DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRÍNTED: 03/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION		SURVEY PLETED	
		345264	B. WING				C /04/2016
NAME OF PI	ROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE	03	70472016
					514 OLD MOUNT HOLLY ROAD		
STANLEY	TOTAL LIVING CENTER				STANLEY, NC 28164		
(X4) ID		ATEMENT OF DEFICIENCIES	[D	_	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLÉTION DATE
F 000	INITIAL COMMENTS	3	F	00	o		
	483.13 (F223) at J	-	-				.
		began on 02/20/16 when NA			-		
	#1 was witnessed be				. 7	2	
		ident #2 and physically	. •				
		. Immediate jeopardy was					., .
		at 7:05 PM when the facility					
		ented an acceptable credible					
		nce. The facility remains out					1 - 125
		wer scope and severity of D	}				- <u>-</u> -
		al harm with potential for]
		arm that is not immediate					
	jeopardy) to complete	and ensure monitoring					
	systems put into plac	e are effective related to				:	
	resident rights to be f					* .	
	483.13 (F225) at J		- "				
	Immediate jeopardy l	egan on 12/28/15 when the					
	facility failed to report	a bruise of unknown origin				: "	
	(Resident #6) within 2	24 hours to the Health Care				-	* · -
		nd failed to conduct a					
		n and report those findings			•		
		eport. Immediate Jeopardy				<u>:</u> .	
		r Residents #1 and #2 when			•		
	the facility also failed						
		buse (Resident #1) and 2					
Ì		use (Resident #1 and			· -		
		4 hours to the Health Care					
	Personnel Registry a						
		n and report those findings	j				
		report. Immediate jeopardy					
	l .	04/16 at 7:05 PM when the					
		mplemented a credible					
		nce. The facility remains out				<u>.</u>	
		wer scope and severity of D					
		al harm with potential for					
		arm that is not immediate					
		education and ensure					
	monitoring systems p	ut into place are effective					
ADODATODY	DIDECTORS OF BROWRESS	SUPPLIER REPRESENTATIVES SIGNATURI				******	
$nuvivnivii_m$	Suren Cours Ou Ludianceur	oor i eiter met metera tanta eta bigiani inki	_ ~		TITLE		(X6) DATE

