PRINTED: 04/07/2015 FORM APPROVED OMB NO. 0938-0391

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	X3) DATE SURVEY COMPLETED	
		345298	B. WING		C <b>03/09/2015</b>
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 111 S CAMPBELL STREET BURGAW, NC 28425	03/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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)	
F 000	INITIAL COMMENT	-S	F 000		
	on 3/5/2015 through		F 226		3/25/15
	policies and proced mistreatment, negle	velop and implement written ures that prohibit ect, and abuse of residents on of resident property.			
	by: Based on record refacility failed to implement the facility product 1 of 1 reside (#3) from sexually in Immediate Jeopard identified on 3/6/15 Jeopardy was removed the facility produced allegation of compliance as (no actual harm with minimal harm that in complete training of and to implement the action.  The findings include A document titled "A Guidelines" update residents have the	eview and staff interview, the lement protective measures to ent (#7) from 1 of 1 resident mappropriate behavior. If y began on 1/6/15 and was at 3:30 PM. Immediate eved on 3/7/15 at 5:15 PM evided an acceptable credible ance. The facility will remain at a scope and severity of D in potential for more than is not immediate jeopardy) to in abuse for 100% of the staff ine monitoring of its corrective ed:  Abuse Prevention Program 10/14/14 read in part: "Our right to be free from abuse, riation of resident property,		Preparation and submission of this of correction is in response to the CN Form 2567 from the 03/09/2015 survidoes not constitute an agreement or admission by Huntington Health Carthe truth of the facts alleged or of the correctness of the conclusions state the statement of deficiency. The fact reserves all rights to contest the deficiencies, findings, conclusions at actions of the Agency. This Plan of Correction (and the attached documalso functions as the facilityKs credit allegation of compliance.  Tag F226  For Resident #7, Resident #3, and A Other current in-house and future residents that may have been/may be	MS vey. It e of d on ility and ents) ble
ABOBATORY	corporal punishmer	nation of resident property, int and involuntary seclusion."  DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	affected:	(X6) DATE

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

03/25/2015

**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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
	345298	B. WING			C <b>09/2015</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	•	30/2010
			311 S CAMPBELL STREET		
HUNTINGTON HEALTH CARE			BURGAW, NC 28425		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
prevention program residents during invineasures:  1. If the alleged at resident, the accuse permitted to make victorial rooms unattended.  2. If resident to reaggressor will be recurrence of such Resident #7 was as 8/30/2013 from the included Dementia, weakness, Anxiety Review of the most 7/24/14 and the model Data Set (MDS) data #7 was presently maked assistance with bed assistance with bed assistance with bed assistance with bed resident #3 was as 4/15/14 and had dia vascular Accident (weakness, Diabetes Review of the Annurevealed Resident #4 impaired. The MDS required extensive of transfer and limited locomotion on unit. of Resident #3 walk side in upper and locomotion on unit. of Resident #3 walk side in upper and locomotion on unit. of Resident #3 walk side in upper and locomotion on unit. of Resident required in Resident required limited locomotion on unit.	read that the abuse included protection of restigations by the following couse involved another ed resident will not be visits to other residents 'sident abuse is observed, the emoved from the situation and loped to prevent the incidents.  Imitted to the facility on community with diagnosis that Depression, Muscle and Congenital Blindness. recent Annual MDS dated est recent Quarterly Minimum ted 1/21/15 revealed Resident oderately cognitively impaired. The Resident required limited is mobility and transfers. Imitted to the facility on agnosis including Cerebral CVA) with left sided is, Depression and Dementia. In MDS dated 4/22/2014 is was moderate cognitively income person assistance in one person assistance in one person assistance in No observations were made king. He was impaired on one	F 2	*On January 6, 2015 Charge L Floor LPNS (3) responsible for Residents #1 and #2 at time of serviced by Director of Nursing policy Abuse Prevention Progra Guideline, to include resident to abuse and the removal of the aresident from the situation, and keeping of the accused resident making visits to other residents unattended until the development plan of care to prevent reoccur *Floor LPN #1 responding to retime of first incident involving Floor and Resident #3 will be counsed Director of Nursing on March 7 failure to implement fully facility Abuse Prevention Program Gurelated to resident to resident additional displinary action as appropriate.  *In servicing of all facility staff Director of Nursing/Designee of 2015 of facility policy Abuse Prevention Program Guideline, to include resident abuse and the remova accused resident from the situ the keeping of the accused resident unattended by providing one of monitoring by staff of accused until the development of a plan prevent reoccurrence. Any facin serviced by March 7, 2015 we serviced via phone or in person Director of Nursing/Designee and their next scheduled shift.	care of fincident in g on facility am o resident accused of the ent from serooms ent of a crence. The eled by the	

