DEPART	MENT OF HEALTH	AND HUMAN SERVICES				ORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		OME	3 NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345492			(X2) MULTIPLE CONSTRUCTION A. BUILDING			3) DATE SURVEY COMPLETED
		B. WING _			C 11/25/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
NC STAT	E VETERANS NURSI			214 COCHRAN AVENUE		
				FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
F 225 SS=D	been found guilty or mistreating residen had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en- involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and ce The facility must haviolations are thoro prevent further pote investigation is in p The results of all in- to the administrator representative and with State law (inclu- certification agency incident, and if the a	PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or the State nurse aide registry ties. usure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). we evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 22			12/15/14
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

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.

12/11/2014

PRINTED: 01/05/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
		345492	B. WING			C 25/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	
NC STAT	E VETERANS NURSI	NG HOME		214 COCHRAN AVENUE FAYETTEVILLE, NC 28	8301	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECT) CROSS-REFERENCI	AN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to thoroughly investigate an abuse allegation by not interviewing and gathering written statements from facility staff working with a resident alleging sexual abuse (Resident #1) for 1 of 3 residents reviewed for abuse. Findings included: Resident #1 was admitted to the facility 10/05/10 with cumulative diagnosis of dementia, hypertension and diabetes. The most recent Minimum Data Set dated 11/11/14 indicated Resident #1 was cognitively intact without behaviors and required extensive assistance with his activities of daily living (ADLs). There was an allegation of a sexual assault made by Resident #1 on 11/14/14 involving a reported incident occurring in his room around 3:00 AM that morning. A review was conducted of the investigation of the alleged anal rape verbally reported by Resident #1 to his assigned nursing assistant on 11/14/14 at approximately 6:30 PM. This investigation did not include written and signed statements from the staff working with Resident #1 during the time of the alleged incident on 11/14/14 at approximately 6:30 PM. The allegation was unsubstantiated based on the outcome of the facility and police investigation. In an interview on 11/25/14 at 2:50 PM, the		F 2	Step 1 - Resident positive well-being facility protected Re well-being by initiat immediately which * Filing a police rep department who th by interviewing Res roommate,staff on video footage of the alleged incident oc investigation was u time by the police of * Resident #1 was emergency room, v examined and inter hospital emergency the allegations and to the facility. * Director of Nursin immediate investig * Direct care staff both nights * Staff members report * Resident #1 * Resident #1 * Resident #1 * Staff members of the alleged incid * The veteran was to a private room to abuse from his roo * Resident #1 will b	ting our investigation included: bort with the police oroughly investigated sident #1, his shift at the time, and e area where the curred. The insubstantiated at that department. sent to the hospital where he was rviewed again. The y room unsubstantiated I veteran was sent back of initiated the ation and interviewed: f member who worked working the night of the who worked the night ent moved on 11/19/2014 o reduce any fear of immate. be followed by our	
	the abuse investiga Resident #1. The D written statements	She confirmed she conducted tion dated 11/14/14 for ON stated she did not get nor did she interview the staff time of the alleged incident at		in-house psych ser for support and mo * Resident #1 will b	vices weekly x 4 weeks onitoring for behaviors. be given further support and various activities to	

