to spe (Resident #1) and ma anything like this ever pursue charges." The the Police had spoker #1) who denied that t told him to stop. The written statement was reviewed. The st with Resident #1. Th when the SW question happened, he stated #2 if he could touch he Resident #1 also indig Resident #2 if he was said he was. Resident asked him if he could could. SW asked him and he said "yes." SV Resident #1 smelled foam cup with him. T smelled of beer. Whe and he replied "yes." office Resident #1 sta stop him from smokin anything he wanted.	rent occasions but he did not the incident. The report nerviewing the victim beared to be cognitively hat happened and appeared ing skills. The victim and the Nurse that he did harges at this time however eak to the offender ake him aware that if r occur again he would e report also revealed that n with the offender (Resident he victim (Resident #2) ever t from the SW dated 5/11/17 atement was an interview e statement indicated that ned Resident #1 what that he had asked Resident his d and he said he could. cated that he asked s in his right mind and he nt #1 then stated that he feel it, and he said he n if he touched Resident #2 W also revealed that alcohol and had a styro the cup was empty but en asked if he was drinking When he was leaving the ated that the facility could not ag, drinking or doing	F	223				
	was reviewed. The s	t from the SW dated 5/11/17 tatement was an interview e statement indicated that			acility (D): 923001		shoot Dogo. 7 of 5	

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345155	B. WING				C 23/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	Resident #2 stated th thought that Resident Resident #1 had told him in his b h and Resident #2 stated th as a boyfriend becaus Resident #1 touching The written statement was reviewed. The si with Resident #8. Res in the smoking area w taking his hands out of waistband. The written statement was reviewed. This si interview with Resider reported to the SW th (Resident #2) were ou resident stated that R pants and he said that they kissed on the mo Resident #11 was not The written statement was reviewed. The st was in the smoking an of Resident #1 down #1 indicated that she appropriate area beca people out there. She but he would not stop The written statement was reviewed. This si with Resident #9. Re that they were all smo	at he was not a gay but he #1 was. He indicated that him that he wanted to do d then he kissed him. at Resident #1 wanted him se he was little. He denied him. t from the SW dated 5/11/17 tatement was an interview sident #8 stated that he was when he saw Resident #1's of top of Resident #2's t from the SW dated 5/12/17 tatement was from an nt #11. Resident #11 at Resident #1 and the guy ut in the smoking area. The esident #1 got in the guy's the was making it hard then buth. t available for interview. t from NA #1 dated 5/12/17 atement revealed that she rea when she saw the hands in Resident #2's pants. NA told them this was not the	F	223			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/27/2017 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345155	B. WING				C 23/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLF	PH HEALTH AND REHAE	BILITATION CENTER			0 EAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	 #1's hands down the She yelled at him ask and he replied "was p Then Resident #1 yel your own business." went to get the nurse Resident #1 lifted Re playing with his chest and the boy gave him The written statemen was reviewed. This s with Resident #10. Re were all smoking in th Resident #9 yelled at what the h he was c and saw Resident #1 Resident #1 stated th the guy's d Reside he was serious, it wa woman out there. Re mind your own busing Resident #1's doctor' 5/15/17 was reviewed revealed that the Nur Resident #1 following The notes indicated t reported to have sexu resident (Resident #1 (Resident #2) was a challenged. A brief tour of the fac 5/16/17 at 11:40 AM. cognitively intact, was Patient Care Assistar outside of Resident # 	boy's pants (Resident #2). king him what he was doing playing with the guy's d" lled saying "you b mind NA #1 was there and she . While the NA was gone, sident #2's shirt up and was t. He asked him for a kiss in a pop kiss on the lips. t from the SW dated 5/12/17 statement was an interview esident #10 stated that they he smoking area when Resident #1 asking him doing. Resident #10 turned playing with the guy. Nat he was about to play with ent #10 asked Resident #1 if s very disrespect with esident #1 replied "b ess." s progress notes dated d. The progress notes se Practitioner had seen g an alleged sexual assault. hat Resident #1 was ually assaulted another	F	223			

Facility ID: 923001

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		345155	B. WING				/23/2017
NAME OF PI	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	was on 1:1 monitoring resident's private area On 5/16/17 at 1:55 Pf was interviewed. She facility when the incid members informed he inappropriately touche interviewed both resid statements. She also The SW added that w Resident #1, he was empty. The cup smell On 5/16/17 at 2:00 Pf interviewed. She stat from the facility on 5/ her of the situation re Resident #2. The Nu was no longer employ Police was called and interviewed. The Adr the interview with Res inappropriately touche talking to the Police, t Resident #1 and #2 w didn't implement the a Administrator had pro of the incident and the the staff. The timeline included 1. 7:21 PM, receive that there was a situa had inappropriately to	g because he had grabbed a a (Resident #2). M, the Social Worker (SW) e stated that she was at the ent happened. The staff er that Resident #1 had ed Resident #2. She dents and had written o called the Administrator. when she interviewed holding a cup that was led of beer. M, the Administrator was red that she received a call 11/17 at 7:21 PM informing garding Resident #1 and rse assigned to Resident #1 ved at the facility. The I staff and residents were ministrator stated that after sident #2 who denied being ed by Resident #1 and after he kissing between vas consensual, so she abuse policy. The wided a copy of the timeline e written statements from : d a call from facility nurse tion in which Resident #1	F	22:			
	was no emotional dis	ute checks to ensure there tress displayed. brought inside the facility					

Facility ID: 923001

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345155	B. WING				_ 23/2017
	ROVIDER OR SUPPLIER PH HEALTH AND REHAB	ILITATION CENTER	•				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	 and placed on 1:1 mod Resident #2 intertime. Resident #1 inter Follow up intervie present at the time of Physician notified orders obtained to se psychiatric evaluation Resident #1's RF Resident #2's guardia via telephone. Messa 8:30 PM, Police in residents at different the Administrator stating committed here and the alert and coherent and that happened, but din around him anymore. this time. Resident #1 out of evaluation. Resident #1 return 10:23 AM from ER wing Resident sat outside in other brought paperwisigned Resident #1 of (LOA). 	onitoring. viewed by the SW at this viewed by SW ews with staff and residents incident. d and Police called. New nd Resident #1 out for P notified at 7:30 PM. an notified by Administrator age left to please return call. nto facility and spoke to both times. Then spoke to that no crime has been hat Resident #2 was very d could explain everything dn't want Resident #1 No arrest where made at of facility via EMS for rmed to facility 5/12/17 at th significant other. in the car and significant ork in from the hospital and ut on leave of absence M, Resident #8, who has nterviewed. He stated that	F	223	3		
	5/11/17 smoking. Sev including Resident #9 smoking. He heard F turned around and sa hands out of Residen	eral other residents					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE		
			A. BUILDI	NG _			C	
		345155	B. WING			05/	23/2017	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
RANDOLF	H HEALTH AND REHAB	ILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 223	at 2:40 PM with Reside Resident #1 had kisse in the past. He indica nurse (didn't know na He added that he didn told him to stop. Resi remember the incider area. On 5/16/17 at 3:44 PP interviewed. She indi Resident #2 and he w times. She also state Resident #1. His cog able to walk but prefe NA #1 reported that s with other residents in and #10 the evening of came and sat beside later, she observed R inside the pants of Residen't say a word. Sh asking permission fro touch him. She told F wrong place for him to "you b if you didn't She then went to get On 5/16/17 at 4:25 PP observed. Resident # observed smoking in member was also obs unusual behavior obs	thing had happened. T was conducted on 5/16/17 dent #2. He stated that ed him on his lips 2-3 times the that he reported it to the me) and the Administrator. In't like him kissing him and ident #2 was unable to the on 5/11/17 in the smoking M, Nursing Aide (NA) #1 was cated that she had known vas alert but confused at ed that she had known nition was intact and he was rred to use a wheelchair. he was outside smoking noluding Resident #1, #8, #9 of 5/11/17. Resident #2 Resident #1. Few minutes esident #1. Few minutes esident #2. Resident #2 e didn't hear Resident #1 m Resident #2 if he could Resident #1 that this was a to do it and he responded like it turn your head away." the nurse. M, the smoking area was #1, #8, #9 and #10 were the smoking area. A staff served. There was no erved. M, Resident #9, who has	F	223				
		M, Resident #9, who has nterviewed. She stated that						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	· <i>`</i>				LETED
							C
		345155	B. WING	_		05/	23/2017
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLP	H HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 223	Continued From page		F	223	3		
		e smoking area smoking					
		ne evening of 5/11/17. She nt #2 came in the door and					
	sat beside Resident #						
		nands inside the pants of					
		led at Resident #1 saying					
	-	doing to that boy?" Resident th his d You b, mind					
		The NA who was in the					
	•	and she went to get the					
		ndicated that Resident #2					
		ged and he didn't know what					
	Resident #1 was doin						
	On 5/16/17 at 5:00 PM	N, Resident #10, who has					
	•	nterviewed. He stated that					
		smoking area smoking the					
	•	le saw Resident #2 came in he observed Resident #1's					
		's pants. When he asked					
		onded "getting ready to play					
		ent #10 stated that he was					
	so mad and wanted to Resident #2 has a min	b hit him. He indicated that					
		nu or a 5 year olu.					
	On 5/16/17 at 5:10 PM	M, Resident #1 was					
		ed that he remembered the					
		t #2 in the smoking area.					
		s "just playing with his d" not a big deal as Resident					
	#2 was okay with it.						
		I, the Police called back and					
	was interviewed. He	stated that the only share was "he handled the					
		ged victim wants it to be					
	handled."						
	On 5/17/17 at 1:40 PM	M, the previous					
	On 5/17/17 at 1:40 PM	M, the previous					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/27/2017 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345155	B. WING			05	C 5/23/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				230	0 EAST PRESNELL STREET		
RANDOLI	PH HEALTH AND REHAB	ILITATION CENTER		AS	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	nobody had reported been kissed by Resid On 5/18/17 at 11:30 A Resident #1 and Res He stated that the fac him about Resident # was also informed tha and there was no har indicated that he carn Resident #2. He ask he acknowledged tha him. He didn't ask hit touching because he facility that he was als by Resident #1. The he went to the assiste Resident #2 was curr him. He asked him a about the kissing and the situation. He didr inappropriate touchin him about it. The phy Resident #2 had told and not man. The ph #2 can make simple of decision and he cons fondling was a compl A telephone interview was conducted with N when she observed F Resident #2 inapprop Resident #2 away fro #2 had refused. The Resident #1 but he lo	erviewed. She stated that to her that Resident #2 had lent #1. AM, the physician of ident #2 was interviewed. Sility had called and informed at the Police was contacted m done to Resident #2. He at the Police was contacted m done to Resident #2. He to facility to assess ed him about the kiss and t Resident #1 had kissed m about inappropriate was not informed by the so inappropriately touched physician also shared that ed living facility where ently residing to interview gain and he remembered he was embarrassed about n't asked him about the g because nobody had told visician also indicated that him that he liked woman hysician stated that Resident decision but not complex idered giving a consent for ex decision to make.	F	223			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345155	B. WING				C 23/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				2	30 EAST PRESNELL STREET		
RANDOLF	H HEALTH AND REHAB	ILITATION CENTER		A	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From page	9 14	F2	223			
	The administrator was jeopardy on 5/17/17 a	s notified of immediate at 2:21 PM.					
	Credible Allegation:						
	Director notified the A event occurring in the Resident #1 allegedly Resident #2. Reside immediately separate Supervisor and Resid on one supervision. R every 15 minute chec emotional support pro Director until discharg 5/12/17. Resident #1 interviewed separatel Director on 5/11/17 in event and both indica was consensual in na Police were notified ir Nurse and came to th to interview Resident the course of this inte a consensual kiss occ physical contact. The communicated to the was committed. Staff when the event occur of the investigation, o interviews showed va event that spanned fm Resident #1 kissing R of Resident #1 touchil	touched the penis of int #1 and Resident #2 were d by the Smoking ent #1 was placed with one Resident #2 was placed on ks by the Charge Nurse with ovided by the Services ge from the Facility on and Resident #2 were y by the Social Services mediately following the ted the event that occurred ture when interviewed. The mmediately by the Charge e facility at 8:30pm 5/11/17 #1 and Resident #2 During rview both parties reported curred and denied other Police determined and Administrator that no crime and Residents present red were interviewed as part n 5/11/17 results of these rying descriptions of the					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/27/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345155	B. WING				C / 23/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				230	0 EAST PRESNELL STREET		
RANDOLI	PH HEALTH AND REHAB	SILITATION CENTER		AS	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	7:30pm. The Admini the Guardian for Resi on 5/11/17 at 8:15pm the Administrator nee that occurred at the fa Administrator attempt Guardian for Residen prior to his discharge. Administrator and the made a third attempt Resident #2 and left to previous. Resident #1 Emergency Room for evaluation, where he Urinary Tract Infection the Facility on 5/12/17 sat outside in the car the facility for a leave 5/12/17 and returned on 5/16/17 and one of immediately restarted will be discontinued w team agrees it is app Medical evaluations to Resident #2 was asso on 5/11/17 following to Charge Nurse this as limits but was not door record. The Social S Health Questionnaire assessment) with sco 5/12/17 Resident #2 was so 5/12/17 Resident #2 was so 5/12/17 Resident #2 was con 5/12/17 Resident #	dministrator on 5/11/17 at istrator attempted to notify ident #2 via phone message , the message stated that ided to discuss the event acility on 5/11/17. The ted again to notify the at #2 at 4:00pm on 5/12/17 . On 5/18/17 at 1:00pm the e Social Services Director to contact the Guardian for the same message as #1 is responsible for his own was transported to the * Psych and Medical was diagnosed with a n and discharged back to 7 at 10:23am. Resident #1 while He was signed out of of absence by his friend on from the leave of absence in One Supervision was 8. One on One Supervision when the Interdisciplinary ropriate based on Psych and o be completed by 5/23/17. essed by the Charge Nurse he event, according to the sessment was within normal cumented in the medical ervices Director completed a and BIMS (Cognitive ore of 8 on 5/12/17. On was discharged to an ty as previously planned	F	223			