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CLIVILI	TO I OIL MILDIONIL	A MEDICAID SERVICES			<u> </u>	VID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
						(	
		345298	B. WING			03/0	09/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIINTING	STON HEALTH CARE			3	11 S CAMPBELL STREET		
HUNTING	STON HEALTH CARE			В	BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	<u> </u>						
F 226	Continued From pa	ge 2	F2	226			
		He was impaired on one side	1 2	-20	*All newly employed staff will be ed	ucated	
		extremities. The Resident			during Employee Orientation by Sta		
		or walker to ambulate.			Development Coordinator/Designer		
		report titled, "Situation,			facility policy Abuse Prevention Pro		
	Background, Asses	•			Guideline, to include resident to res		
		Response " (SBAR) dated			abuse and the removal of the accu-		
		sident #3 was found in			resident from the situation, and the		
	Resident #7 room g	grabbing and trying to tear			keeping of the accused resident fro	m	
		f off. Resident #3 was			making visits to other residents roo		
	•	ner breast and trying to push		unattended by providing one on one			
		a lying position. Resident #3		monitoring by staff of accused resident			
		Resident #7 room and brought			until the development of a plan of o	are to	
	back to Resident #3				prevent reoccurrence.		
		ctor of Nursing (DON)			*Effective March 8, 2015, Random		
		ted 1/8/15 revealed on 1/6/15			Auditing of 25% of facility staff as t		
		Assistant (NA) #1 heard			understanding of the facility policy		
		out for help. NA #1 entered dent #3 was observed with his			Prevention Program Guideline ( to resident to resident abuse and the	include	
		st and pulling at her brief. NA			removal of the accused resident fro	m the	
		and Nurse #1 entered the			situation, and the keeping of the ac		
		mediately removed Resident			resident from making visits to other		
		Nurse #1 then ensured			residents rooms unattended by pro		
		afe and went to alert			one on one monitoring by staff of a		
		The nursing staff were			resident until the development of a		
		:1 supervision on Resident # 3			care to prevent reoccurrence) to be		
		could initiate one-on-one			conducted by SDC/Designee week		
	supervision Reside	nt #3 was observed in			times 4 weeks to total 100% of faci		
		vith his hand in Resident #7			staff then 25% of facility staff montl	nly	
		witness statement by NA #2.			thereafter.		
		sident #3 from the room and			*Area Ombudsman to be contacte	-	
		staff member after this time.			Administrator/Designee on March 7	7, 2015	
		changed from across the hall			for scheduling of Resident Rights/		
		o a private room by the Nurses			Resident Abuse Staff in-service wi		
	station for closer m				ongoing Resident Rights/Resident		
		on 3/7/15 at 10:04 AM, the			in servicing of staff at least annually	,	
		pectations of the facility staff			thereafter by Director of Nursing/St		
		emoved Resident #3 from the			Development Coordinator/Designed		
	area, tollow the fac	ility's protocol and provide one			Inservice scheduled for April 7, 201	ე.	

on one staff care.