Facility ID: 970225

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0938-039	
		A. BUILDING			COMPLETED C		
		B. WING			11/25/2014		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL			
NC STAT	E VETERANS NURS	ING HOME		214 COCHRAN AVENUE FAYETTEVILLE, NC 28301			
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 225	 225 Continued From page 2 approximately 3:00 AM on 11/14/14. The DON stated she only interviewed the staff present working with Resident #1 at the time he reported incident the evening of 11/14/14. The DON recalled being at the facility when Resident #1 verbalized the allegation at approximately 6:30 PM. The facility notified the police, the physician, emergency medical services and the responsible party. The DON stated she was present during the police interview with Resident #1 and his roommate. She stated she was present with the police during the review of the video surveillance footage for third shift on 11/14/14. There was no male shown entering or exiting Resident # 1's room during the entire shift. The DON stated there was no medical evidence of a rape on his hospital evaluation either. The DON stated it was an oversight that she did not interview and obtain written statements from the staff who worked after midnight on 11/125/14 at 3:50 PM, the administrator stated the abuse investigation should have included interviews and written statements from staff working at the time of the alleged incident involving Resident #1. 		F 22	 perform to divert his mind to r pleasant thoughts. Additionall Chaplain will continue to prov and spiritual care. Step 2 - 100% audit was perforesidents who reported abuse six months and the investigatic conducted according to policy Step 3 - All current staff and new himble in-serviced on reporting ab abuse to the Director of Nursi Administrator immediately. If present the staff member will RN Supervisor who will then r Director of Nursing and Admir immediately. The Director of Nursing, Ad Social Worker's, and all Regis Nurses (RN's) will be in-service "Abuse Investigating" (ABUSE policy and the Director of Nursi monitor completion. 	y, the de 1:1 visits ormed on in the last ons were r. re staff will buse/alleged ng, or to the heither is report to the hotify the histrator liministrator, stered ced on the E 1.108) sing will se I by the		
F 226	483.13(c) DEVELC)P/IMPLMENT	F 22	Social Workers, Director of N and Administrator to ensure a allegations are investigated p Continued monitoring will ther weekly x 2 weeks, 3 x weekly weekly x 2 weeks, and month months.	ursing (RN), Il abuse er policy. n occur 5 x x 2 weeks,	12/15/14	

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		AND HUMAN SERVICES				FORM	01/05/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345492	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NC STAT	E VETERANS NURSI	NG HOME			14 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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	Continued From pa	ige 3	F 2	226			
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.					
	by: Based on staff inter facility failed to imp investigation policy gathering written st working with a resid	by not interviewing and atements from facility staff dent alleging sexual abuse of 3 residents reviewed for			Step 1 - Resident affected will mai positive well-being and quality of life facility protected Resident #1 and h well-being by initiating our investiga immediately which included: * Filing a police report with the polic department who thoroughly investig by interviewing Resident #1, his	e. The is ition ce	
	dated 2006 read th documentation will signed statements Resident #1 was ad with cumulative dia hypertension and d Minimum Data Set Resident #1 was co	itled "Abuse Investigating" e following: "Investigation include, but not be limited to from pertinent parties." dmitted to the facility 10/05/10 gnosis of dementia, iabetes. The most recent dated 11/11/14 indicated ognitively intact without ired extensive assistance with			 by interviewing Resident #1, his roommate, staff on shift at the time, video footage of the area where the alleged incident occurred. The investigation was unsubstantiated a time by the police department. * Resident #1 was sent to the hosp emergency room, where he was examined and interviewed again. Thospital emergency room unsubstatthe allegations and veteran was set to the facility. 	e at that ital he ntiated	
	his activities of dail There was an alleg by Resident #1 on incident occurring i that morning. A re investigation of the reported by Reside assistant on 11/14/				 * Director of Nursing initiated the immediate investigation and intervie * Direct care staff member who w both nights * Staff members working the nigh report * Resident #1 * Resident #1's roommate * Staff members who worked the of the alleged incident 	orked	