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		MEDICAID SERVICES	(X2) MULTE	PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · ·	APLETED
					с	
		345155	B. WING		0	5/23/2017
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
				230 EAST PRESNELL STREET		
KANDULF	H HEALTH AND REHAE	SELITATION CENTER		ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 223	Continued From page	e 16	F 22	23		
	Assistant, Activities					
		audits of current residents				
	•	8-15. This audit was				
		 This audit include one on 				
		estioning each resident to				
		residents who have been				
		ppropriate way by any other eel uncomfortable. For				
		S score is below 8 the same				
		as conducted with their				
		No new allegations of abuse				
		e been approached in an				
		any other resident or made				
		were identified as a result				
	of these audits comp					
		inistrator, Social Services nical Services and Nurse				
		interviews with all facility				
		r unreported allegations of				
	abuse occurred. No					
		of the interviews conducted				
	by 5/18/17. No facilit	y staff shall return to work				
		ompleted. The Facility's				
		licy was reviewed by the				
		nical Services, the Director				
		dministrator and all required o F 223 were present.				
		ved a planned discharge to				
		icility on 5/12/17. Resident				
		n One Supervision in the				
		disciplinary Team agrees to				
		ych services and Medical				
	-	7. The Administrator and				
		ere immediately re-educated				
	by the District Directo					
		bhibition to include the Elder ediate notification to the				
		ations of abuse or neglect				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	
		345155	B. WING				23/2017
NAME OF PI	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2011
					230 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 223	Maintenance, Busines were re-educated by Nurse Managers, and Coordinator regarding " The definition of a Abuse means the wil unreasonable confine punishment with resu mental anguish. Abus deprivation by an indi of goods or services to or maintain physical, is well-being. It includes abuse, physical abuse including abuse facilit use of technology. Inj occur as a result of al " Immediate interva " No tolerance for a Beginning 5/18/17 no Nursing, Therapy, Ho Maintenance, Busines shall work prior to rec	 Housekeeping, Dietary, ss Office and Administration the Director of Nursing, d Staff Development g; Abuse: Iful infliction of injury, ement, intimidation, or lting physical harm, pain, or se also includes the vidual, including a caretaker, that are necessary to attain mental, and psychosocial s verbal abuse, sexual e, and mental abuse, tated or enabled through the uries of unknown origin may puse. ention to stop abuse Facility staff including 	F	22:			
	on the above prior to area by the Administra Staff Development Co will be provided this e via the Administrator, Development Coordin included in the facility newly hired Facility S	working in resident care ator, Director of Nursing or bordinator. Facility Staff education at least annually Director of Nursing or Staff nator. This education will be 's new hire orientation and taff will not be permitted to sponsibilities until they have					

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	-	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING							SURVEY PLETED
		345155	B. WING				C 23/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				2	230 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER		ł	ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	The credible allegatio 5:00 PM as evidence abuse policy and prod abuse, what to do if a aggressive behaviors abuse was observed and resident assessm residents were also in other residents were also residents were also in other residents were also Review of in-service management staff (licensed nursing staff, administrative s had been in-serviced not have the in-serviced not have the in-serviced not have the in-serviced not have the in-serviced working on floor. Review of list of alert list of families who we any other residents we 2. Resident #7 was and 11/3/14 with multiple of malignant neoplasm of Review of Resident #7 assessment dated 4/2 cognition was intact and Review of Resident #7 3/28/17 revealed "ress his nurse because hered (narcotic pain medicad was threatening his no to prioritize her care for When I asked him to me and he repeated ' me to swing at him. I	n was verified on 5/18/17 at d by staff interviews on cedures, different types of resident displayed and actions to be taken if and/or suspected, reporting nents. Alert and oriented netrviewed to assess if any affected. records revealed 142 facility g staff, unlicensed nursing taff, activities, social worker) by 5/18/17 and staff who did e will be in-serviced prior to and oriented residents and ere interviewed to assess if ere affected.	F	223			

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/27/2017 APPROVED D: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		(X3) DATE COMF	SURVEY
		345155	B. WING					C 23/2017
NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CO	DE	-	
					230 EAST PRESNELL STREET			
RANDOLF	H HEALTH AND REHAB	BILITATION CENTER			ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 223	Continued From page	- 19	E E	223	3			
1 220	he "would take care of			22.				
	ne would take care o	orme.						
		se's notes dated 3/28/17 was not available for						
		personnel records revealed ed on 4/5/17 due to no call						
	(March 2017 to prese the Administrator. The folders containing write residents and staff. T	here were 2 incidents were ere alleging abuse.One of						
	Nurse #3 revealed "a was in a room giving a Certified Medication room with a look of fe need you now." I we hear 2 people arguing When I got over to st Resident #7 were in w stop the verbal alterc became very angry c cursing him. Residen 2 Resident Care Assi and another RCA wa This is when Nurse # Resident #7 "hit me M unable to stop this for and the Activity Assis	M-F!!" over and over. I was om happening and the RCA						
	between Nurse #2 ar probably 5 minutes w	nd Resident #7 lasted						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345155	B. WING_				C 23/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			30 EAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From page	20	F 2	223			
	Review of the statemer CMA revealed "aroun heard a loud altercatic corner on station 3 be Nurse #2. Both were one another. Resider #2. Nurse #2 was tell and hit me, come on, to see if she could he said it was so sudden lot of shouting and cu individuals." A telephone interview Administrator was con PM. She indicated th incident with Residen acknowledged that sh statements from the s revealed that she had and Nurse #2 and the and so she did not pro policy. She also indic document her interview Nurse #2. An interview with the conducted on 5/17/17 Administrator read the the staff members and verbal abuse. 5/17/17 at 2:05 PM, F interviewed. He reme Nurse #2. He was ve He went to the nurse	ent written on 3/29/17 by d 5:30 PM on 3/28/17 I on coming from around the etween Resident #7 and cursing and arguing with ht #7 was threatening Nurse ling Resident #7 "go ahead f-me, f-you." I got Nurse #3 lp the confrontation. Like I and off guard there was a rsing between both with the previous nducted on 5/17/17 at 1:40 at she remembered the t #7 and Nurse #2. She he had read the written taff members. She Interviewed Resident #7 by both denied verbal abuse based that she did not with Resident #7 and current Administrator was a t 1:45 PM. The current e 3 written statements from d stated that this was a					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/27/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345155	B. WING			_		C 23/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			30 EAST PRESNELL STR	EET		
				A	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From page	21	F	223				
		2 stepped in. He was so						
		ed that he did scream at his						
		started screaming at him mad to him (Nurse #2) for						
		ot his nurse. Resident #7						
		at Nurse #2 had told him						
	because he was very	mad at him.						
	An interview with the	Activity Assistant (AA) was						
		at 2:13 PM. The AA stated						
	that she was at the nu	urse's station and she heard						
	-	r his medication. The nurse						
		#7, responded to him "it's						
		you are not going to die." k to his room and asked for						
		went to get a concern form						
	for Resident #7. Whe	-						
		creaming and cursing saying						
		ral times to Resident #7.						
		the Director of Nursing and she requested to write a						
		d that the response from the						
	nurse to the resident	was inappropriate.						
		as #2 was conducted on						
		se #3 was conducted on She stated that she was on						
		n the other station passing						
		uld hear the screaming and						
	-	A staff member (CMA)						
		come now. When she						
		esident #7 and Nurse #2 sing very loudly. She tried						
		rcation. Staff members						
	•	nem, when Nurse #2 began						
	-	#7 "hit me, hit me m-f-"over						
	and over again. The 5 minutes while she v	verbal altercation lasted for						
	An interview with CM	A was conducted on 5/18/17						