\*All alert and oriented interviewable

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/07/2015 FORM APPROVED MR NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					<u>UI</u>	VIB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COMI	SURVEY PLETED
		345298	B. WING			02/0	
NAME OF F	DOVIDED OD CUDDUED	040230	2		TREET ADDRESS CITY STATE 7ID CODE	03/0	9/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTING	TON HEALTH CARE				11 S CAMPBELL STREET		
				В	SURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	During an interview DON stated on 1/6/ shift (11-7 nurse) m facility and informed	on 3/6/15 at 9:15 AM the 15 around 8:10 AM the night let her at the entry to the d her about the incident with	F2	226	in-house residents interviewed by E of Nursing/Designee on 3/6/2015 for potential previously unreported alle of Resident to Resident Abuse as it	or any gations may	
	staff reported that N went back into Res she was safe with r DON stated Nurse notifying administra incident. The DON immediately place is supervision. Nurse arrange the one-on	esident #7. The DON stated Nurse #1 left Resident #3 and ident #7 's room to make sure to immediate injuries. The #1 was in the process of tive staff concerning the instructed Nurse #1 to Resident #3 on one-on-one #1 went back down to -one supervision and was dont #7 room by NA#2 NA#2			relate to the January 6, 2015 incide Any reported allegations of abuse f these interviews will be investigated facility abuse policy.  *Audit of all in-house residents Med Records to be conducted by Direct Nursing/Designee on March 7, 201 review of Significant Change Documentation/SBAR Documentat from January 6, 2015 thru March 7 for indication of reports of residents.	rom I per Ilical or of 5 for ion , 2015	
	reported that she we check on her and Rebedside and his had was observed in his out of Resident #7 NA#2 remained with relieved her for one DON stated Reside room. The DON stated when there was a residence of the check of the c	dent #7 room by NA#2. NA#2 ent into Resident #7 room to desident #3 was again at her and was on genital area. He s wheelchair and was removed froom. The DON stated that h Resident #3 until NA #1 e-on-one supervision. The ent #3 was moved to private atted she would expect her staff desident to resident altercation			for indication of reports of resident resident abuse to ensure implement of facility policy Abuse Prevention Program Guideline. *Effective March 8, 2015, Random Auditing of 25% of in-house resident Medical Records to be conducted burector of Nursing/Designee for resignificant Change Documentation. Documentation for indication of resident to resident abuse to ensure the second control of the se	nts by view of /SBar ports	
	#7. The DON also Resident #7 while N his room. NA #1 le breakfast trays. Th Resident #3 after the stated she would exthat to have immed Resident #3. They the hall they would supervise until direct did immediate in-seprotocol for the nurse.	y done 1 on 1 with Resident stated that NA #1 stayed with Nurse #1 took Resident #3 to eft Resident #7 to pass out ere was no staff watching he first incident. The DON expect her staff in a case like iately done 1 on 1 with thought since they were all on have enough people to closely eted to do something. Facility ervice on the facility's abuse ses at the facility at that time.			implementation of facility policy Abu Prevention Program Guideline wee times 4 weeks to total 100% of in-h residents then 25% of in-house res audited monthly thereafter. *Facility Grievance Logs and 24/5 of reports for January 7, 2015 thru Ma 2015 will be reviewed by Administrator/Designee on March 7 for indication of reports of resident resident abuse to ensure implement of facility policy Abuse Prevention Program Guideline. *Effective March 8, 2015, Facility	kly ouse idents day arch 7,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		345298	B. WING			03/0	) 09/ <b>2015</b>
NAME OF I	PROVIDER OR SUPPLIER	0.0200			REET ADDRESS, CITY, STATE, ZIP CODE	03/0	J9/2015
INAME OF I	- NOVIDEN ON SOFFEIEN						
HUNTING	GTON HEALTH CARE				1 S CAMPBELL STREET		
				В	URGAW, NC 28425		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From parable plan of correction and abuse on 1/6/15 or incident in their moon The administrator of jeopardy on 3/6/15 jeopardy was remoon The following intervative facility to remove the facility to resident facility to remove the facility to	Inge 4 Ifter the resident to resident have any discussion of the inthly QA meeting. If was notified of the immediate at 3:30 PM. Immediate wed on 3/7/15 at 5:15 PM. If wentions were put into place by the Immediate Jeopardy: If we the Immediate Je	F 2			orts will then for esident facility /on icated at next mittee ittee time for	
	from making visits	to other residents rooms riding one on one monitoring					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		345298	B. WING _			09/2015	
	PROVIDER OR SUPPLIER  GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425		30/23.13	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 226	of a plan of care to facility staff not in s be in serviced via p of Nursing/Designe scheduled shift.  *All newly employed Employee Orientatic Coordinator/Designer to resident abuse a resident from the staccused resident from the staccused resident from the staccused resident from the development of residents rooms under the development of reoccurrence.  *Area Ombudsman Administrator/Designer Staff in-service with Rights/Resident Ableast annually there Nursing/Staff Dever Coordinator/Designer All alert and orient residents interview Nursing/Designer opreviously unreport Resident Abuse as 2015 incident. Any from these interview facility abuse policy *Audit of all in-house to be conducted by on March 7, 2015 f. Change Document from January 6, 20	resident until the development prevent reoccurrence. Any erviced by March 7, 2015 will whone or in person by Director be at beginning of their next and staff will be educated during on by Staff Development nee on facility policy Abuse in Guideline, to include resident and the removal of the accused ituation, and the keeping of the form making visits to other nattended by providing one on staff of accused resident until fa plan of care to prevent in to be contacted by gnee on March 7, 2015 for dent Rights/ Resident Abuse in servicing of staff at eafter by Director of lopment nee.  The ded interviewable in-house and interviewable in-hou	F 22				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C <b>09/2015</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425	<u>,                                      </u>	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323 SS=J	Prevention Program *Facility Grievance January 7, 2015 thr reviewed by Admini 2015 for indication resident abuse to e facility policy Abuse Guideline. Immediate Jeopard PM. On 3/6/15, the all staff presently w on the facility 's Ab Guideline policy, to abuse and the reme from the situation, a accused resident fr residents rooms un one monitoring by s the development of reoccurrence. Any f March 7, 2015 will b person by the Direct beginning of their n oriented residents w feeling safe in your were no issues ider involved in resident facility on 3/6/15 at the Abuse policy the supervision for a re inappropriate behav 483.25(h) FREE Of	ntation of facility policy Abuse in Guideline. Logs and 24/5 day reports for u March 7, 2015 will be strator/Designee on March 7, of reports of resident to insure implementation of Prevention Program  by was lifted on 3/7/15 at 5:15 of facility provided evidence of orking had been in-serviced use Prevention Program include resident to resident eval of the accused resident and the keeping of the facility staff not in-serviced by the in-serviced via phone or in external facility staff not in-serviced by the in-serviced via phone or in external facility staff not in-serviced by the in-serviced via phone or in external facility staff not in-serviced by the in-serviced via phone or in external facility staff not in-serviced by the in-serviced via phone or in external facility staff not in-serviced by the in-serviced with all staff care presently working at the revealed they were aware of at included implementing sident identified with viors.  FACCIDENT	F 220			3/25/15
	environment remain	sure that the resident ns as free of accident hazards each resident receives				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345298	B. WING		C <b>03/09/201</b>	5
	PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 11 S CAMPBELL STREET BURGAW, NC 28425	0.00.201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉ	TION
F 323	prevent accidents.	ge 7 on and assistance devices to  NT is not met as evidenced	F 323			
	Based on record re resident, Family Nu interviews the facili interventions to pre inappropriate behavith sexually inappr #3) toward one of commediate Jeopard became aware Resinappropriately towadministrator was repopardy on 3/6/15 jeopardy was remowhen the facility procompliance. The facompliance at a scractual harm with poharm that is not imit	eview, police report review, arse Practitioner and staff ty failed to implement event reoccurrence of sexually vior for one of one resident repriate behaviors (Resident are resident (Resident #7). By began on 1/6/15 when staff sident #3 acted sexually ard Resident #7. The notified of the immediate at 3:30 PM. Immediate eved on 3/7/15 at 5:15 PM evided a credible allegation of acility will remain out of the pe and severity of D (no otential for more than minimal mediate jeopardy) to complete		Preparation and submission of this of correction is in response to the C Form 2567 from the 03/09/2015 su does not constitute an agreement of admission by Huntington Health Cathe truth of the facts alleged or of the correctness of the conclusions state the statement of deficiency. The fareserves all rights to contest the deficiencies, findings, conclusions a actions of the Agency. This Plan of Correction (and the attached docur also functions as the facilityKs crediallegation of compliance.	CMS rvey. It or ure of ne ed on ucility and finents)	
	implement the mon The findings include Resident #7 was at 8/30/2013 from the that included Deme weakness, Anxiety Resident #7 was in survey. Review of the most Set (MDS) dated 7/ Quarterly MDS date	or 100% of the staff and to itoring of its corrective action. ed: dmitted to the facility on community with diagnoses entia, Depression, Muscle and Congenital Blindness. the facility at the time of the recent Annual Minimum Data (24/14 and the most recent ed 1/21/15 revealed Resident cognitively impaired and		For Resident #7:  *On January 6, 2015, at approxima 7:50am Resident #3 was removed room of Resident #7 by floor Cnas was redirected to his room.  * On January 6, 2015, at approxima 8:20 am Resident #3 was removed room of Resident #7 by floor CNA a Resident #3 was immediately place one on one observation by Director Nursing, and remained on this observation status until discharge of January 7, 2015, not being allowed	from and ately from and ed on of	