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	MULTIPLE CONSTRUCTION JILDING			SURVEY
			7 55(25	1110	<u> </u>	! ,	c
		345264	B. WNG			}	04/2016
NAME OF P	ROVIDER OR SUPPLIER	•		Т	STREET ADDRESS, CITY, STATE, ZIP CODE	1 001	0472010
074 MI = M	TOTAL LUMBO OFFITEE				514 OLD MOUNT HOLLY ROAD		
SIANLEY	TOTAL LIVING CENTER				STANLEY, NC 28164		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF. TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	COMPLETION DATE
F 000	Continued From page	e 1	F	00	00		
	with the immediate re	emoval of residents from					
	abusive situation and	I the immediate reporting of					
	witnessed abuse to the	ne management staff.					
						4.	the section of the se
	483.13 (F226) at J	+, F - 1					
		pegan on 12/28/15 when the			•		
		t a bruise of unknown origin			·		필.
		24 hours to the Health Care				-	
		nd failed to conduct a			-	-	
		n and report those findings			-		25 4-
		report. Immediate Jeopardy				•	•
		r Residents #1 and #2 when to report a witnessed					
	-	buse (Resident #1) and 2				-	
		use (Resident #1 and	''	-			14.0 11.1
		4 hours to the Health Care	1				-
		nd failed to conduct a					
		n and report those findings					1.5
•		eport. Immediate jeopardy			·		
		04/16 at 7:05 PM when the					1 1 a
		mplemented a credible					
		nce. The facility remains out	*.				
		wer scope and severity of D ~				=	
	(isolated with no actu	al harm with potential for			-	٠	
	more than minimal ha	arm that is not immediate					
		education and ensure 💷 -					
	monitoring systems.p	ut into place are effective 💎 🖘 🔩	_ .				_ `
		moval of residents from					
		the immediate reporting of					
	witnessed abuse to the						
F 223	483.13(b), 483.13(c)(F	22	3		_ [.
SS=J	ABUSE/INVOLUNTA	RY SECLUSION					-
			1 .				
		right to be free from verbal,					
		mental abuse, corporal					
	punishment, and invo	nuntary seclusion.					
	The facility must not u	use verbal, mental, sexual,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345264	B. WNG			02/0	
NAME OF PI	ROVIDER OR SUPPLIER	570201	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/0	04/2016
STANLEY	TOTAL LIVING CENTER			51	14 OLD MOUNT HOLLY ROAD TANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	by: Based on observation interviews the facility is sampled residents rigical abuse (Resident #1 at to maintain 1 of 6 samfree from physical abuse (maintain 1 of 6 samfree from physical abuse to Resident #2. removed on 03/04/16 provided and implemental end of compliant and implement than minimal hard jeopardy) to complete monitoring systems purelated to resident right The findings included: 1. Resident #1 was account of the findings included: 1. Resident #1 was account of the findings included: 1. Resident #1 was account of the findings included: 1. Resident #1 was account of the finding included: 1. Resident #1 was account of the finding included: 1. Resident #1 was account of the finding included: 1. Resident #1 was account of the finding included: 1. Resident #1 was account of the finding included: 1. Resident #2.	is not met as evidenced n, record reviews and staff failed to maintain 2 of 6 Ints to be free from verbal and Resident #2) and failed inpled residents rights to be use (Resident #1). Integration on 02/20/16 when Integration of the most property was at 7:05 PM when the facility Immediate jeopardy was at 7:05 PM when the facility Immediate jeopardy was at 7:05 PM when the facility Immediate jeopardy was at 7:05 PM when the facility Immediate jeopardy was at 7:05 PM when the facility Immediate jeopardy was at 7:05 PM when the facility Immediate jeopardy was at 7:05 PM when the facility Immediate jeopardy was at 7:05 PM when the facility Integration of D Integration of S Integrati	F	A Proposition of the control of the	(1) Residents #1 and #2 were immediat protected from any further verbal and physical abuse by NA#1 by the Nursi Supervisor on 2/20/16 when NA#1 physically removed from their unit. residents were further protected from abuse by NA#1 upon her suspension on 2/26/16 and subsequent termina 2/26/16 by the Director of Nursing. A full body skin assessment was comon Residents #1 and #2 by Nursing Swith no concerns noted related to possible. Residents #1 and #2 were assessed by 100 unit Social Services Coordinator determine any residual effects of physical abuse of Resident #1 was cowith all required reporting to the NC Care Personnel Registry by the Admin on 3/8/16. A full investigation of the verbal abuse of Resident #1 was cowith all required reporting to the NC Care Personnel Registry by the Admin on 3/8/16.	ind/or ing was All many tion on pleted upervise tential by the to sical s noted. mpleted Health histrator	3/3/16 3/8/16 dent to the