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/27/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE COMF	SURVEY PLETED
		345155	B. WING			C 1 23/2017
NAME OF P	ROVIDER OR SUPPLIER	I	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLI	PH HEALTH AND REHAB	ILITATION CENTER		EAST PRESNELL STREET IEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223 F 226 SS=J	at 9:04 AM. The CM/ another station workin loud altercation from s station 3 and observe cursing at each other, threatening Nurse #2. Resident #7 "hit me, o went to get Nurse #3. 483.12(b)(1)-(3), 483. DEVELOP/IMPLMEN POLICIES 483.12 (b) The facility must of written policies and pro- (1) Prohibit and preve exploitation of residen resident property, (2) Establish policies investigate any such a (3) Include training as §483.95 (c) Abuse, neglect, an the freedom from abur requirements in § 483 provide training to the educates staff on- (c)(1) Activities that con exploitation, and misa property as set forth a	A indicated that she was on ng and she could hear a station 3. She went to ed Resident #7 and Nurse #2 . Resident #7 was . Nurse #2 responded to come on, f-me, f-you." She . 95(c)(1)-(3) IT ABUSE/NEGLECT, ETC levelop and implement rocedures that: ent abuse, neglect, and nts and misappropriation of and procedures to allegations, and as required at paragraph as required at paragraph and exploitation. In addition to use, neglect, and exploitation a.12, facilities must also eir staff that at a minimum onstitute abuse, neglect, appropriation of resident	F 223			6/26/17

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/27/201 RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		345155	B. WING				C)5/23/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RANDOLP	H HEALTH AND REHAB	ILITATION CENTER			30 EAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	Continued From page	23	F	226			
		or the misappropriation of					
	prevention.	agement and resident abuse					
	resident and physicia determined that the fa abuse policies and pr identification (immedi residents could have (notifying the state ag services) for 2 (Resid	d on record review, observation and staff, nt and physician interview, it was nined that the facility failed to operationalize policies and procedures in the areas of ication (immediately assessing if other nts could have been affected) and reporting ing the state agency and adult protective es) for 2 (Resident #2 & #7) of 2 sampled nts reviewed for abuse.			Preparation and/or execution of this of Correction does not constitute admission by the provider of the truth facts alleged or the conclusions set f in the statement of deficiencies. This of correction is prepared and/or solel because it is required by the provision the Federal & State Law.	n of orth plan y	
	assessed for potentia abuse was not report adult protective servic sexually abused by R jeopardy was remove acceptable credible a 5/23/17. The facility r and severity of D (iso with potential for more not immediate jeopar Resident #7 and to er on abuse and the mo place are effective. Findings included:	her residents were not al abuse and the allegation of ed to the state agency and ces after Resident #2 was tesident #1. Immediate ed on 5/18/17. An illegation was provided on remains out at a lower scope lated with no actual harm e than minimal harm, that is dy) for example #2, nsure all staff are in-serviced nitoring systems put into			1. On 5/11/17 at 7:21pm the Social Services Director notified the Administrator via phone of an event occurring in the smoking area where Resident #1 allegedly touched the pe of Resident #2. Resident #1 and Resident #2 were immediately separ by the Smoking Supervisor and Resi #1 was placed with one on one supervision. Resident #2 was placed every 15 minute checks by the Charg Nurse with emotional support provide the Services Director until discharge the Facility on 5/12/17. Resident #1 Resident #2 were interviewed separa by the Social Services Director on 5/ immediately following the event and indicated the event that occurred war consensual in nature when interviewe	enis ated dent on ge ed by from and ately 11/17 both s ed.	
	January 2017 was re- Identification read in p	olicy and procedure dated viewed. The policy under part "The facility Quality rmance Improvement			The Police were notified immediately the Charge Nurse and came to the fa at 8:30pm 5/11/17 to interview Resid #1 and Resident #2 During the court	acility ent	

Event ID: MSU711

Facility ID: 923001

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/27/2017 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345155	B. WING				C 23/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLI	PH HEALTH AND REHAB	BILITATION CENTER			30 EAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 226	identify patterns and presence of abuse, n origin or misappropria facility supervisory st supervisory process of and residents for beh stress levels that may may escalate a contin The policy under Rep part "The facility will r substantiated occurre exploitation, mistreatt origin and misapprop administrator, State S Enforcement officials services (where state in long term care faci State Law through es Findings included: 1. Resident #2 was a 4/14/17 with multiple Intellectual Disability, ventriculo peritoneal substance abuse. He Preadmission Screer (PASRR) level II. Re an assisted living faci Resident #2's admiss (MDS) assessment d he had impaired cogr Assessment (CAA) in cognition related to B status (BIMS) score of includes Mental Reta	Ill review available data to trends that may indicate the eglect, injuries of unknown ate of resident property. The aff will integrate into the monitoring staff members vavior indicative of high y lead to abuse/neglect or nuum of aggression." porting and Response read in report all allegation and ences of abuse, neglect, ment, injuries of unknown riation of property to the Survey Agency, Law and adult protective e law provides for jurisdiction lities) in accordance with stablished procedures." dmitted to the facility on diagnoses including hydrocephalus status post (VP) shunt and Poly e was assessed as ning Resident Review sident #2 was discharged to ility on 5/12/17. sion Minimum Data Set ated 4/20/17 indicated that nition. The Care Area ndicated "triggered for vief Interview for mental	F	226	this interview both parties reported a consensual kiss occurred and denied other physical contact. The Police determined and communicated to the Administrator that no crime was committed. Staff and Residents prese when the event occurred were intervie as part of the investigation, on 5/11/17 results of these interviews showed var descriptions of the event that spanned from observations of a Resident #1 kissing Resident #2 to observations of Resident #1 touching the outside of Resident #1 touching the outside of Resident #2 spants and another that described Resident #1 placing his har in the pants of Resident #1 and Residert was notified by the Administrator on 5/11/17 at 7:30pm. The Administrator on 5/11/17 at 8:15pm, the message on 5/11/17 at 8:15pm, the message on 5/11/17. The Administrator attempted again to notify the Guardian for Resident #2 via phone message on 5/11/17. The Administrator attempted again to notify the Guardian for Resident #2 and left same message as previous. Resider #2 and left same message as previous. Resider is responsible for his own affairs. Resident #1 was transported to the Emergency Room for Psych and Medie evaluation, where he was diagnosed valuation, where he was diagnosed val	wed rying l ds t #2 d ss on ent ct the t #1 cal vith ed	

Facility ID: 923001

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVICED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVICED NAME OF PROVIDER OR SUPPLIER 345155 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET RANDOLPH HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET	RVEY
345155 B. WING 05/23/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH HEALTH AND REHABILITATION CENTER 230 EAST PRESNELL STREET	LD
RANDOLPH HEALTH AND REHABILITATION CENTER 230 EAST PRESNELL STREET	/2017
RANDOLPH HEALTH AND REHABILITATION CENTER	
RANDOLPH HEALTH AND REHABILITATION CENTER ASHEBORO. NC 27203	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE
F 226 Continued From page 25 F 226 verbalize needs. Had prior placement in group home setting but cannot return. Currently receiving skilled therapy. Displays behaviors which are not of new onset. Has support from family." F 226 Resident #2's care plan dated 4/26/17 was reviewed. One of the care plan problems was reviewed. The approaches included to identify polysubstance abuse and epilepsy." The goal was Resident #2 'n will be able to communicate basic needs on a daily basis and how eminimal risk of injury related to cognitive impairment through the review date." The approaches included to identify self at each interaction, face resident when speaking and make eye contact, reduce any givers as much as possible in order to decrease confusion. F 226 List of abuse investigations since the last survey (March 2017 to present time) was requested from the Administrator provided folders containing written statements from residents ware alleging abuse. One of the two incidents was for Resident #1. Current residents have the potential to be affected by this alleged deficient practice. The Social Services Director, Social Services Director, Social Services Director, Social Services Director, and Nurse Managers conducted audits of current residents with BIMS score of 8-15. This audit includes one on one interviews by questioning each resident who have been approached in an inappropriate way by any other residents who	