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` '	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					C	
	345298	B. WING			03/0	9/2015
NAME OF PROVIDER OR SUPPLIER HUNTINGTON HEALTH CARE			31	TREET ADDRESS, CITY, STATE, ZIP CODE 11 S CAMPBELL STREET URGAW, NC 28425		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BY BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
transfers. The Care Area Assessm dated 8/20/14 for Comme resident could verbally mand although she could towards vocalization. Tould see light in the roos shapes but was unable Area Assessment for Ac (ADL) revealed the Resassistance with bed monambulate with her walked one person. The Resident's Care Pon 2/11/2015, revealed supervision and cueing related to her dementia required limited to exter ADLs related to blindner Resident #3 was admitted 4/15/14 and discharged diagnosis including Cere (CVA) with left sided we Depression and Demen A review of the Annual Merevealed Resident #3 we impaired. The Resident moods, delirium or acut during the 7 day observe extensive one person as limited one person assis unit. He was impaired of lower extremities. The Care Area Assessment for Commentary to the Care Area Assessment #3 had cognitive Resident #4 had cognitive Resident	nent Summary (CAAS) nunication revealed the make her needs known not see, she would turn the Resident stated she om and could see some to see detail. The Care ctivities of Daily Living ident required limited bility and was able to er with the assistance of  Plan most recently updated Resident #7 required with daily decision making and blindness. She nsive assistance with her ss and limited mobility. ted to the facility on I from facility 1/7/15 with ebral Vascular Accident eakness, Diabetes, titia.  MDS dated 4/22/2014 tas moderate cognitively thad no psychosis, te change of behavior ration period. He required ssistance in transfer and stance in locomotion on on one side in upper and	F3	323	Resident #7's room or any other re room.  *Resident #3 also had an immediate change following the 8:20 am inciderelocation into another wing of facil removed from room area of Reside.  * Floor LPN for Resident #7 notified Attending Physician/Medical Directincident on January 6, 2015 at approximately 8:30 am, with examinating of resident by Attending Physician immediately following notification, roorders received. Communication by Attending Physician with Responsit Party regarding visit/examination of on January 6, 2015 as documented note. Follow-up visit by Attending Physician on January 8, 2015 with orders received and implemented, include Mental Health Consult, with continued follow-up by Attending Physician as needed  *Responsible Party was notified of incident by Nursing Home Administ and Director of Nursing on January 2015 of incident.  *24 Hour report submitted to Health Personnel Registry by Director of Nursing/Designee on January 6, 20 with completed 5 Day Investigation submission on January 8, 2015 by Director of Nursing/Designee.  *Local Law Enforcement notified of incident and responded to facility of January 6, 2015, initiating legal investigation.  *Resident #3 was discharged from to care of Responsible Party on January 6, 2015, initiating legal investigation.	e room ent for ty, nt #7. I or of nation new y bility ccurred I in visit new to rator 6, n Care 15, Report	

was able to make himself understood. He

7, 2015.

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			<u>OMB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY PLETED
		345298	B. WING			C <b>09/2015</b>
NAME OF F	PROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	09/2015
NAIVIE OF F	ROVIDER OR SUPPLIER					
HUNTING	STON HEALTH CARE			311 S CAMPBELL STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	some coaxing to an Care Area Assessm Resident #3 had de and ability to comple CVA. He had left si to turn and reposition most part and rise f without assistance. assistance for sit to from his wheelchair A review of the most 12/17/14 revealed for cognitively impaired psychosis, moods, behavior during the required limited one transfer, locomotion and corridor. He rewith bed mobility. Hin upper and lower used a wheelchair of the Care Plan date 12/17/14 revealed for enhance daily decis CVA with short term Review of the first reackground, Assest Recommendation/Fithat on 1/6/15 at 7:5 in Resident #7 room Resident #7 room Resident #3 was reroom and brought to the complete the company of the complete for the complete	as appropriately but required aswer detailed questions. The nent for ADL revealed colined in functional mobility ete ADL's as a result of new ided weakness. He was able on himself in the bed for the from lying to sitting position. He required one person a stand and transfers to and control of the recent quarterly MDS dated resident #3 was moderated. The Resident had no delirium or acute change of a 7 day observation period. He reperson assistance for an on unit and walking in room quired extensive assistance he was impaired on one side extremities. The Resident rewalker for mobility. For additional report titled, "Situation, assent, assent, "Situation, assent, "Sesponse" (SBAR) revealed resident #3 was found an grabbing and trying to tear of off. Resident #3 was resident #7's breast and an the bed into a lying position. The resident #3's room. The report titled, "Situation, and report titled, "Situation," Situation, "Situation," Si	F 32	For Resident #3:  *On January 6, 2015, at approxin 8:20 am Resident #3 was remove room of Resident #7 by floor CN. Resident #3 was immediately play one on one observation by Direct Nursing, and remained on this observation status until discharg January 7, 2015. not being allow Resident #7's room or any other room.  *Resident #3 also had an immediately play one on one observation or any other room.  *Resident #3 also had an immediately following the 8:20 am increlocation into another wing of faremoved from area of Resident #1 floor LPN notified Attending Physicial incident on January 6, 2015 at approximately 8:30 am. Resider assessed by Attending Physician notification.  *Responsible Party was notified incident by Nursing Home Adminand Director of Nursing on January 2015.  *24 Hour report submitted to Head Personnel Registry by Director of Nursing/Designee on January 6, with completed 5 Day Report sult on January 8, 2015 by Director of Nursing/Designee.  *Local Law Enforcement notified responded to facility on January initiating legal investigation.  *Resident #3 was discharged from to care of Responsible Party on 7, 2015.	ed from A and liced on liced o	