	revealed that she had	been in the dining room on approximately 5:30 PM		N	NC Health Care Personnel Registry by dministrator on 3/11/16.	the	3/11/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY PLETED	
					· : : : 	1	С	
		345264	B. WNG			03/04/2016		
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
STAMI EV	TOTAL LIVING CENTER			5	14 OLD MOUNT HOLLY ROAD			
SIANLET	TOTAL LIVING CENTER			s	TANLEY, NC 28164			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	<u>'</u>	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF! TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 223	Continued From page	. 3	_	000				
1 220			F.	223				
		NA #1 yelling at Resident #1		_	2)	_ '	'	
		ind to leave her alone. NA nt#1 would pat your leg if			'ull body skin assessments were cond			
		le her and she was patting			ll residents by Nursing Managers to		ŧ	
		1 got angry and began			ny signs of potential physical abuse	with no	3/4/16	
	yelling at Resident #1		-	C	oncerns noted.			
		on 03/02/16 at 3:05 PM		Al	l residents who are alert and oriente	d were	3/4/16	
	1	working in the dining room		in	terviewed by the MDS Coordinators t	to	7 .,	
	on the evening of 02/2			de	termine any concerns related to abu	ise with		
	Resident #1 patting th	e leg of NA #1. NA #1 then		no	negative responses. Each resident			
	stated "oh my God st	op it, why do u keep patting	reminded /educated at that time on the proper					
		" and then NA#1 leaned		re	porting procedures if abuse occurs.			
		ent #1 and grabbed her right						
		into the lap of Resident#1						
		e table. NA#3 described it		Tł	ne Administrator conducted an in-sen	rvice for	3/4/16	
		VA #3 further stated that		\mathbf{a}	l staff between 3/3/16 - 3/4/16 on 1	evision	s	
		eaction except mumbling		m	ade to the Abuse Policy & Procedure	s includ	ing:	
		had done a staff statement			 definitions, examples, and sce 	narios o	f .	
	felt like NA #1 had ab	rse. NA #3 stated that she			abuse		1	
		ment for Incident/Accident"	ŕ		 immediate steps required who 	en abusc	e is	
		witnessed NA #1 slam	ing the		suspected and/or reported in			
		nd tell her to stop patting			immediate removal of the resi			
		ember also witnessed the			situation, immediate verbal re			
		the resident and stated			facts as witnessed to the direct			
		ite. Signed by NA #3 and			nurse on duty, immediate ren	_	- 174	
	dated 02/20/16,	· -			accused employee from all du			
	Interview with NA #2 of	on 03/02/16 at 4:13 PM			immediate verbal reporting to			
	revealed that she was	present in the dining room			and Administrator for timely			
		with supper and witnessed			procedures	Ü	-	
		d with Resident #1 who was			F		· .]	
	patting her leg and gra							
		ent #1's lap grazing the			-		-	
		1 state to Resident #1 "stop						
		." NA #2 stated that what						
		en NA #1 and Resident #1						
		l verbal abuse because they						
		ry training on abuse and						
1	were educated on the	different types of abuse						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE	SURVEY LETED		
			/ N. Boilebii			,	o .		
		345264	B. WING_				04/2016		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
STANLEY	TOTAL LIVING CENTER			5′	14 OLD MOUNT HOLLY ROAD				
0000000	TO TALL ENTING GENTLEN		Į	STANLEY, NC 28164					
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 223	revealed that she was at that facility. Visitor at the dining room at sur Resident #1 rubbing Noom at the forced it down onto he NA #1 was very angry nose with Resident #1 stop that" and "keep to Visitor #1 further state grab the wrist of Resident #1 was patting as in the dining Resident #1 was patting assisting her with supptook the hand of Resident #1 was patting assisting her with supptook the hand of Resident #1 did now as saying to her. NA Supervisor had come got her so they could it Nurse Supervisor state complaint that she was residents but did not set #1 stated that she told was upset at the situal switched to a different NA #1 stated she was secure memory care to Interview with Nurse States.	