Facility ID: 923001

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	<u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
						С
		345155	B. WING		05	/23/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
RANDOLF	PH HEALTH AND REHAE	BILITATION CENTER		230 EAST PRESNELL STREET		
				ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 226	Continued From page	e 26	F 22	6		
	notes dated 5/11/17 a	at 9:07 PM revealed "at		have been approached in an i	nappropriate	
	approximately 7:15 P	M this nurse was called to		way by any other resident or n		
		g area because Resident #1		uncomfortable were identified	as a result	
	-	nt #2 inappropriately. When I		of these audits completed on s		
		ea I noted Resident #1		On 5/18/17 the District Directo		
		back into Resident #2's		Services re-educated the Adm		
		sident #1 that he needed to		and the Director of Nursing on		
		ng right now. Resident #1		Facility s Policy for Abuse Pr	•	
		rk him off he likes it." I told n the open for all to see.		the Elder Justice Act, reporting for the 24 Hour and 5 Day Re		
		sidents and family members		NC Health Care Personnel, ir		
		After I started talking to		and her responsibilities to coo	-	
	-	e sure his penis was in his		effective investigation by ensu		
	underwear and not ha	anging out I realized he may		interviews and assessments, i		
	not understand what	was going on. At that time		results and findings, and dete	rmining	
		e's a grower not a shower." I		interventions according to opp		
	told Resident #1 that	5		identified during the investigat		
		aid " I'm going to suck his		as assessment of all other res	idents that	
		ht I'm getting me some d		might be affected.		
	-	rect the conversation by		On 5/18/16 facility staff, the N	-	
		/hat was he doing and he ated "We mad at each other		Department including Nursing Therapy, Housekeeping, Dieta		
		aide brought Resident #2		Maintenance, Business Office		
		and took him to the social		Administration were re-educa		
		sistant asked Resident #1		Administrator and Staff Develo	-	
	-	nd he stated "Molesting this		Coordinator regarding; Abuse		
	-	1 then came inside and said		Reporting.		
		out loud "it's nothing you all				
		et me some of that d and		Beginning 5/18/17 no Facility	staff	
		We immediately began 1 on		including Nursing, Therapy,		
		1 to monitor his behavior. At		Housekeeping, Dietary, Mainte		
	7:20 PM, the adminis			Business Office and Administr		
		contacted. At 7:30 PM, I an and he returned the call at		not work prior to receiving this All new employees and any ag		
	7:45 PM. (Name of p			educated on the above prior to		
		nt to the emergency room		resident care area by the Adm		
		evaluation. The responsible		Director of Nursing or Staff De		
	party (RP) of Resider	-		Coordinator. Facility Staff will	•	
		IL # I Was contacted and			De provided	

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/27/201 MAPPROVE
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DAT	<u>O. 0938-039</u> E SURVEY IPLETED
		345155	B. WING		05	C 5/23/2017
NAME OF PR	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO		
				230 EAST PRESNELL STREET		
RANDOLP	H HEALTH AND REHAE	BILITATION CENTER		ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	Police department an Officer) came to the B report. I explained to showed him the area well. At 8:30 PM, we #2 and we asked wha Resident #1 permissi penis. Resident #2 s touched his penis and (times) and Resident like that (meaning ga #1 kept doing it and F Resident #1 had kiss mouth. Resident #2 a Resident #1 around P police to tell Resident time he'll testify again didn't want Resident we interviewed Resid Resident #2 wanted to Consequences of his acknowledged the far the officer was stating nonemergency transp and transported him for the psych evaluat to ER at 9:15 PM. Re condition."	200 PM, contacted county ad at 8:15 PM (name of puilding to do the police him what happened. I also the incident happened in as both interviewed Resident at happened and if he gave on to touch him on his aid that Resident #1 had d he told him to stop 3x #1 did not. That he was not y) like Resident #1. Resident Resident #2 said that ed him 2x before in the also said he didn't want him anymore. He wanted the t #1 this as well and that next has thim. But right now he #1 to go to jail. At 8:45 PM lent #1 who said that to be touched and liked it. is lesson this time. (Name of Resident #1 the actions and he ct that he understood what g to him. At 9:00 PM, bort picked up Resident #1 to the emergency room (ER) ion. Called and gave report esident #1 left in stable	F 2	 Administrator, Director of Nu Development Coordinator. will be included in the facility orientation and newly hired will not be permitted to assu- responsibilities until they ha this education. On 5/18/17 the Administrator of Nursing implemented a ni monitor the management of reviewing all events with the Director of Clinical Services ensure adherence to the Fa Abuse Prohibition and condi focus call, if needed, to furthe events occurring throughour ensure completion of investing reporting as required. 3. 5/17/17 -5/18/17 In-servition to all nursing and non nursing Administrator and Staff Dev Coordinator on Abuse Prohi include Elder Justice Act, with resident displays aggressive and actions to be taken if at observed and or suspected resident assessment. Facility and review all new grievand meeting to ensure proper for identify any possible alleged Compliance rounds complet Administrator and Social Set to provide in-services on set intimate relationships in long settings to all nursing and ni staff. To be completed by 6/ 	ursing or Staff This education y s new hire Facility Staff ume their floor ve completed or and Director ew system to allegations by e Division weekly to weekly to weekly to uct a weekly ther review t the week to igations and ces provided ng staff by elopment ibition to hat to do if a e behaviors, ouse was reporting and ty to monitor wes in morning illow up and to d abuse. ted daily. ervices Director xuality and g term care on nursing '29/17.	
		e statement indicated that		Administrator, Social Worke	er, or Staff	
	when the SW question	oned Resident #1 what		Development Coordinator w		

Facility ID: 923001

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CENTERS FOR MEDICARE & MEDICARE S OMB NO. 0938-039 MUTTENT ON CONSENTATION CONTENT AND CONSENTATION ADJUST AND CONSENTATION MARE OF PROVIDER OF SUPPLIER AND CONSENTATION CONTENT SUMMERS CONSENTATION NAME OF PROVIDER OF SUPPLIER SUMMERS DIAL TERM FOR MEDICARES CONSENTATION NAME OF PROVIDER OF SUPPLIER SUMMERS DIAL TERM FOR MEDICARES CONSENTATION RANDOLPH HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE 2P CODE CONSENTATION PREFX SUMMERY STREEM OF DEPICIENCES STREET ADDRESS, CITY, STATE 2P CODE CONSENTATION PREFX SUMMERY STREEM OF DEPICIENCES STREET ADDRESS, CITY, STATE 2P CODE CONSENTATION PREFX SUMMERY STREEM OF DEPICIENCES INTERCENT ADDRESS, CITY, STATE 2P CODE CONSENTATION PREFX SUMMERY STREEM OF DEPICIENCES INTERCENT ADDRESS, CITY, STATE 2P CODE CONSENTATION PREFX SUMMERS SUMMERS DEPICIENCE CONSENTATION PREFX CONSENTATION INTERNATION CENTER CONSENTATION PREFX SUMMERS DEPICIENCE DEPICIENCE CONSENTATION			ID HUMAN SERVICES				FOR	D: 06/27/2017 MAPPROVED O. 0938-0391
344155 NMME OS23/2017 NAME OF PROVIDER OR BUPPLIER STREET ADDECTORS <	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,			(X3) DAT	E SURVEY IPLETED
RANDOLPH HEALTH AND REHABILITATION CENTER 230 EAST PRESNELL STREET ASHEBORO, NC 27203 WAID PREFX TAG SUMMARY STREMENT OF DEPICIENCES (EACH DEPICENCY MUST BE PRECEDED BY FULL REQUISION OR LSCIDENTIFYING INFORMATION) ID PREFX (EACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTION (CACH CORREC			345155	B. WING			05	-
FANDOLPH HEALTH AND REHABILITION CENTER ASHEBORO, NC 27233 OWID TWEETK ISUMMARY STATEMENT OF DEPORTIONES (EACH DEPORTORY MUST BERECEDED BY TULL RECOLLATORY OR LSCIDENT PYNAG RECOLLATORY OR LSCIDENT PYNAG RECOLLATO	NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Askebor, NC 27203 WH ID PHETRY To Summary structure of DEFICIENCIES (EACH DEFICIENCY MISS E PRECEEDED by FULL PRECIDENCY Not LSC DEFILIE/ING INFORMATION) IPREFIX PREVIDERS FLANDE CORRECTION (EACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED to The APPROPRIATE DEFICIENCY) Comparison (EACH CORRECT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Comparison (EACH CORRECTION (EACH CORRECT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Comparison (EACH CORRECT ACTION (EACH CORRECT ACTION (EACH CORRECT ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION (EACH CORRECT ACTION (EACH CORRECT ACTION (EACH CORRECT ACTION THE ACTION (EACH CORRECT ACTION THE STATE (EACH CORRECT ACTION ACTION (EACH CORRECT ACTION (EACH CORRECT ACTION ACTION (EACH CORRECT ACTION ACTION (EACH CORRECT ACTIO					2	30 EAST PRESNELL STREET		
Prefix Txg reach deficiency must be preceded by Full. Resultatory or USC IDENTFYING INFORMATION) Prefix Txg reach deficiency may be a set of the could could be added to the deficiency of the could could be added to the deficiency of the could could be added to the deficiency of the could could be added to the deficiency of the could could be added to the deficiency of the could could be added to the deficiency of the could could be added to the deficiency of the could could be added to the deficiency of the	KANDOLF	T NEALIN AND RENAD	SELITATION CENTER		A	SHEBORO, NC 27203		
 happened, he slated that he had asked Resident #2 if he could touch his d— and he said he could. Resident #2 if he was in his right mind and he said he could feel if and he said he could feel if, and he said he could. SW asked him if he touched Resident #2 and he said "yes." The written statement from the SW dated 5/11/17 was reviewed. The statement indicated that Resident #1 was. He indicated that Resident #1 was not a gay but he thought that Resident #1 was. He indicated that Resident #1 was ned to do him in his b-h— and then he kissed him. Resident #2 stated that he wasted to do him in his b-h— and then he kissed bit. The written statement from the SW dated 5/11/17 was reviewed. The statement was an interview with Resident #1 was ned to go freesident #2 stated that he wass in the smoking area. The switten statement from the SW dated 5/12/17 was reviewed. This statement was an interview with Resident #1. Resident #11 and the guy (Resident #2 were was then form the SW dated 5/12/17 was reviewed. This statement was an interview with Resident #1 and the guy (Resident #2 were was then the switch #11 nerview with Resident #1 and the guy (Resident #2 were was then the switch #11 and he guy (Resident #2 were was thing in hand the uwas making it hard then they kissed on the mouth. 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
The written statement from NA #1 dated 5/12/17	F 226	happened, he stated #2 if he could touch h Resident #1 also india Resident #2 if he was said he was. Resider asked him if he could could. SW asked him and he said "yes." The written statement was reviewed. The s with Resident #2. Th Resident #2 stated th thought that Resident Resident #1 had told him in his b-h and t Resident #1 touching The written statement was reviewed. The s with Resident #8. Resi in the smoking area v taking his hands out of waistband. The written statement was reviewed. This s interview with Reside reported to the SW th (Resident #2) were our resident stated that R pants and he said that they kissed on the mod Resident #11 was not	that he had asked Resident his d and he said he could. cated that he asked is in his right mind and he in #1 then stated that he feel it, and he said he in if he touched Resident #2 t from the SW dated 5/11/17 tatement was an interview e statement indicated that him that he wanted to do then he kissed him. Hat Resident #1 wanted him se he was little. He denied him. t from the SW dated 5/11/17 tatement was an interview sident #8 stated that he was when he saw Resident #1's of top of Resident #2's t from the SW dated 5/12/17 statement was from an int #11. Resident #11 hat Resident #1 and the guy ut in the smoking area. The resident #1 got in the guy's at he was making it hard then both. t available for interview.	F	226	 provide education on Abuse Prohibition Reporting and the Elder Justice Act to include all new hires and any new age staff during initial orientation prior to t assuming responsibilities on the floor This will be completed by date of compliance. All new admission packed will include the facilities Abuse Prohib Policy and Facility Grievance Policy to discussed during admission process. new alleged allegations will be report the Administrator or Director of Nursin the state and proper authorities. 4. Audit tools will be used by Social Services Director to interview 10 Fam Resident weekly x 6 weeks, then 5 Family/Residents weekly x 6 weeks to determine if there are any new allege allegations. Audit tools will be used by Administrator, Director of Nursing, Ur Managers and Therapy Manager to interview 10 staff members weekly x weeks, and then 5 staff members weekly x 6 weeks to determine if there are are any new alleged allegations. The Administ or Director of nursing will report any r allegations of abuse to state and the proper authorities. Results will be bro to QAPI monthly x 3 to assure 	b ency heir ts ition be Any ed by hg to ily/ b d y it 6 ekly hy trator ew	