Recommendation/Response " (SBAR) revealed

For Resident #7, Resident #3, and All

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		345298	B. WING		03/0	) 9/2015
	PROVIDER OR SUPPLIER  GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425	, 00.0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	that on 1/6/15 at 8:3 observed in Resider Resident #7 's vag down. Resident #3 #7 's room and wa supervision.  A review of Resider Observation on 1/3 revealed she had not breast or perineal at A review of Resider Observation on 1/6 #1 and Nurse #2 reslight abrasion to hot the bottom of her lest Review of Family Now assessment noted of revealed Resident follow-up of report of found with a male of revealed she had resident had resident had resident had resident had resident had resident and clitoris/urexam. There was skin or bleeding. Review of the incident medicumented that Resident #7 's room after he tore her bri stated Resident #7 and trying to stop hinjury to Resident #7	20 AM Resident #3 was nt #7 's room with his hand on ina and trying to push her was removed from Resident s placed on 1 on 1  nt #7 's Weekly Skin /15 on 7 AM to 3 PM shift o redness or bruising to her irea.  nt #7 's Weekly Skin /15 at 8:30 AM done by Nurse evealed she had redness and a er pubic area and redness at eff breast.  lurse Practitioner (FNP) ated 1/6/15 at 2:14 PM #7 was seen by the FNP for a from staff that she had been esident 's hand in her brief sh her back in bed. The report edness under her left breast erineum. Upon examination dness under and on the reast with no bruising. Her had redness on her upper ethral area with no pain on no vaginal drainage or broken ent report dated 1/6/15 (no revealed Nurse #1 esident # 3 was observed in m with his hands on her vagina efs off of her. The report also was observed yelling for help im. The report revealed no	F 323	Other current in-house residents the have been affected:  *Resident #3 placed on one-on-one observation until discharge from fadanuary 7, 2015.  *On January 6, 2015 Charge LPN, Floor LPNS (3) responsible for car Residents #1 and #2 at time of inciserviced by Director of Nursing on policy Abuse Prevention Program Guideline, to include resident to reabuse and the removal of the accuresident from the situation, and the keeping of the accused residents from aking visits to other residents rocunattended until the development of plan of care to prevent reoccurrent *24 Hour report submitted to Healt Personnel Registry by Director of Nursing/Designee on January 6, 20 with completed 5 Day Report submon January 8, 2015 by Director of Nursing/Designee.  *Floor LPN #1 responding to reside time of first incident involving Resident #3 will be counseled Director of Nursing on March 7, 20 failure to implement fully facility po Abuse Prevention Program Guidel related to resident to resident abus additional displinary action as deer appropriate.  *All alert and oriented interviewable in-house residents interviewed by I of Nursing/Designee on 3/6/2015 f potential previously unreported alle of Resident to Resident Abuse as i relate to the January 6, 2015 incide	e cility on and e of dent in facility sident sed om oms of a ce. h Care 015, hission ents at dent #7 by 15 for licy ines as se, with med e Director or any egations t may	

PRINTED: 04/07/2015 FORM APPROVED OMB NO. 0938-0391

CLIVILI	TO I OIL MILDIONIL	A MEDICAID SERVICES			<u> </u>	VID INO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
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		345298	B. WING				9/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIINTING	STON HEALTH CARE			3	11 S CAMPBELL STREET		
HUNTING	STON HEALTH CARE			В	BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pashe documented the statement) she were get Resident #3 for #7 screaming for he observed to be closs and observed Resident who was sitting upedocumented that she to pull off Resident #7 was holding onto closed. NA #1 documented for Nurse #1 A review of the with 1/6/15 at 8:20 AM resident #3 was in then she immediate for help. NA #2 first Resident #3 was in then she immediate room. The door was #2 opened the door touching Resident with his hands insicobserved screamin away. Review of the Direct summary report data to 7:45 AM, Nursing Resident #7 calling room and Resident hands on her breas NA #1 called for he room. Nurse #1 im #3 from the room.	ge 11 at on 1/6/15 (No time on at down to the Skilled Hall to breakfast and heard Resident elp and her room door was sed. NA #1 opened the door dent #3 in front of Resident #7 on the side of the bed. NA #1 are observed Resident #3 trying #7 's brief and that Resident to her brief with her legs tightly umented that she immediately 's assistance. ess statement by NA #2 dated evealed she was passing out sidents on the skilled hall and eresident (Resident #7) yelling to went to check to see if his room. He was not and ely went to Resident #7 's as observed to be closed. NA and observed Resident #3 #7. Resident #3 was observed the her brief. Resident #7 was grand trying to push his hand extor of Nursing (DON) ted 1/8/15 revealed on 1/6/15 grand Assistant (NA) #1 heard for help. NA #1 entered the #3 was "observed with his at and pulling at her brief." Ip and Nurse #1 entered the mediately removed Resident Nurse #1 then ensured		323	There were no allegations of Resid Resident Abuse.  *Audit of all in-house residents Med Records to be conducted by Direct Nursing/Designee on March 7, 201 review of Significant Change Documentation/SBar Documentation January 6, 2015 thru March 7, 201 indication of reports of resident to rabuse to ensure implementation of policy Abuse Prevention Program Guideline. Audit did not identify ar indications of reports of resident to resident abuse.  *Audit of all in-house residents Med Records to be conducted by Direct Nursing/Designee on March 7, 201 review of Significant Change Documentation/SBar Documentation January 6, 2015 thru March 7, 201 indication of tendency toward verba abusive behaviors by resident. Au not identify any indications of these behaviors.  *Effective March 8, 2015, Random Auditing of 25% of in-house resident Medical Records to be conducted to Director of Nursing/Designee for resignificant Change Documentation Documentation for indication of resident to resident abuse to ensimplementation of facility policy Abuse Prevention Program Guideline weetimes 4 weeks to total 100% of in-house times 4	ent to dical or of 5 for on from 6 for esident facility by dical or of 5 for on from 6 for al or dit did onts by view of /SBar ports sure use kly ouse	DATE
	administrative staff, advised (by DON) t	safe and went to alert ." The nursing staff were o initiate 1 on 1 supervision on efore the staff could initiate 1			residents then 25% of in-house res audited monthly thereafter. *Facility Grievance Logs and 24/5 of reports for January 7, 2015 thru Ma	day	