es of each type. #1 on 03/04/16 at 9:53 AM s a sitter for another resident #1 stated that on 02/20/16 in oper time she witnessed NA #1's leg and NA #1 got 1 she took her arm and or lap. Visitor #1 stated that or and got almost nose to I and stated "I told you to your hand to yourself." ded that she witnessed NA #1 dent #1 and shove it into her nile she was in the dining esident she worked for. on 03/04/16 at 10:27 AM as terminated from the A #1 stated that on 02/20/16 room at supper time ong her leg while she was per and NA #1 stated she dent #1 and put it back in of stop hitting NA #1. NA #1 s between 10 to 15 times one meal. NA #1 confirmed out understand what she out understand what she out understand what she into the dining room and talk. NA #1 stated that ed he had received a s rude to one of the opecify which resident. NA I Nurse Supervisor that she	TI si to di a fo di po A in ab Ab A Do 3/ res im Ab rep A ne assi duty to be act all i duty	ne V taff o receiver orm irecossil All collinia the use ouse ouse ouse ouse ouse ouse ouse o	Witness/Staff Statement form was reuse when reporting witnessed event sident care, including abuse. This forts staff to only provide the written stolal report has been given to the nursualso specifically directs staff to place to quotes, to use full names, and to be ble for further investigation. Idepartment managers were in-service nistrator on 3/21/16 on the use of the event they are the manager on duty to be reported directly to them following Policy. Idensed nurses will be in-serviced by dopment Coordinator between 3/23/216 on the use of this form as they winsible for obtaining such statements diate steps have been taken following Policy for protection of the resident ting of the concern. 'Abuse Investigation' form was creat the licensed nurse or department man the time abuse is reported on the real ken and the required timeframe. The timeline for the investigation process itself.	is related in speciatements on du concern as special s	d ifically it after ity. This ns in ific as		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILD		, , , , , , , , , , , , , , , , , , , 			
		345264	B. WING			1	C 04/2016	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	04/2010	
021111				5	14 OLD MOUNT HOLLY ROAD			
SIANLEY	TOTAL LIVING CENTER			s	TANLEY, NC 28164			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	<u>' </u>	PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 223	Continued From page	. 5		223				
		pally aggressive and very	'	220				
-		I, so Nurse Supervisor	İ	Δ	Il department managers were in se-		43	
		dining room and asked to		Ad	Il department managers were in-ser ministrator on 3/21/16 on the use o	vicea by	the	
		asked what was going on.		int	the event they are the manager on di	I this fo	rm	
-		sident #1 was rubbing her		ahı	use he reported directly to them. F-11.	ity snou	ıld	
	leg near her private a	rea and NA #1 stated that		Pol	use be reported directly to them follo	wing th	ie Abuse	
		dent #1's hand away and		10	ncy.		3/26/16	
		. Nurse supervisor stated he		A	ll licensed nurses will be in-serviced	: la 23 (n. cc	
		as being verbally aggressive		De	evelopment Coordinator between 3/1	oy me a	Starr	
		O" and so Nurse Supervisor		3/2	25/16 on the use of this form as they	22/10 H	na - .	
		e the tone of her-voice-could ally aggressive and NA #1		res	ponsible for initiating this form if ab	wm be	1	
		supervisor again stated		ren	ported.	use 12		
		ed NA #1 to the 400 secure]			· ,	
		the remained of her shift.						
-		d 02/21/16 at 7:15 PM from		(4)			2/20/40	
	Nurse Supervisor to D	Director of Nursing (DON)			Abuse Investigation forms and Witnes	ess/Staf	3/26/16	
	read in part that a visi	tor had witnessed NA #1			tements initiated upon the report of			
-		nt#1 and shoving her arm			reviewed thoroughly by the Adminis			
Ø 19		uld pat NA #1 on the leg.	-	wit	thin 24 hours of the reported abuse c	r by Mo	nday	
		A#1 about it she became	1	for	any reports occurring after 4:30pm	on the p	revious	
•		with an aggressive attitude.		Fri	day to ensure all required steps have	been ta	iken to	
		ed to NA #1 under the edication unit so the DON	Ì		otect the resident(s) involved as wel			
		dy language an attitude. I			idents from potential abuse in a time			
		secure memory care unit			t detailed steps of the investigation l			
	for the remainder of h	-			the required timeframe by the Direct			
		footage of Nurse Supervisor			designee. The Controller (also a lice			
		medication room was			me Administrator) will act in the abs	ence of t	the	
		at 6:10 PM. There was no		Ad	ministrator to review these forms.	1		
		urse Supervisor and NA#1					. <u>.</u>	
		:17 PM and NA #1 was						
		with both arms crossed			-	, 1 to		
		nile Nurse Supervisor talked				.]		
	to her. At one point in					. 1		
		ace. NA #1 was shaking						
		rth and using hand gestures						
	during most of the cor	ed on NA #1 appeared to						
		va ou ista te i abbagaion in	1				i I	