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 06/27/2017 ORM APPROVED 3 NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION		OATE SURVEY
		345155	B. WING				C 05/23/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
	H HEALTH AND REHAB			:	230 EAST PRESNELL STREET		
INANDOLI					ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	was in the smoking a of Resident #1 down #1 indicated that she appropriate area becc people out there. Sh but he would not stop The written statemen was reviewed. This s with Resident #9. Re that they were all smo just happened that sh #1's hands down the She yelled at him ask and he replied "was p Then Resident #1 ye your own business." went to get the nurse Resident #1 lifted Re playing with his chest and the boy gave him The written statemen was reviewed. This s	a 29 atement revealed that she rea when she saw the hands in Resident #2's pants. NA told them this was not the ause there were other e told Resident #1 to stop b. She went to get the nurse. t from the SW dated 5/12/17 statement was an interview esident #9 informed the SW oking in the smoking area. It he looked and saw Resident boy's pants (Resident #2). sting him what he was doing olaying with the guy's d" lled saying "you b mind NA #1 was there and she . While the NA was gone, sident #2's shirt up and was t. He asked him for a kiss h a pop kiss on the lips. t from the SW dated 5/12/17 statement was an interview esident #10 stated that they	F	226			
	were all smoking in the Resident #9 yelled at what he was doing. If Resident #1 playing we stated that he was ab d Resident #10 as serious, it was very d	he smoking area when Resident #1 asking him Resident #10 turned and saw with the guy. Resident #1 bout to play with the guy's ked Resident #1 if he was isrespect with woman out eplied "b mind your own					
	5/15/17 was reviewed	s progress notes dated d. The progress notes se Practitioner had seen			nevility. (D): 022001 (F o		

If continuation sheet Page 30 of 52

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/27/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345155	B. WING		05/23/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STAT	•
RANDOLF	PH HEALTH AND REHAE	BILITATION CENTER		230 EAST PRESNELL STREE	ET
				ASHEBORO, NC 27203	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENC	2LAN OF CORRECTION (X5) TIVE ACTION SHOULD BE COMPLETION CED TO THE APPROPRIATE DATE FICIENCY) DATE
F 226	Continued From page	e 30	F 2	226	
	The notes indicated t reported to have sexu resident (Resident #1	ually assaulted another			
	challenged.				
	A brief tour of the facility was conducted on 5/16/17 at 11:40 AM. Resident #1, who was cognitively intact, was observed in his room. Patient Care Assistant (PCA) #1 was observed outside of Resident #1's room. At 11:45 AM, PCA #1 was interviewed. She stated that Resident #1 was on 1:1 monitoring because he had grabbed a resident's private area (Resident #2).				
	was interviewed. She facility when the incic members informed he inappropriately touch interviewed both resid	M, the Social Worker (SW) e stated that she was at the lent happened. The staff er that Resident #1 had ed Resident #2. She dents and had written to called the Administrator.			
	interviewed. She sta from the facility on 5/ her of the situation re Resident #2. The NL was no longer emplo Police was called and interviewed. The Adu the interview with Re inappropriately touch talking to the Police, Resident #1 and #2 v didn't implement the Administrator had pro	M, the Administrator was ted that she received a call 11/17 at 7:21 PM informing garding Resident #1 and urse assigned to Resident #1 yed at the facility. The d staff and residents were ministrator stated that after sident #2 who denied being ed by Resident #1 and after the kissing between vas consensual, so she facility's abuse policy. The pyided a copy of the timeline and the written statements			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345155	B. WING				C 23/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		20/2011
					230 EAST PRESNELL STREET		
RANDUL	PH HEALTH AND REHAB	ILITATION CENTER			ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	from the staff. The tim assessment of other r identify other resident the abuse nor the aller reported to the state a services. The timeline included 1. 7:21 PM, receive that there was a situal had inappropriately to 2. Resident #2 was and placed on 15 min was no emotional dist 3. Resident #1 was and placed on 1:1 mo 4. Resident #2 inter time. 5. Resident #1 inter 6. Follow up intervise present at the time of 7. Physician notified orders obtained to se psychiatric evaluation 8. Resident #1's RF Resident #2's guardia via telephone. Messa 9. 8:30 PM, Police i residents at different the Administrator stating committed here and the alert and coherent an that happened, but di around him anymore. this time. 10. Resident #1 out of evaluation.	heline did not indicate that residents was completed to is who might be affected by egation of abuse was agency and adult protective : d a call from facility nurse tion in which Resident #1 buched Resident #2 removed from smoke area oute checks to ensure there tress displayed. brought inside the facility onitoring. viewed by the SW at this rviewed by SW ews with staff and residents incident. d and Police called. New nd Resident #1 out for age left to please return call. into facility and spoke to both times. Then spoke to that no crime has been hat Resident #2 was very d could explain everything dn't want Resident #1 No arrest where made at of facility via EMS for rmed to facility 5/12/17 at	F	220	6		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345155	B. WING			C 05/23/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RANDOLI	PH HEALTH AND REHAB	ILITATION CENTER			30 EAST PRESNELL STREET ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 226	Resident sat outside i other brought paperw signed Resident #1 o (LOA). On 5/16/17 at 2:05 PI intact cognition, was i he was in the smoking 5/11/17 smoking. Sev including Resident #9 smoking. He heard F turned around and sa hands out of Residen was a young guy who and he acted as if not A telephone interview at 2:40 PM with Resid Resident #1 had kisse in the past. He indica nurse (didn't know na He added that he didu told him to stop. Res remember the incider area. On 5/16/17 at 3:44 PI interviewed. She indica Resident #2 and he w times. She also state Resident #1. His cog able to walk but prefe #1 reported that she w other residents includ #10 the evening of 5/ and sat beside Reside	in the car and significant ork in from the hospital and ut on leave of absence M, Resident #8, who has nterviewed. He stated that g area the evening of eral other residents and #10 were there Resident #9 screaming, he w Resident #1 pulling his t #2's pants. Resident #2 o was mentally challenged thing had happened. was conducted on 5/16/17 dent #2. He stated that ed him on his lips 2-3 times thed that he reported it to the me) and the Administrator. n't like him kissing him and ident #2 was unable to at on 5/11/17 in the smoking M, Nursing Aide (NA) #1 was cated that she had known vas alert but confused at ed that she had known nition was intact and he was rred to use a wheelchair. NA was outside smoking with ing Resident #1, #8, #9 and 11/17. Resident #2 came ent #1. Few minutes later, nt #1 put his hands inside	F	226				

Facility ID: 923001

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345155	B. WING				C 23/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	On 5/16/17 at 4:25 Pl observed. Resident # observed smoking in member was also obs unusual behavior obs On 5/16/17 at 4:45 Pl intact cognition, was i she was outside in the with other residents the indicated that Resident sat beside Resident # Resident #1 with his h Resident #2. She yel "what the h are you #1 replied "playing wi your own business." smoking area saw it a nurse. Resident #9 in was mentally challeng Resident #1 was doin On 5/16/17 at 5:00 Pl intact cognition, was i he was outside in the evening of 5/11/17. H the door and later on hands in Resident #2 Resident #1, he respon with his d" Reside so mad and wanted to Resident #2 has a mi On 5/16/17 at 5:10 Pl interviewed. He state incident with Residen He stated that he was	M, the smoking area was #1, #8, #9 and #10 were the smoking area. A staff served. There was no erved. M, Resident #9, who has interviewed. She stated that e smoking area smoking ne evening of 5/11/17. She nt #2 came in the door and #1. Later on, she saw hands inside the pants of led at Resident #1 saying doing to that boy?" Resident th his d You b, mind The NA who was in the and she went to get the ndicated that Resident #2 ged and he didn't know what ig to him. M, Resident #10, who has interviewed. He stated that smoking area smoking the de saw Resident #2 came in he observed Resident #1's 's pants. When he asked onded "getting ready to play ent #10 stated that he was o hit him. He indicated that ind of a 5 year old.	F	226			

Facility ID: 923001

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE			
		345155	B. WING				C 23/2017		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·			
				2	30 EAST PRESNELL STREET				
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER		A	SHEBORO, NC 27203				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 226	Continued From page	2 34	F	226					
	On 5/17/17 at 1:40 PI Administrator was internobody had reported been kissed by Resid The administrator was jeopardy on 5/17/17 at Credible Allegation: 1. On 5/11/17 at 7:21 Director notified the A event occurring in the Resident #1 allegedly Resident #2. Reside immediately separate Supervisor and Resid on one supervision. F every 15 minute cheo emotional support pro Director until discharg 5/12/17. Resident #1 interviewed separatel Director on 5/11/17 in event and both indical was consensual in na Police were notified ir Nurse and came to th to interview Resident the course of this inter	M, the previous erviewed. She stated that to her that Resident #2 had lent #1. s notified of immediate at 2:21 PM. pm the Social Services administrator via phone of an e smoking area where v touched the penis of ent #1 and Resident #2 were							
	communicated to the was committed. Staff when the event occur of the investigation, o	Police determined and Administrator that no crime f and Residents present red were interviewed as part n 5/11/17 results of these rying descriptions of the om observations of a							