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	(X2) MULTIF		0MB NO. 0938-039 (X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			COMPLETED	
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345492			11/25/2014	
R		STREET ADDRESS, CITY, STATE, ZIP CODE		
SING HOME				
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		
bage 4	F 226	6		
EVETERANS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 signed statements from the staff working with Resident #1 during the time of the alleged incident on 11/14/14 at approximately 3:00 AM. The allegation was unsubstantiated based on the outcome of the facility and police investigation. In an interview on 11/25/14 at 2:50 PM, the director of nursing (DON) confirmed she was the abuse coordinator. She confirmed she conducted the abuse investigation dated 11/14/14 for Resident #1. The DON stated she did not get written statements nor did she interview the staff working during the time of the alleged incident at approximately 3:00 AM on 11/14/14. The DON stated she only interviewed the staff present working with Resident #1 at the time he reported incident the evening of 11/14/14. The DON stated she only interviewed the staff present working with Resident #1 at the time he reported incident the evening of 11/14/14. The DON recalled being at the facility when Resident #1 verbalized the allegation at approximately 6:30 PM. The facility notified the police, the physician, emergency medical services and the responsible party. The DON stated she was present during the police interview with Resident #1 and his roommate. She stated she was present with the police during the review of the video surveillance footage for third shift on 11/14/14. There was no male shown entering or exiting Resident #1's room during the entire shift. The DON stated there was no medical evidence of a rape on his hospital evaluation either. The DON stated it was an oversight that she did not interview and obtain written statements from the staff who worked after midnight on 11/12/14 at 3:50 PM, the administrator stated the abuse investigation		 * The veteran was moved on 11/1 to a private room to reduce any fer abuse from his roommate. * Resident #1 will be followed by or in-house psych services weekly x for support and monitoring for beffer to active listening, and various act perform to divert his mind to more pleasant thoughts. Additionally, the Chaplain will continue to provide and spiritual care. Step 2 - 100% audit was performed residents who reported abuse in the six months and the investigations conducted according to policy. Step 3 - 1. All current staff and new hire states be in-serviced on reporting abuse abuse to the Director of Nursing, and Administrator immediately. If neith present the staff member will report RN Supervisor who will then notify. Director of Nursing and Administration immediately. The Director of Nursing, Admin Social Worker's, and all Registerer Nurses (RN's) will be in-serviced on "Abuse Investigating" (ABUSE 1.1 policy and the Director of Nursing monitor completion. Step 4 - Monitoring of the abuse investigating will be monitored by Performance Improvement Nurse 	ar of bur 4 weeks haviors. support tivities to e 1:1 visits ed on he last were aff will /alleged br to the her is brt to the her is or to the her is brt to the (N), ng (RN),	
	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345492 SING HOME SING HOME TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) page 4 IS from the staff working with ng the time of the alleged /14 at approximately 3:00 AM. as unsubstantiated based on the acility and police investigation. 11/25/14 at 2:50 PM, the g (DON) confirmed she was the r. She confirmed she conducted gation dated 11/14/14 for DON stated she did not get s nor did she interview the staff e time of the alleged incident at 00 AM on 11/14/14. The DON therviewed the staff present ident #1 at the time he reported ing of 11/14/14. The DON the facility when Resident #1 egation at approximately 6:30 ootified the police, the physician, cal services and the responsible stated she was present during ew with Resident #1 and his tated she was present with the review of the video surveillance shift on 11/14/14. There was no ring or exiting Resident #1's entire shift. The DON stated dical evidence of a rape on his on either. The DON stated it was she did not interview and obtain is from the staff who worked 11/14/14 as part of the facility	RE & MEDICAID SERVICES (X1) PROVIDERSUPPLIERCLIA (X2) MULTIF INTERNATION NUMBER: A. BUILDING 345492 B. WING	(X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345492 B. WING R STREET ADDRESS, CITY, STATE, ZIP CODE SING HOME STREET ADDRESS, CITY, STATE, ZIP CODE STATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOLL) STATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOLL) 11/25/14 at 2:50 PM, the g (DON) confirmed she was the in: S. Shc offirmed she conducted gation dated 11/14/14 for DON stated she did not get s s nor did she interview the staff e time of the alleged ind atter 11/14/14. The DON the facility when Resident #1 og also no tid, she interview was the ing of 11/14/14. The DON the facility when Resident #1 egation at approximately 6:30 otified the police, the physician, rais services and the responsible stated she was present with the review of the video surveillance she did not interview and obtain on either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on his no either. The DON stated ifcal evidence of a rape on	

Facility ID: 970225

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL	(X3) DA	X3) DATE SURVEY COMPLETED		
345492			ING		C		
NAME OF PROVIDER OR SUPPLIER			D. WING	STREET ADDRESS, CITY, STATE		11/25/2014	
				214 COCHRAN AVENUE FAYETTEVILLE, NC 2830			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 226		volving Resident #1 as	F 2	allegations are investig Continued monitoring weekly x 2 weeks, 3 x weekly x 2 weeks, and months.	will then occur 5 x weekly x 2 weeks,		

Facility ID: 970225

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