on 1 supervision, Resident #3 was observed in

2015 will be reviewed by

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, 20.22			(	
		345298	B. WING				09/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	370N UEALTU 0ADE			3	11 S CAMPBELL STREET		
HUNTING	STON HEALTH CARE			В	BURGAW, NC 28425		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE RIATE	COMPLÉTION DATE
F 323	Continued From pa	ge 12	F :	323			
	'	m with his hand in Resident #7	. `		Administrator/Designee on March 7	2015	
		per witness statement by NA			for indication of reports of resident		
		mary report stated Resident			resident abuse to ensure implemen		
		ring the room and removed his			of facility policy Abuse Prevention		
		ved Resident #3 from the			Program Guideline. No Grievances	or	
	room and he was s	upervised by staff continually			24/5Day reports indicated reporting		
		Resident #3 room was			resident to resident abuse.		
		ss the hall from Resident #7 to			*Effective March 8, 2015, Facility		
		different hall near the Nurses			Grievance Logs and 24/5 days repo		
		onitoring. The report also			be reviewed weekly times 4 weeks		
		olice Department was notified			monthly by Administrator/Designee		
		n initiated. On 1/6/15 at 8:30 ceived a head to toe			indication of reports of resident to r abuse to ensure implementation of		
		lurse #1 and Nurse #2. The			policy Abuse Prevention Program	lacility	
		oted redness to her pubic			Guideline.		
		ness to her left breast. The			*In servicing of all facility staff initia	ed by	
		itioner (FNP) assessed			Director of Nursing/Designee on M		
	Resident #7 on 1/6/	/15 and noted there were no			2015 of facility policy Abuse Prever		
	penetrating injuries	. The DON stated in her			Program Guideline, to include resid		
		t #3 was assessed as alert			resident abuse and the removal of		
		eriods of confusion. He could			accused resident from the situation		
		when questioned by facility			the keeping of the accused residen		
		o Nurse #1 that he was trying			making visits to other residents roo		
		button her blouse. When law ewed Resident #3, he stated			unattended by providing one on one		
		dent #7 room to talk to her but			monitoring by staff of accused residuntil the development of a plan of c		
		ent #7. Resident #3 's wife			prevent reoccurrence. Any facility s		
		ncident and law enforcement			in serviced by March 7, 2015 will be		
		DON summary stated that the			serviced via phone or in person by		
		notified the facility that they			Director of Nursing/Designee at be	ginning	
		esident #3 ' s arrest			of their next scheduled shift.	_	
		on 1/6/15) and picked			*All newly employed staff will be ed		
		I brought him to jail. Resident			during Employee Orientation by Sta		
		acility the evening of 1/6/15			Development Coordinator/Designe		
		bond and 1 to 1 supervision			facility policy Abuse Prevention Pro		
		esident #3 was issued an			Guideline, to include resident to res		
		ge notice to maintain safety of			abuse and the removal of the accuracident from the cituation, and the	sea	
		e was picked up by his family			resident from the situation, and the	m	
	∣ to attend his court h	nearing on 1/7/15 and			keeping of the accused resident fro	m	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
			7 BOILDI		<del></del>	(	;
		345298	B. WING				09/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0.2010
				3	11 S CAMPBELL STREET		
HUNTING	GTON HEALTH CARE	:		В	URGAW, NC 28425		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 323	Continued From pa	age 13	F 3	23			
	discharged from th	e facility with home health			making visits to other residents roo	ms	
		in care of his family.			unattended by providing one on one		
					monitoring by staff of accused resid		
		e Report submitted 1/6/15 at			until the development of a plan of c	are to	
		d a complaint was called into			prevent reoccurrence.		
		at 8:20 AM, regarding a male			*Area Ombudsman to be contacted		
		#3) who sexually assaulted a sident #7) 1/6/15 at 7:30 AM.			Administrator/Designee on March 7 for scheduling of Resident Rights/	, 2015	
		n that everything was okay			Resident Abuse Staff in-service with	th	
		I. Resident #7 had minor			ongoing Resident Rights/Resident		
	injuries. Resident	#7 was listed as a victum of			in servicing of staff at least annually		
		rual offense and sexual battery.			thereafter by Director of Nursing/St		
		dent #3) used personal			Development Coordinator/Designed		
		eet, teeth etc). The Police			Inservice scheduled for April 7, 201	5.	
		on 1/6/15 at approximately			*Effective March 8, 2015, Random	thair	
		went to the facility in sault. The Officer interviewed			Auditing of 25% of facility staff as to understanding of the facility policy		
		#3, Resident #7, NA #1, and			Prevention Program Guideline ( to		
	NA #2.				resident to resident abuse and the	ITIOIGGO	
		s note on 1/6/15 at 4:45 PM,			removal of the accused resident fro	m the	
		ediate discharge notice was			situation, and the keeping of the ac	cused	
		43 and family due to the			resident from making visits to other		
		The social progress note on			residents rooms unattended by pro		
		stated the wife and son of			one on one monitoring by staff of a		
		given discharge information			resident until the development of a		
		nd concerns were addressed.  on 3/6/15 at 10:00 AM, NA #1			care to prevent reoccurrence) to be conducted by SDC/Designee week		
		Restorative Aid and on 1/6/15			times 4 weeks to total 100% of faci		
		ssist Resident # 3 in			staff then 25% of facility staff mont		
		She stated on 1/6/15 between			thereafter.		
		esident #3 was observed in his			*Results of all audits completed by/		
		urses station. NA#1 further			March 7, 2015 and subsequent ind		
		eakfast food trays came out			Audits and results will be reviewed		
		r him and he was not in his			scheduled Quality Assurance Com	nittee	
		she heard Resident #7 yelling			Meeting and again at the following	ittoo	
		e entered Resident #7 's room			quarterly Quality Assurance Comm Meeting with determination at that t		
		dent #3 sitting in his was grabbing on Resident #7			continued need for monitoring.	1116 101	
		pic area. Resident #7 was			cog.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	IPLE CONSTRUCTION IG	COM	(X3) DATE SURVEY COMPLETED	