Facility ID: 923001

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM	: 06/27/201 APPROVE . 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			()	X3) DATE S COMPL	ETED
		345155	B. WING				C 05/2	; 23/2017
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					230 EAST PRESNELL STREET			
RANDOLP	H HEALTH AND REHAE	BILITATION CENTER			ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	E	(X5) COMPLETION DATE
F 226	Continued From pag	e 35	F	226	6			
		Resident #2 to observations		220				
	5	ing the outside of Resident						
		er that described Resident						
		in the pants of Resident #2.						
		sident #1 and Resident #2						
	-	dministrator on 5/11/17 at						
	7:30pm. The Admin	istrator attempted to notify						
		ident #2 via phone message						
		n, the message stated that						
		eded to discuss the event						
		acility on 5/11/17. The						
	-	ted again to notify the						
		nt #2 at 4:00pm on 5/12/17 e. On 5/18/17 at 1:00pm the						
		e Social Services Director						
		to contact the Guardian for						
	•	the same message as						
		#1 is responsible for his own						
	affairs. Resident #1	was transported to the						
	Emergency Room fo	r Psych and Medical						
		was diagnosed with a						
		n and discharged back to						
	-	7 at 10:23am. Resident #1						
		while He was signed out of of absence by his friend on						
	•	I from the leave of absence						
		on One Supervision was						
		d. One on One Supervision						
		when the Interdisciplinary						
		propriate based on Psych and						
		to be completed by 5/23/17.						
		essed by the Charge Nurse						
		the event, according to the						
	-	ssessment was within normal						
		cumented in the medical						
		Services Director completed a						
		e and BIMS (Cognitive						
	-	ore of 8 on 5/12/17. On						
	5/12/17 Resident #2	was discharged to an						

Facility ID: 923001

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMP	LETED
		045455					C I
	ROVIDER OR SUPPLIER	345155	B. WING			05/	23/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 230 EAST PRESNELL STREET		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page assisted Living Facilit to this event. On 5/23/17 the Admir hour report outlining t 5/11/17 and will comp details of the investiga On 5/23/17 the Admir occurring on 5/11/17 2. Current residents h affected by this allege Social Services Direc Assistant, Activities D Managers conducted with a BIMS score of completed on 5/18/17 one interviews by que determine any other n approached in an ina- resident or made to fe Residents who's BIM3 audit and interview wa Responsible Party. If or residents who have inappropriate way by to feel uncomfortable of these audits compl On 5/18/17, the Admin Director, Director Clim Managers completed staff to verify no other abuse occurred. No no	e 36 y as previously planned prior histrator completed a 24 he events occurring on blete a 5 day report with ation on 5/26/17. histrator reported the events to Adult Protective Services. have the potential to be ed deficient practice. The tor, Social Services birector, and Nurse audits of current residents 8-15. This audit was 7. This audit include one on estioning each resident to residents who have been ppropriate way by any other eel uncomfortable. For S score is below 8 the same as conducted with their No new allegations of abuse e been approached in an any other resident or made were identified as a result eted on 5/18/17. histrator, Social Services interviews with all facility r unreported allegations of		220	DEFICIENCY)		
		mpleted. The Facility's licy was reviewed by the					

Facility ID: 923001

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
				_		(C
		345155	B. WING			05/	23/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	PH HEALTH AND REHAB	ILITATION CENTER		2	30 EAST PRESNELL STREET		
10.112.021				A	ASHEBORO, NC 27203		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION
PREFIX TAG	(Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		DATE
					DEFICIENCY)		
			1				
F 226	Continued From page		F	226			
		nical Services, the Director					
	-	Iministrator and all required					
	components related to	o F 223 were present.					
	1. Resident #2 receiv	ed a planned discharge to					
		cility on 5/12/17. Resident					
		n One Supervision in the					
		disciplinary Team agrees to					
		/ch services and Medical 7. The Administrator and					
	-	ere immediately re-educated					
	by the District Directo						
		phibition to include the Elder					
		ediate notification to the					
	-	ations of abuse or neglect					
		acility staff, the Nursing , Housekeeping, Dietary,					
		ss Office and Administration					
	-	the Director of Nursing,					
	Nurse Managers, and	-					
	Coordinator regarding						
	" The definition of	Abuse:					
	Abuse means the wil	Iful infliction of injury.					
	unreasonable confine						
	-	lting physical harm, pain, or					
	mental anguish. Abus						
		vidual, including a caretaker, that are necessary to attain					
		mental, and psychosocial					
		verbal abuse, sexual					
	abuse, physical abuse	e, and mental abuse,					
	•	ated or enabled through the					
		uries of unknown origin may					
	occur as a result of al	uuse.					
	" Immediate interv	ention to stop					
	" No tolerance for	abuse					

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		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES	(X2) MUI		CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	, í				LETED
							C
		345155	B. WING			05/	23/2017
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLP	H HEALTH AND REHAB	ILITATION CENTER			30 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	REGULATORTORT		IAG		DEFICIENCY)		
F 226	Continued From page	2 38	F	226			
				0			
		Facility staff including					
	Nursing, Therapy, Ho						
		ss Office and Administration eiving this education. All					
		any agency will be educated					
		working in resident care					
		ator, Director of Nursing or pordinator. Facility Staff					
	-	education at least annually					
		Director of Nursing or Staff					
	· · · · · · · · · · · · · · · · · · ·	nator. This education will be 's new hire orientation and					
		taff will not be permitted to					
	assume their floor res	sponsibilities until they have					
	completed this educa	tion.					
	The credible allegatio	n was verified on 5/18/17 at					
	5:00 PM as evidence	d by staff interviews on					
		cedures, different types of					
	abuse, what to do if a	and actions to be taken if					
		and/or suspected, reporting					
		nents. Alert and oriented					
	residents were also in other residents were	nterviewed to assess if any					
		records revealed 142 facility					
		g staff, unlicensed nursing taff, activities, social worker)					
		by 5/18/17 and staff who did					
	not have the in-servic	e will be in-serviced prior to					
	working on floor.						
	Review of list of alert	and oriented residents and					
	list of families who we	ere interviewed to assess if					
	any other residents w	vere affected.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345155	B. WING				C /23/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	and a letter that the A incident 5/11/17 with with the Administrator	r report to the state agency PS was informed of the Resident #2 and interview	F	226			
	11/3/14 with multiple of malignant neoplasm of Review of Resident # assessment dated 4/2 cognition was intact a Review of Resident # 3/28/17 revealed "reshis nurse because he (narcotic pain medicated was threatening his not prioritize her care for When I asked him to me "F-you." I asked I me and he repeated "me to swing at him. I	diagnoses including of bone and prostate.					
	was Nurse #2 and he interview. Review of Nurse #2's that he was terminate no show. List of abuse investiga (March 2017 to prese	se's notes dated 3/28/17					

Facility ID: 923001

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						O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED
			A. BOILDING			С
	A BUILDING 345155 B WING STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cast PRESSUL STREET AMDOLPH HEALTH AND REHABILITATION CENTER COMPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cast PRESSUL STREET ASMDOLPH HEALTH AND REHABILITATION CENTER ID PREFIX CANDOLPH HEALTH AND REHABILITATION CENTER ID PREFIX Continued From page 40 F 226 Continued From page 40 F 226 Continued From page 40 F 226 Continued From page 40 Review of the statement written on 3/28/17 by Nurse #3 revealed "at approximately 4:30 PM I was in a room giving a resident medications when a Certified Medication Aide (CMA) came into the room with a look of fear on her face and said "1 need you now." I went out in the hall and I could hear 2 people arguing and cursing very loudly. When I got over to station 3, Nurse #2 and 2 Resident #7 were in verbal altercation. I tried to stop the verbal altercation and Resident #7 became very angry calling Nurse #2 afaggot and cursing him. Resident #7 jumped at Nurse #2 and 2 Resident #7 Abististant Was able to get Resident #7 Thite M-FI! over and over. I was unable to stop this from happening and the RCA and the Activity Assistant Was able to get Resident #7 This Nurse #2 and Resident #7 Review of the statement written on 3/29/17 by CMA rev	05	5/23/2017			
NAME OF P	ROVIDER OR SUPPLIER	·	· ·	STREET ADDRESS, CITY, STATE, ZIP COD	E	
RANDOLF	PH HEALTH AND REHAE	BILITATION CENTER				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETIO DATE
F 226	Continued From page	e 40	F 22	26		
	the two incidents was	s for Resident #7.				
	Review of the statem	ent written on 3/28/17 by				
	•					
		, ,				
	Review of the statem	ent written on 3/29/17 hv				
	heard a loud altercati	on coming from around the				
		etween Resident #7 and				
		cursing and arguing with				
		nt #7 was threatening Nurse lling Resident #7 "go ahead				
		f-me, f-you." I got Nurse #3				
		Ip the confrontation. Like I				
	said it was so sudder					
		-				
	lot of shouting and cu individuals."	-				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345155	B. WING				C 23/2017
NAME OF PF	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLP	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page A telephone interview Administrator was con PM. She indicated the incident with Residen acknowledged that sh statements from the s revealed that she had and Nurse #2 and the and so she did not pre abuse policy. She als document her intervie Nurse #2. An interview with the conducted on 5/17/17 Administrator read the have been implement that she could not find indicate that this alleg nor reported to the sta protective services. S could not find informar residents were assess residents who might h The current Administrat 2017. On 5/17/17 at 2:05 Pt interviewed. He reme	e 41 with the previous inducted on 5/17/17 at 1:40 at she remembered the t #7 and Nurse #2. She he had read the written staff members. She interviewed Resident #7 ey both denied verbal abuse occed to follow the facility's so indicated that she did not ew with Resident #7 and current Administrator was a 1:45 PM. The current e 3 written statements from d stated that this was a facility's abuse policy should ted. She further indicated d any documentation to pation had been investigated ate agency or adult She also stated that she ition to indicate that other sed to identify other have been verbally abused. ator indicated that she for of the facility on May		226			
	his pain medication a nurse was explaining was late and Nurse #	s station to ask his nurse for s it was already late. His as to why his medication 2 stepped in. He was so ed that he did scream at his					