CENTER	S FUR MEDICARE &	MEDICAID SERVICES	,			OMB NO	<u>0. 0938-03</u> 91		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345264	B. WNG				C /04/2016		
NAME OF P	ROVIDER OR SUPPLIER	I		T s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	04/2016		
					14 OLD MOUNT HOLLY ROAD				
STANLEY	TOTAL LIVING CENTER			1					
		·		8	TANLEY, NC 28164				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE :	(X5) COMPLETION DATE		
F 223	Continued From page	o 6		223					
,			-	223			3/26/16		
		and again wiped her face NA #1 and Nurse Supervisor		Tł	roughout an abuse investigation, the	e Directo	orof		
		om and the video ended.			arsing will review all steps taken thu				
		dmitted to the facility on			ocess daily with the Administrator (
		ses that included diabetes —			the absence of the Administrator) in				
		, Alzheimer's disease, and			orough review of all witness/staff st				
	dementia. Review of	·			otained for further direction.				
		ssion MDS dated 10/26/15			wanton for further an obtain				
	revealed that Resider						3/26/16		
	cognitively impaired a	-		Тŀ	ne Director of Nursing will review all	finding	bace		
		Iso indicated that Resident	<u>-</u>		inclusions of the detailed investigation				
		assistance with ADLs.		Administrator (the Controller in the absence of the					
	Review of care plan d	ated 10/27/15 read in part	- -						
,	Resident #2 had impa	ired thought process and			lministrator) prior to final submissio				
	was forgetful at times.	. The goal of stated care			nal report to ensure completion of al				
	plan was to accept jud	dgment of staff/significant			e investigation process and determin				
	other as appropriate a	and interventions included		пr	ial outcome related to the accused ei	npioyee			
	approach resident wa	rmly and positively and in a					3/26/16		
	calm manner and calr	nly talk with resident and			ny staff member who fails to follow a				
	offer reassurance price	- ·			ouse Policy as written, including the				
		on 03/03/16 at 10:27 AM			e Abuse Investigation Form, will be s				
		0/16 they were in the dining			scipline including unpaid suspension	i up to a	nd		
		er and Resident #2 was		in	cluding termination.		٠.		
		ing room and had got his	-				7/26/44		
	_	the chair she was sitting in.					3/26/16		
-	NA #1 stated she got				l reports of abuse including findings				
	wheelchair and the ch			of	the investigation will be reported to	the mor	nthly -		
		and would not let go NA #1 m" and then jerked her arm		Q_{I}	A&A Committee by the Director of N	arsing fo	or		
	away from Resident#		-	ar	ny further recommendations to ensu	re contir	nued		
	•	and was twisting NA #1's		CO	mpliance.		-		
		in NA #1 stated she jerked				1	·		
		t #2 and then walked out of				1	' '		
	dining room to calm d						-		
		on 03/02/16 at 5:09 PM							
		0/16 at approximately 5:00							
		n the dining room waiting				-			
	for supper and had be								
		ed to leave the dining room.							
	•	· · · · ·				,	ı		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	TEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		E CONSTRUCTION		SURVEY PLETED
		345264	B. WNG			C /04/2016	
NAME OF PI	ROVIDER OR SUPPLIER		1	T	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	10412016
STANLEY	TOTAL LIVING CENTER				514 OLD MOUNT HOLLY ROAD		
	TO THE ENTITE OF THE I				STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC [DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	Continued From page	a 7	, 	223	3		,
		took Resident#2 to see a	' '		· .		
		lso resided at the facility to					-
		Resident #2 down. NA #2			_		
		dent #2 had visited with the			·		
		ew minutes he had calmed					
İ	=	able to return Resident #2					
		A #2 further stated that when					
		t #2 to the dining room NA					
		t is his issue?" NA #2 stated					
	to NA #1 that Resider	nt #2 had delusions that his .				_	<u> </u>
ļ	daughter had been ki	lled. NA#2 stated that NA					.
Ì		Resident #2 and got down in				r	
		nat was a stupid reason-to					
		o reason to act like way" in a 💄	.* -				
		hreatening tone. NA #2 also					-27.
		s very hateful in the way NA.				-	
		#2 that evening in the	-	-		* -	
	dining room.						
		on 02/21/16 at 7:15 PM			·		
		to the DON read in part on -	-		-		
-		20/16 NA#2 witnessed NA				-	-
		ressive to Resident #2 when	-				
		ome combative. Nurse	-		-	-	to the second
		ne email that he had talked					
		tated she was being picked	-=	-			
		ad already gotten in trouble					-F277 (# 437 -
- 1		informed nurse supervisor					7 - 2 - 4 - 1
		g at the facility and it was					
		ce she had ever worked at		-	-		
		that the staff did not like					
		a Yankee, NA #1's body —					
		was aggressive and more					
j		ed that she had changed				-	
}		uld not get along with her					
		he could not get along with					' '
	the staff that was ther						
		rest of the shift and I moved memory care unit for the					
	remainder of her shift						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					OI	MB NC	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA. BUILD!		ISTRUCTION			3) DATE	SURVEY LETED
	:	345264	B. WNG						
NAME OF P	ROVIDER OR SUPPLIER			етрес	T ADDRESS, CITY,	PTATE 710 AODE		03/	04/2016
	TO TIBELLON OUT LIET				LD MOUNT HOLLY				
STANLEY	TOTAL LIVING CENTER				ILEY, NC 28164	RUAD			
W () ID	PLIMA DV PT	TEMENT OF DECIDIENDING		0,,,,,	···				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH COR	R'S PLAN OF CORF RECTIVE ACTION S RENCED TO THE AF DEFICIENCY)	HOULD BE	:	(X5) COMPLETION DATE
F 223	Continued Faces are	٥							
F 223	Continued From page		F 2	223					
		footage of Nurse Supervisor							
		medication room was					٠	-	
		at 6:10 PM. There was no	İ		-				7
		urse Supervisor and NA #1						.*	. •
		:17 PM and NA#1 was							•
		vith both arms crossed ile Nurse Supervisor talked -			÷				*
	to her. At one point in								
	•	ace. NA#1 was shaking				_			
·		th and using hand gestures.							_ [
	during most of the cor								
		d on NA #1 appeared to						£ 4	
		and again wiped her face						7.	
,		IA #1 and Nurse Supervisor				-			· .
ļ		om and the video ended.	-						
	The administrator and	DON were notified on -							
	-03/03/16 at 2:30 PM c	f-immediate-jeopardy . The———							
	administrator provided								:
		ce on 03/04/16-at 6:45 PM.		-				لتو	E
	Credible Allegation of								
		n, Nursing Assistant (NA) —						٠.,	out to the factor
	#1, who physically and								in the state of
		on 02/20/16, left the facility							
		eishift: On 2/22/16'at 3:23						1.0	
		was suspended (she had ince leaving on 2/20/16 @	ļ						
		mately terminated from						*	
	employment on 2/26/1					•		**	
	omprojinane on zazori	o da 1.20pin.	1						
	On 02/22/16 an inves	tigation was initiated on the			-				
		by the Director of Nursing							
		ination of NA #1 on 2/26/16							
	at 1:20pm.								
									_
1	On 02/22/16 the family	of Resident #2 was							
	involved in the investig	gation and was made aware							
ĺ		iated on 2/22/16 as well as							ļ
		investigation on 2/26/16 by							
	the Director of Nursing].	Ì						