		345298	B. WING _			C <b>09/2015</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 311 S CAMPBELL STREET BURGAW, NC 28425		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 323	observed sitting up the door. Resident facing the door while wheelchair. NA #1 sout of the room into called Nurse #1 in t #1 stated after Nurshandle the situation in the restorative di #1 further stated the #3 was brought to NA #1 had to sit with During an interview DON stated on 1/6/shift (11-7 nurse) m facility and informed Resident #3 and Re NA #1 had heard R 7:45 AM. NA #1 er and observed Resident #7 was other bed. NA #1 call the doorway. NA #1 room together and #3 back to his room stated staff reported his room and went to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries. The DON process of notifying concerning the incident to make sure she winjuries.	on the side of her bed facing #3 's back was observed to he was sitting in his stated she immediately backed the doorway and immediately he hallway for assistance. NA se #1 entered the room to a, she left the room to go assist ning on the opposite hall. NA at later that morning, Resident restorative dining to eat and	F 32		Date: March	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		345298	B. WING	i		C <b>3/09/2015</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 311 S CAMPBELL STREET BURGAW, NC 28425		3/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE
F 323	bedside and his ha genital area. He wa and was immediate s room. The DON's with Resident #3 ur on one supervision Police Department notified and Reside private room. The I her staff when there altercation to have Resident #3. During an interview #1 stated on 1/6/15 for help in Resident #3 in from Resident #3 in from Resident #3 in from Resident #3 #7 's brief and she #1 further informed yelling and had gor see what was happ wheeled Resident #3 back to Resident #3 to stay figure out what to do Resident #3 agreed the interview Nurse been seen getting of wheelchair by hims do so. Nurse #1 s #7 's room and obspanicky. Resident with her. While talk Resident #3 was try laying position. Re	Ind was on Resident #7 's as observed in his wheelchair ely removed from Resident #7 's stated that NA #2 remained intil NA #1 relieved her for one. The DON stated the FNP, and family members were ent #3 was transferred to a DON stated she would expect e was a resident to resident immediately done 1 on 1 with e on 3/6/15 at 10:32 AM, Nurse e, she heard NA #1 yelling out the error of the was a resident wheeling away in the part of the error of		323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING _			C / <b>09/2015</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 311 S CAMPBELL STREET BURGAW, NC 28425		103/2013
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	after she had felt R the room and went Nurse Practicioner stated that she thow with Resident #7 by #1 stated she woul immediately if she going to get up and room again.  During an interview stated that on 1/6/1 she had heard Res checked to see if R and he was not. R and NA #2 opened #3 's hands inside Resident #7 was ye stated she called fo NA #2 asked Resid he removed his had NA#2 stated Nurse Resident #3 from F During an interview FNP stated she wa informed that a ma put his hands on a #7) female parts ar she recalled. The trained to do rape of exam on Resident assessment the FN had no vaginal drai opening of vagina. left breast and her revealed that Resid Resident #3 had no that she (Resident	lesident #7 was safe she left to notify the DON and Family (FNP). Nurse #1 further ught she told someone to stay at could not recall who. Nurse d have placed one on one care had known Resident #3 was a go back into Resident #7 's on 3/6/15 at 11:51 AM, NA #2 5 between 8:15 to 8:25 AM, ident #7 yelling for help. She desident #3 was in his room esident #7 's door was closed the door and found Resident of Resident #7 's brief and elling for help. NA #2 further or help and stayed in the room. Ident #3 what he was doing and and out of Resident #7 's brief. If a the came and removed Resident #7 's room. If a the came and removed Resident #7 is good and the came and removed Resident #7 is good. If a the came and removed Resident #3 had female resident (Resident #3) had female resident (Resident #3) had female resident (Resident #3) had female resident that she was not exams but did a superficial #7 on 1/6/15. Upon IP revealed that Resident #7 nage or redness at the She did have redness on her labia/clitoris. The FNP further that #7 had told the FNP that of penetrated her vagina and #7) kept trying to push him fer. The FNP stated that her	F 32	3		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C <b>03/09/2015</b>	
NAME OF I	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	00/(	33/2013
HUNTING	GTON HEALTH CARE				I1 S CAMPBELL STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	removed Resident: facility's protocol at care. On 3/6/15 at 4:30 F interviewed and had inappropriately or o The administrator of jeopardy on 3/6/15 jeopardy was remo The following intervithe facility to remove Resident #7 Resident #3 For Resident #7: *On January 6, 201 Resident #3 was re #7 by floor CNA's room. * On January 6, 20: Resident #3 was re #7 by floor CNA and immediately placed Director of Nursing, observation status 2015, not being allo room or any other r *Resident #3 also h change following th relocation into anot from room area of I * Floor LPN for Res Physician/Medical I 6, 2015 at approxin examination of resi- immediately following immediately following examination of resi- immediately following immediately immedia	facility staff would be to have #3 from the area, follow the nd provide one on one staff  PM, Resident #7 was dono recall of being touched frecent events.  Was notified of the immediate at 3:30 PM. Immediate ved on 3/7/15 at 5:15 PM.  Pentions were put into place by re the Immediate Jeopardy:  5, at approximately 7:50 am moved from room of Resident and was redirected to his  15, at approximately 8:20 am moved from room of Resident dono none on one observation by and remained on this until discharge on January 7, owed to visit Resident #7's resident #7's resident #7.  Sident #7 notified Attending Director of incident on January nately 8:30 am, with dent by Attending Physician ing notification, new orders nication by Attending Physician	F3	323			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		345298	B. WING			C <b>03/09/2015</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 311 S CAMPBELL STREET BURGAW, NC 28425	P CODE	00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIA	
F 323	visit/examination or documented in visit Attending Physiciar orders received and Mental Health Cons by Attending Physic *Responsible Party Nursing Home Adm Nursing on January *24 Hour report sub Personnel Registry Nursing/Designee or completed 5 Day In on January 8, 2015 Nursing/Designee. *Local Law Enforce responded to facility legal investigation. *Resident #3 was of Responsible Part For Resident #3:  *On January 6, 201 Resident #3 was re #7 by floor CNA and immediately placed Director of Nursing observation status 2015 not being allow room or any other room or any other room area of Resident #3 also he change following the relocation into anot from area of Resider was Physician following	courred on January 6, 2015 as a note. Follow-up visit by a on January 8, 2015 with new d implemented, to include sult, with continued follow-up sian as needed was notified of incident by hinistrator and Director of 6, 2015 of incident. Omitted to Health Care by Director of 90 January 6, 2015, with evestigation Report submission by Director of ement notified of incident and y on January 6, 2015, initiating discharged from facility to care the ty on January 7, 2015.  5, at approximately 8:20 am moved from room of Resident desident #3 was on one on one observation by and remained on this until discharge on January 7, wed to visit Resident #7's esident 's room. In ad an immediate room e 8:20 am incident to ther wing of facility, removed ent #7.  Attending Physician of 6, 2015 at approximately 8:30 assessed by Attending		323		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		345298	B. WING _			C / <b>09/2015</b>	