Facility ID: 923001

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345155	B. WING			05	C 5/23/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	nurse. Then Nurse #2 back. He was also so stepping in, he was n did not remember wh because he was very An interview with the conducted on 5/17/17 that she was at the nur Resident #7 asking fo Nurse assigned to Re "it's only 2 hours late die." Resident #7 wer asked for a concern for concern form for Res back she observed N cursing saying F, M Resident #7. The AA of Nursing (DON) was requested to write a so the response from the inappropriate. An interview with Nur 5/18/17 at 8:00 AM. So the medication cart of medications. She con cussing on station 3. came and told her to arrived at station 3, R were arguing and cur to stop the verbal alter tried to stop both of th shouting to Resident and over again. The 5 minutes while she w	2 started screaming at him o mad to him (Nurse #2) for ot his nurse. Resident #7 at Nurse #2 had told him mad at him. Activity Assistant (AA) was 7 at 2:13 PM. The AA stated urse's station and heard or his medication. The esident #7, responded to him and you are not going to th back to his room and orm. She went to get a ident #7. When she came urse #2 screaming and M-F-words several times to . indicated that the Director is informed and she statement. She stated that e nurse to the resident was se #3 was conducted on She stated that she was on in the other station passing uld hear the screaming and A staff member (CMA) come now. When she tesident #7 and Nurse #2 sing very loudly. She tried ercation. Staff members nem, when Nurse #2 began #7 "hit me, hit me m-f-"over verbal altercation lasted for	F	226	3		

Facility ID: 923001

If continuation sheet Page 43 of 52

		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVE D. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED			
		345155	B. WING				C / 23/2017
	PLAN OF CORRECTION IDENTIFICATION NUMBER: Jatistication Number: Jatistic			23	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	another station workin loud altercation from station 3 and observe were cursing at each threatening Nurse #2 Resident #7 "hit me, went to get Nurse #3. 483.70 EFFECTIVE ADMINISTRATION/R 483.70 Administration A facility must be adm enables it to use its re efficiently to attain or practicable physical, well-being of each res This REQUIREMENT by: Based on record rev residents and physici administration failed to facility's abuse policy of 2 sampled resident were free from abuse abused by Resident # abused by Nurse #2. Immediate jeopardy to Resident #2 when he Resident #1. Immediate	ng and she could hear a station 3. She went to ed Resident #7 and Nurse #2 other. Resident #7 was . Nurse #2 responded to come on, f-me, f-you." She		490	Preparation and/or execution of this Pl of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set for in the statement of deficiencies. This pl of correction is prepared and/or solely because it is required by the provision the Federal & State Law. 1. On 5/11/17 at 7:21pm the Social Services Director notified the Administrator via phone of an event	of th Ian	6/26/17
	on 5/18/17. An accept was provided on 5/23 at a lower scope and no actual harm with prinimal harm, that is example #2, Residen	bable credible allegation 4/17. The facility remains out severity of D (isolated with botential for more than not immediate jeopardy) for t #7 and to ensure all staff use and the monitoring			occurring in the smoking area where Resident #1 allegedly touched the peni of Resident #2. Resident #1 and Resident #2 were immediately separate by the Smoking Supervisor and Reside #1 was placed with one on one supervision. Resident #2 was placed of every 15 minute checks by the Charge	ed ent n	

Event ID: MSU711

Facility ID: 923001

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	06/27/2017 APPROVED 0.0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING			SURVEY LETED	
		345155	B. WING			05/2	23/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLP	H HEALTH AND REHAB	ILITATION CENTER			30 EAST PRESNELL STREET SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	e 44	F	490			
	The findings included 1. Cross Refer to F22 observation and staff interview, the facility f # 2 & # 7) of 2 sample Resident #2, who was witnessed by resident abused by Resident # intact. Resident #7, w was verbally abused 2. Cross Refer to F22 Based on record revia resident and physicia determined that the fa abuse policies and pr identification (immedi residents could have (notifying the state ar for 2 (Resident #2 & # reviewed for abuse. The facility Administra were informed of Imma at 2:21 PM. The facility provided a compliance: 1. On 5/11/17 at 7:21 Director notified the A event occurring in the	23: Based on record review, , resident and physician failed to protect 2 (Residents ed residents from abuse. s cognitively impaired, was ts and staff, being sexually #1, who was cognitively /ho was cognitively intact, by Nurse #2. 26: ew, observation and staff, n interview, it was acility failed to operationalize ocedures in the areas of ately assessing if other been affected) and reporting ad adult protective services) #7) of 2 sampled residents ator and Director of Nursing nediate Jeopardy on 5/17/17 a credible allegation of pm the Social Services administrator via phone of an e smoking area where			Nurse with emotional support provided the Services Director until discharge fm the Facility on 5/12/17. Resident #1 ar Resident #2 were interviewed separate by the Social Services Director on 5/11 immediately following the event and bo indicated the event that occurred was consensual in nature when interviewed The Police were notified immediately b the Charge Nurse and came to the fac at 8:30pm 5/11/17 to interview Resider #1 and Resident #2 During the course this interview both parties reported a consensual kiss occurred and denied other physical contact. The Police determined and communicated to the Administrator that no crime was committed. Staff and Residents prese when the event occurred were interview as part of the investigation, on 5/11/17 results of these interviews showed vary descriptions of the event that spanned from observations of a Resident #1 kissing Resident #2 to observations of Resident #1 touching the outside of Resident #1 touching the outside of Resident #1 touching the dutside of Resident #2 is pants and another that described Resident #1 and Resident was notified by the Administrator on 5/11/17 at 7:30pm . The Administrator attempted to notify the Guardian for Resident #2 via phone message on 5/11/17 at 8:15pm, the message stated	om hd ely //17 oth I. y ility ht e of nt wed ying ds t #2 r	
	Resident #2. Reside immediately separate Supervisor and Resid	 touched the penis of ent #1 and Resident #2 were ed by the Smoking lent #1 was placed with one Resident #2 was placed on 			that the Administrator needed to discuss and event that occurred at the facility of 5/11/17. The Administrator attempted again to notify the Guardian for Reside #2 at 4:00pm on 5/12/17 prior to his	n	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/27/20 MAPPROVE: 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		345155	B. WING _			05	C 5/23/2017
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				23	30 EAST PRESNELL STREET		
RANDOLP	H HEALTH AND REHAB	BILITATION CENTER		A	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 490		ks by the Charge Nurse with	F4	490	discharge. On 5/18/17 at 1:00pm the		
	Director until discharg 5/12/17. Resident #1 interviewed separatel Director on 5/11/17 in	ovided by the Services ge from the Facility on and Resident #2 were ly by the Social Services nmediately following the ated the event that occurred			Administrator and the Social Services Director made a third attempt to conta the Guardian for Resident #2 and left same message as previous. Reside is responsible for his own affairs. Resident #1 was transported to the	act the	
	was consensual in na Police were notified in Nurse and came to th to interview Resident	ature when interviewed. The mmediately by the Charge ne facility at 8:30 pm 5/11/17 #1 and Resident #2 During erview both parties reported			Emergency Room for Psych and Mec evaluation, where he was diagnosed a Urinary Tract Infection and discharg back to the Facility on 5/12/17 at 10:23am. Resident #1 sat outside in	with ged	
	physical contact. The communicated to the was committed. Staf	curred and denied other Police determined and Administrator that no crime f and Residents present rred were interviewed as part			car while He was signed out of the fa for a leave of absence by his friend o 5/12/17 and returned from the leave of absence on 5/16/17 and One on One Supervision was immediately restarted	n of	
	of the investigation, o interviews showed va event that spanned fr	on 5/11/17 results of these arying descriptions of the			One on One Supervision will be discontinued when the Interdisciplina team agrees it is appropriate based of Psych and Medical evaluations to be	ry	
	#2's pants and anoth #1 placing his hands The Physician of Res	ng the outside of Resident er that described Resident in the pants of Resident #2. ident #1 and Resident #2			completed by 5/23/17. Resident #2 w assessed by the Charge Nurse on 5/ following the event, according to the Charge Nurse this assessment was v	11/17 vithin	
	7:30 pm. The Admir the Guardian for Res on 5/11/17 at 8:15 pm	dministrator on 5/11/17 at histrator attempted to notify ident #2 via phone message h, the message stated that			normal limits but was not documented the medical record. The Social Servi Director completed a Health Questionnaire and BIMS (Cognitive	ces	
	occurred at the facility Administrator attempt	eded to discuss an event that y on 5/11/17. The ted again to notify the ht #2 at 4:00 pm on 5/12/17			assessment) with score of 8 on 5/12/ On 5/12/17 Resident #2 was discharg to and Assisted Living Facility as previously planned prior to this event	ged	
	prior to his discharge Administrator and the made a third attempt	On 5/18/17 at 1:00 pm the Social Services Director to contact the Guardian for the same message as			 Current residents have the potenti be affected by this alleged deficient practice. The Social Services Director 	al to	
	previous. Resident #	#1 is responsible for his own was transported to the			Social Services Assistant, Activities Director, and Nurse Managers condu		

Facility ID: 923001

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/27/2017 M APPROVED O. 0938-0391
STATEMENT O	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED					
		345155	B. WING			C / 23/2017
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RANDOLP	H HEALTH AND REHAB	ILITATION CENTER		230 EAST PRESNELL STREET ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 490	Urinary Tract Infection the Facility on 5/12/12 sat outside in the car the facility for a leave 5/12/17 and returned on 5/16/17 and one of immediately restarted will be discontinued we team agrees it is app Medical evaluations to Resident #2 was assed on 5/11/17 following to Charge Nurse this as limits but was not door record. The Social S Health Questionnaire assessment) with sco 5/12/17 Resident #2 we Assisted Living Facility prior to this event. On 5/23/17 the Admir hour report outlining to 5/11/17 and will comp details of the investig On 5/23/17 the Admir occurring on 5/11/17 1. Current residents ha affected by this allege Social Services Direct Assistant, Activities D Managers conducted with a BIMS score of completed on 5/18/17	Psych and Medical was diagnosed with a n and discharged back to 7 at 10:23 am. Resident #1 while he was signed out of of absence by his friend on from the leave of absence in one supervision was d. One on One Supervision when the Interdisciplinary ropriate based on Psych and o be completed by 5/23/17. essed by the Charge Nurse he event, according to the sessment was within normal cumented in the medical ervices Director completed a and BIMS (Cognitive ore of 8 on 5/12/17. On was discharged to an ty as previously planned histrator completed a 24 the events occurring on olete a 5 day report with ation on 5/26/17. histrator reported the events to Adult Protective Services.	F 49	 audits of current residents with score of 8-15. This audit was in on 5/18/17. This audit include: one interviews by questioning resident to determine any other who have been approached in inappropriate way by any other made to feel uncomfortable. For Residents who is BIMS score the same audit and interview v conducted with their Responsi No new allegations of abuse or who have been approached in inappropriate way by any other made to feel uncomfortable were identified as a result of these are completed on 5/18/17. On 5/18/17, the Administrator at Development Coordinator comminterviews with all facility staff to other unreported allegations of occurred. No new allegations of occurred. No new allegations of occurred. No new allegations identified as a result of the intervicompleted. The Facility is Abu Prohibition Policy was reviewe District Director of Clinical Sem Director of Nursing and the Ad and all required components results and all required components results and the Director of Nursing on Facility is Policy for Abuse Prithe Elder Justice Act, reporting for the 24 Hour and 5 Day Results. 	completed s one on each r residents an r resident or or is below 8 vas ble Party. r resident or ere audits and Staff apleted to verify no f abuse were erviews ility staff iews are use d by the vices, the ministrator elated to F r of Clinical inistrator the ohibition , g guidelines ports to the	