PRINTED: 03/18/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ C 345264 B. WING 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY TOTAL LIVING CENTER STANLEY, NC 28164 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 223 Continued From page 9 F 223 On 03/03/16, the Nursing Supervisor was placed on suspension pending further investigation of his role in the allegations of abuse, which occurred on 02/20/16, for failure to protect residents and

the Nursing Supervisor will remain on suspension until the investigation is complete.

On 03/03/16 at 2:19 pm The 24 hour Health Care Personnel Registry (HCPR) abuse/neglect investigation report form for Resident #1 was completed by the Director of Nursing and faxed to

properly report resident abuse. As of 03/04/16 the results of this investigation are pending and

On 03/03/16 a head to toe skin assessment was: completed on Residents #1 and #2 by the 1st and 2nd shift House Supervisors with no concerns related to potential physical abuse.

HCPR for further investigation of alleged abuse.

On 03/03/16 The 100 unit Social Services
Coordinator met with Residents #1 and #2. Eachwas interviewed regarding the physical and/or verbal abuse that occurred on 2/20/16 to determine any residual effects from the alleged physical/verbal abuse with no concerns noted.

On 03/03/16 The Administrator revised the facility's Abuse/Neglect Policy and Procedures. These revisions included: Immediate removal of the resident from the abusive situation by the employee who witnesses the abuse.

Immediate reporting of the abusive situation by the employee who witnesses the abuse to the

·Immediate suspension of the alleged employee

direct supervisor or any other member of

management currently on duty.

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 03/18/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		ONSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STA					C (0.4120.4.c			
	ROVIDER OR SUPPLIER TOTAL LIVING CENTER		l <u></u>	514	EET ADDRESS, CITY, STATE, ZIP CODE OLD MOUNT HOLLY ROAD ANLEY, NC 28164	03/04/2016		
(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 223	the direct supervisor of to the Director of Nursing Con 03/04/16 at 8:42 at Resident #1 was notificable physical abuse by the phone as well as the presults to follow. On 03/04/16 at 9:00 at completed the NC Both Evaluation Tool to determine the properties of the probability of Nursing consultation reporting. The Director Nursing Consultation on 03/04/16 at 10:00 at was given a phone apon Monday, 03/07/16. On 03/04/16 all other oriented were intervied Services Coordinator determine if there were and/or neglect with notice of the properties of abuse by the Coordinators, and Ris	or or member of of the abusive situation by or member of management sing or the Administrator. Im The Responsible Party of ied of the allegations of Director of Nursing via bending investigation with Im, the Director of Nursing and of Nursing Complaint ermine reporting Nursing Supervisor and I which indicated NC Board In but no requirement for or of Nursing contacted the for the required consultation Im. The Director of Nursing Ipointment for further review at 1:30pm. residents who are alert and wed by the 100 unit Social- and MDS Coordinators to be any reports of abuse onegative responses. oe skin assessments were lents to assess for possible Nursing Supervisors, MDS k Management sessments revealed no	F	223				
	Between 03/03/16 and	d 03/04/16 an in-service						