	PROVIDER OR SUPPLIER  GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425			
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	Nursing Home Adm Nursing on January *24 Hour report sult Personnel Registry Nursing/Designee of completed 5 Day R 8, 2015 by Director *Local Law Enforce to facility on January investigation. *Resident #3 was of Responsible Par For Resident #7, R current in-house reaffected: *Resident #3 place until discharge fron *On January 6, 201 LPNS (3) responsible and #2 at time of in of Nursing on facility Program Guideline abuse and the rem from the situation, a accused resident for residents rooms undevelopment of a preoccurrence. *24 Hour report su Personnel Registry Nursing/Designee of completed 5 Day R 8, 2015 by Director Floor LPN #1 responsible of the completed of	ninistrator and Director of (6, 2015.) In the committed to Health Care by Director of con January 6, 2015, with eport submission on January of Nursing/Designee. In the committed and responded by 6, 2015, initiating legal discharged from facility to care try on January 7, 2015.  I discharged from facility to care try on January 7, 2015.  I discharged from facility to care try on January 7, 2015.  I do none-on-one observation on facility on January 7, 2015.  I charge LPN, and Floor cole for care of Residents #1 incident in serviced by Director try policy Abuse Prevention, to include resident to resident and the keeping of the commaking visits to other inattended until the colan of care to prevent bmitted to Health Care	F 3:	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		345298	B. WING			C <b>09/2015</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425	1 00/	00/2010
(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 APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 323	related to resident to additional displinary appropriate. *All alert and orient residents interviewed Nursing/Designee of previously unreport Resident Abuse as 2015 incident. Ther Resident to Reside *Audit of all in-house to be conducted by on March 7, 2015 for Change Documents from January 6, 20 indication of reports to ensure implement Prevention Program identify any indication seident abuse. *Audit of all in-house to be conducted by on March 7, 2015 for Change Documents from January 6, 20 indication of tender behaviors by reside indications of these *Facility Grievance January 7, 2015 the reviewed by Admini 2015 for indication resident abuse to efacility policy Abuse Guideline. No Grievance Guideline. No Grievance	rition Program Guidelines as to resident abuse, with a action as deemed and by Director of an 3/6/2015 for any potential and allegations of Resident to it may relate to the January 6, we were no allegations of ant Abuse. The residents Medical Records Director of Nursing/Designee for review of Significant action/SBAR Documentation 15 thru March 7, 2015 for a for resident to resident abuse and Guideline. Audit did not cons of reports of resident to resident to the resident section of Significant action/SBAR Documentation and for the program of Significant action/SBAR Documentation 15 thru March 7, 2015 for action to the significant action/SBAR Documentation 15 thru March 7, 2015 for action of SBAR Documentation 15 thru March 7, 2015 for action of the significant action of the significant of the significant action of the significant of	F3	23		
	*In servicing of all	of resident to resident abuse. facility staff initiated by //Designee on March 6, 2015 of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345298	B. WING	· · · · · · · · · · · · · · · · · · ·	03	C / <b>09/2015</b>
	PROVIDER OR SUPPLIER  GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ULD BE	(X5) COMPLETION DATE
F 323	Guideline, to include and the removal of situation, and the ke from making visits to unattended by provide by staff of accused of a plan of care to facility staff not in sube in serviced via poof Nursing/Designescheduled shift.  *All newly employed Employee Orientatic Coordinator/Design Prevention Program to resident abuse a resident from the si accused resident from the si accused resident for residents rooms un one monitoring by sith development of reoccurrence.  *Area Ombudsman Administrator/Design Staff in-service with Rights/Resident Ableast annually there Nursing/Staff Devel Coordinator/Design Immediate Jeopard PM. On 3/6/15, the all staff presently woon the facility 's Ab Guideline policy, to abuse and the removes the side of the sid	e Prevention Program e resident to resident abuse the accused resident from the eeping of the accused resident to other residents rooms iding one on one monitoring resident until the development prevent reoccurrence. Any erviced by March 7, 2015 will hone or in person by Director e at beginning of their next  d staff will be educated during on by Staff Development lee on facility policy Abuse in Guideline, to include resident and the removal of the accused tuation, and the keeping of the om making visits to other attended by providing one on staff of accused resident until a plan of care to prevent  to be contacted by gnee on March 7, 2015 for dent Rights/ Resident Abuse in ongoing Resident use in servicing of staff at eafter by Director of lopment	F3	23		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C 3/09/2015
	PROVIDER OR SUPPLIER  GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CO 311 S CAMPBELL STREET BURGAW, NC 28425		3/23/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 323	accused resident frresidents rooms un one monitoring by sthe development of reoccurrence. Any March 7, 2015 will be person by the Direct beginning of their noriented residents of feeling safe in your were no issues ider involved in resident facility on 3/6/15 at the Abuse policy that	om making visits to other attended by providing one on staff of accused resident until a plan of care to prevent facility staff not in-serviced by be in-serviced via phone or in stor of Nursing/Designee at the ext scheduled shift. Alert and were interviewed regarding living environment and there natified. Interviews with all staff care presently working at the revealed they were aware of at included implementing sident identified with	F3	323		