Facility ID: 923001

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	<u>3-03</u> Y
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED	•
					С	
		345155	B. WING		05/23/201	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	PH HEALTH AND REHAE			230 EAST PRESNELL STREET		
NANDOLI				ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMP THE APPROPRIATE DA	K5) LETIO ATE
F 490	Continued From page	e 47	F 49	90		
		residents who have been		responsibilities to coordin	ate an effective	
	-	ppropriate way by any other		investigation by ensuring		
		eel uncomfortable. For		interviews and assessme	-	
	Residents who's BIM	S score is below 8 the same		results and findings, and	-	
		as conducted with their		interventions according to		
		No new allegations of abuse		identified during the inves	•	
		e been approached in an		as assessment of all othe	r residents that	
		any other resident or made were identified as a result		might be affected.		
	of these audits comp			On 5/18/16 facility staff, t Department including Nur		
				Therapy, Housekeeping,	-	
	1. On 5/18/17. the Ad	Iministrator, Social Services		Maintenance, Business C		
		ctor of Clinical Services and		Administration were re-e		
		completed interviews with all		Administrator and Staff D	-	
	facility staff to verify r	no other unreported		Coordinator regarding Ab	use and Abuse	
	allegations of abuse			Reporting.		
	-	tified as a result of the		Beginning 5/18/17 no Fac		
		by 5/18/17. No facility staff		including Nursing and Nu		
	shall return to work u			Therapy, Housekeeping,		
		cility's Abuse Prohibition		Maintenance, Business C		
		by the District Director of Director of Nursing and the		Administration shall work	-	
		required components		this education. All new er any agency will be educa		
	related to F 226 were			prior to working in resider		
		strict Director of Clinical		Facility Staff will be provid		
		the Administrator and the		education at least annual		
	Director of Nursing o	n the Facility's Policy for		Administrator or Staff Dev	-	
	Abuse Prohibition, the	ne Elder Justice Act,		Coordinator. This educat	ion will be	
		or the 24 Hour and 5 Day		included in the facility s r		
		lealth Care Personnel, and		orientation and all newly h	-	
		o coordinate an effective		Staff will not be permitted		
		iring timely interviews and		floor responsibilities until	2	
	determining intervent	ring results and findings, and		completed this education. On 5/18/17 the Administra		
	-	ed during the investigation as		of Nursing implemented a		
		of all other residents that		monitor the management		
	might be affected.			allegations by reviewing a		
	3. On 5/18/16 facility	v staff, the Nursing		Division Director of Clinica		
	Department including			(DDCS) weekly to ensure		

Facility ID: 923001

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	S FOR MEDICARE &	PLE CONSTRUCTION	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` <i>`</i>		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		с	
345155		B. WING		/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/23	2017
				230 EAST PRESNELL STREET		
RANDOLI	PH HEALTH AND REHAE	BILITATION CENTER		ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE
F 490	Continued From page	o 48				
1 430			F 49		hitian	
		bing, Dietary, Maintenance,		the Facility Policy on Abuse Prohi		
	Business Office and			and conduct a weekly focus call to		
		Director of Nursing, Nurse		review events occurring througho	ut the	
	regarding;	Development Coordinator		week to review completion of investigations and reporting as re-	guired.	
	4. The definition of A	buse:		3. 5/17/17 -5/18/17 In-services pr	ovided	
	E Abuse means the	willful infliction of injuny		to all staff including nursing and	to	
		willful infliction of injury, ement, intimidation, or		non-nursing on Abuse Prohibition include Elder Justice Act, what to		
		ulting physical harm, pain, or		resident displays aggressive beha		
	mental anguish. Abu			and actions to be taken if abuse v		
	-	lividual, including a caretaker,		observed and or suspected, repor		
		that are necessary to attain		resident assessment. Weekend a	-	
	-	mental, and psychosocial		part-time nursing and non-nursing		
		s verbal abuse, sexual		were in-serviced via phone by Sta		
		se, and mental abuse,		Development Coordinator. Nursin		
		itated or enabled through the		non-nursing staff unable to assume	•	
		juries of unknown origin may		floor responsibilities until they con		
	occur as a result of a			this education. This will be comple		
				date of compliance. All new admis	-	
	6. Immediate interve	ntion to stop		packets will include the facilities A		
				Prohibition Policy and Facility Grie		
	7. No tolerance for al	buse		Policy to be discussed during adn		
				process. All new alleged allegatio		
	8. Maintaining a profe	essional relationship with		be reported to the state and prope		
		s and the Resident's Right to		authorities by the Administrator or	Director	
	live in the facility free	e from abuse and neglect.		of Nursing.		
		lerate abuse and will follow				
		Prohibition to investigate all		4. Audit tools will be used by Soc		
	allegations of abuse	or neglect thoroughly		Worker to contact Family and inte		
				Residents to determine if any new		
		vill report all allegations and		allegations have been reported. 1		
		ences of abuse, neglect,		Family/Residents will be interview	ed	
		ment, injuries of unknown		weekly x 6 weeks, then 5		
		priation of property to the		Family/Residents weekly x 6 wee		
		Survey Agency, and law		tools will be used by Administrato		
		according to the required		Director of Nursing, Staff Develop		
	timeline as follows: If	the events that caused the		Coordinator, Unit Managers and	herapy	

Facility ID: 923001

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						NO. 0938-03	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345155 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
							B. WING
			STREET ADDRESS, CITY, STATE, ZIP COE				
			PH HEALTH AND REHAB			230 EAST PRESNELL STREE	ET
				ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE (FICIENCY)	(X5) COMPLETIC DATE	
F 490	Continued From page	e 49	F 49	0			
		use or result in serious bodily		Manager to interview	unursing and non		
		le not later than 2 hours		nursing staff to deter	-		
		It staff becomes aware of		alleged allegations a	-		
		ne events that cause the		members will be inte	rviewed weekly x 6		
	-	lve abuse and do not result		weeks, then 5 staff n			
		y, a report is made not later		weeks. Any new repo			
	than 24 hours after th			be followed up by Ad			
	becomes aware of the	0		Director of Nursing.			
	10. In accordance with the Elder Justice Act, the facility will report to law enforcement agencies			brought to QAPI mor	ntniy x 3 to assure		
	and to the state agency any reasonable suspicion			compliance.			
	of a crime against any individual who is a resident						
	of, or receives care from the facility						
		7 no Facility staff including					
	Nursing and Nursing						
	Housekeeping, Dieta	ry, Maintenance, Business					
		tion shall work prior to					
		on. All new employees and					
		lucated on the above prior to					
	working in resident care area. Facility Staff will be provided this education at least annually via						
	-	-					
		g or Staff Development ucation will be included in					
		orientation and newly hired					
		be permitted to assume their					
		until they have completed					
	this education.						
		and Director of Nursing will					
	complete a root cause						
		orting and investigation within					
	the facility.	and Director of Nursian will					
	hold weekly staff mee	and Director of Nursing will					
	re-educate Facility staff on Abuse Prohibition. During these meetings the Administrator will						
		it's Right to remain free from					
	abuse and neglect.						
	-	ility of the Administrator, as					

Facility ID: 923001

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING						
		345155	B. WING			C 05/23/2017				
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	•				
RANDOLF	PH HEALTH AND REHAB	ILITATION CENTER			230 EAST PRESNELL STREET ASHEBORO, NC 27203					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE				
F 490	 Continued From page 50 Facility staff are trained regarding the policy for abuse prohibition, to ensure staff and residents understand the process and are comfortable reporting allegations of abuse, to investigate allegations of abuse, and to complete timely 24 hour and 5 day reports to the State agency. The Division Director of Clinical Services will provide weekly support and education to the Administrator regarding her responsibilities to Abuse prohibition in the Facility. 15. On 5/18/17 the Administrator and Director of Nursing implemented a new system to monitor the management of abuse allegations by reviewing all events with the Division Director of Clinical Services (DDCS) daily to ensure adherence to the Facility Policy on Abuse Prohibition and conduct a weekly focus call to further review events occurring throughout the week to review completion of investigations and reporting as required. 		F	490						
	5:00 PM as evidenced abuse policy and prod abuse, what to do if a aggressive behaviors abuse was observed and resident assessm residents were also in other residents were a Review of in-service m staff (licensed nursing staff, administrative s had been in-serviced	and actions to be taken if and/or suspected, reporting nents. Alert and oriented nterviewed to assess if any								

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		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILI		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY
							C 05/23/2017
NAME OF PI		STREET ADDRESS, CITY, STATE, ZIP CODE			05/25/2017		
NAME OF PROVIDER OR SUPPLIER					0 EAST PRESNELL STREET		
RANDOLF	H HEALTH AND REHAB	ILITATION CENTER			SHEBORO, NC 27203		
(X4) ID	SUMMARY ST	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORT ORT		IAG		DEFICIENCY)		
F 490	Continued From page	e 51	F	490			
		and oriented residents and					
		ere interviewed to assess if					
	any other residents w	vere affected.					
	Review of the 24 hour report to the state agency						
	and a letter that the APS was informed of the						
	incident 5/11/17 with Resident #2 and interview						
	with the Administrator	was conducted.					

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