was conducted by the Administrator for all staff on

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345264	B. WNG				С
NAME OF P	ROVIDER OR SUPPLIER	0.000		r	TOTAL ADDRESS OF STATE OF STATE	03/	04/2016
12.41/2.07 11	NO VIDER BICOGNI LIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
STANLEY	TOTAL LIVING CENTER			ı	14 OLD MOUNT HOLLY ROAD		
				S	TANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 223	Continued From page	11	F:	223			
	duty regarding resider agenda included:	nt abuse. The in-service	-				
		& Neglect policy/procedure					
	· Immediate remov	ral of the resident from the ne employee who witnesses			,		
i	· Immediate report	ing of the abusive situation witnesses the abuse to the					
	management currently Immediate suspe	on duty nsion of the alleged				-	
	management	t supervisor or member of ng of the abusive situation					-
	by the direct supervisor management to the Di Administrator	or or member of rector of Nursing or the					
	2: Definitions of phy	sical and verbal abuse	-				- "
	towards any resident i	and temperament used ncluding scenarios of both	-				
	physical and verbal at 3. Definition of how notification of abuse a	to make the immediate		į	-		
	expectation that such verbally.	allegations will be reported	-	1		-	_
	 Expectations for t any resident in which a suspected. 	he irnmediate protection of abuse/neglect are					
		- 					=
	allowed to perform any	iding contract staff, will be york-related duties until n completed following the				-	-
	In-service on 03/04/16 directly by the Adminis	. All in-services were given trator.					
	Any new employees h	ired after the final in-service					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE (COMPL	.eted
		345264	B. WING			03/C) 04/2016
	ROVIDER OR SUPPLIER TOTAL LIVING CENTER		•	5 5		7-11 2.0 1.0	
(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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 223	abuse policy/procedu	ve a review of the revised res by the HR Director lopment.Coordinator before	F	223			
	7:05 PM when staff in administrative staff, a confirmed that they had training on the facilities and neglect, the immedirom the abusive situations.	ad received in service se revised policy on abuse ediate removal of resident ation, and the immediate ve situation to the direct er member of the					
F 225 SS=J	483.13(c)(1)(ii)-(iii), (o INVESTIGATE/REPO ALLEGATIONS/INDI\	(2) - (4) RT	- F:	225 .}.			
	been found guilty of a mistreating residents had a finding entered registry concerning ak of residents or misapp and report any knowle court of law against an	employ individuals who have busing, neglecting, or by a court of law; or have into the State nurse aideouse, neglect, mistreatment propriation of their property; edge it has of actions by a nemployee, which would service as a nurse aide or		p Si P P re fu	esidents #1 and #2 were immediately rotected from any further verbal and/hysical abuse by NA#1 by the Nursing upervisor on 2/20/16 when NA#1 was hysically removed from their unit. All esidents were further protected from auther abuse by NA#1 upon her suspens 2/26/16 and subsequent termination/26/16 by the Director of Nursing.	or s any nsion	2/26/16
	or licensing authorities The facility must ensu involving mistreatmen including injuries of ur misappropriation of re	re that all alleged violations t, neglect, or abuse,		or St to	full body skin assessment was completed Residents #1, #2, and #6 by Nursing apervisors with no concerns noted related potential abuse. esidents #1, #2, and #6 were assessed to unit Social Services Coordinator to	ated	3/3/16
	to other officials in acc	cordance with State law rocedures (including to the		de	etermine any residual effects of physic nd/or verbal abuse with no concerns n	al oted.	3/3/16

O ILIT I LI	COTOTA MEDICALE CO	MEDIO/ (ID OLIVVIOLO				OIME ME	<i>).</i> 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345264	B. WING				C (04/2046	
NAME OF P	ROVIDER OR SUPPLIER			T 6	TREET ARREST OF THE TIP CORE	03/04/2016		
MANUE OF F	NO VIDEN ON GOFFEIEN			1	TREET ADDRESS, CITY, STATE, ZIP CODE			
STANLEY	TOTAL LIVING CENTER			5	14 OLD MOUNT HOLLY ROAD			
				s	TANLEY, NC 28164			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	 -	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	;	CROSS-REFERENCED TO THE APPROPRI	ATE	DATE	
			<u> </u>		DEFICIENCY)		ļ	
Ì			ĺ					
F 225	Continued From page	: 13	F	225			٠.	
	State survey and certi	ification agency).		The	e Director of Nursing who failed to co	ımnleta	the	
	· ·			ren	uired 24 hour and 5 day reports with	inbiere	are	
	The facility must have	evidence that all alleged		int	rectigation for Posidents #1 #2 I	ra comi	nete	
		hly investigated, and must		1111	restigation for Residents #1, #2, and	#b was	3/8/16	
	prevent further potent			sus	pended on 3/4/16 with disciplinary	action a	ļs i	
	investigation is in prog			rec	juired by the NC Board of Nursing up	ion rețu	rn,to	
				WO	rk on 3/8/16.		- • •	
	The results of all inves	stigations must be reported						
	to the administrator or		Ī	Αfι	ıll investigation of the verbal and		•	
		other officials in accordance		phy	rsical abuse of Resident #1 was comp	leted 3	3/8/16	
-		ng to the State survey and		wit	h all required reporting to the NC He	alth		
		vithin 5 working days of the		Car	e Personnel Registry by the Adminis	trator		
		eged violation is verified		on i	3/8/16.	Hawi		
		action must be taken.		OII.	5/ 0/ 10.			
	appropriate corrective	action must be taken,		A 6.	Il investigation of business form			
				A.R.	ill investigation of bruise of unknown	ı orıgin	of	
	•			Res	ident #6 was completed with all req	nired re	porting	
	This DEALIDEMENT	is not met as evidenced		tot	he NC Health Care Personnel Registr	y by the	2/0/16	
	by:	is not met as evidenced		Adr	ninistrator on 3/9/16.		3/9/16	
,		ews and staff interviews the		Λfi	ill investigation of the workel above	en in	n or	
	facility failed to thorou	ghly investigate and submit		A11	ıll investigation of the verbal abuse o	r Reside	ent	
		day reports to the North	-	#44	was completed with all required rep	orting to	the	
		Personnel Registry (state			Health Care Personnel Registry by th			
	agency) for a resident	with a bruise of unknown		Adr	ninistrator on 3/11/16.		3/11/16	
***.		The facility also failed to 🖫 🕘 –				•		
		al abuse when observed	ļ	The	Nursing Supervisor who failed to in	ımediat	elv	
	(Resident #1 and Res			pro	tect Resident #1 and #2 from report	ed abusi	Δ .	
		use (Resident #1), failed to	i		also failed to immediately report th			
		or from resident areas, failed		the	Director of Nursing was suspended	on 2 /4 /	16	
		he Administrator and once		TATİ	th disciplinary action as required by	лго/4/. Ц. Мот	16	
		ed to report the incidents of		of N	luncing and return to second a 2 (4.8)	me NC E	soara	
		ouse to the North Carolina	I	OT I/	lursing upon return to work on 3/12	/ ±6.		
		el Registry in 24 hours and			. <u> </u>	-	3/12/16	
		igs in the 5 working day		- -	-1	·		
	_			· · ·	-			
		led residents for abuse				:-		
	(Resident #6, #1 and a	# ∠ }.						
	Immediate iconardy b	egan on 12/28/15 when the						
		a bruise of unknown origin						
		a arasa ar armitawii angin	1					

_ <u> </u>	OT OIT MEDIOMILE	WEDIO/ND CERVICEO				ONR BIND	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	
		345264	B. WNG			03/0	04/2016
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	14 OLD MOUNT HOLLY ROAD		
STANLEY	TOTAL LIVING CENTER	L		ı	TANLEY, NC 28164		
0/ A) ID	CI BANADY CT	TATEMENT OF DETICIENCIES			<u> </u>		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
		· ·					
F 225	Continued From page	e 14	F.	225			
:	(Resident #6) within 2	24 hours to the Health Care		(2)		'	
	Personnel Registry a	nd failed to conduct a			l body skin assessments were condu	atod on	1
-	thorough investigation	n and report those findings		all	residents by Nursing Managers to ass	cted on	Ì
	in the 5 working day i	report. Immediate Jeopardy-	- 25	an	signs of potential physical abuse wi	sess for	3/4/16
	began on 02/20/16 fo	r Residents #1 and #2 when 🕒	-		ocerns noted.	шцо	
		to report a witnessed .		COL	icerns noted.		·
		buse (Resident #1) and 2		A 11	residents who are alert and oriented		
	incidents of verbal ab						
		4 hours to the Health Care			erviewed by the MDS Coordinators to		3/4/16
	Personnel Registry a		-	uec	ermine any concerns related to abuse	e with	
		n and report those findings	-	110	negative responses. Each resident w	as also	
		report, Immediate jeopardy -		Ten	ninded /educated at that time on the	proper	
		04/16 at 7:05 PM when the mplemented a credible		rep	orting procedures if abuse occurs.		
	allegation of complian	nce. The facility remains out		Thi	e Administrator conducted an in-serv		-
		wer scope and severity of D					l
		al harm with potential for		au i	staff between 3/3/16 - 3/4/16 on re de to the Abuse Policy & Procedures :	visions	3/4/16
		arm that is not immediate			efinitions, examples, and scenarios of		g:
: [e education and ensure		abu			,
		ut into place are effective			nmediate steps required when abuse	ia	n 711 - 5
		moval of residents from 😑 🗀		C110	pected and/or reported including the	is	5 14 5 2
	abusive situation and	the immediate reporting of		imr	nediate removal of the resident from	tha	v
	witnessed abuse to the	ne management staff.			nation, immediate verbal reporting of		
		· · · · · ·		fact	ts as witnessed to the direct supervis	oror	1,75
	Findings included:	The second secon			se on duty, immediate removal of the		
	1 Dooldont #6 was a	idmitted to the facility on	_		used employee from all duties, and	-	-
		es listed on the diagnosis			nediate verbal reporting to the DON		r Paris
		edical record of congestive			Administrator for timely investigati	n a	<u>-</u> -,
	heart failure, high blo				cedures	пg	11
		disease, dementia, anxiety		ا	ccum cs		1 - 3
	and depression.	incodes demonsia, and out			-		
		·					*
	A review of the most a	recent annual Minimum					
	Data Set (MDS) dated				:		
		t and long term memory					
		verely impaired in cognition				. !	
	for daily decision mak				<u>-</u>		
	indicated Resident #6	was totally dependent on				ļ	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIB	TIOI E	CONSTRUCTION		0.0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345264	B, WNG			1	C	
NAME OF P	ROVIDER OR SUPPLIER		L	6.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	04/2016	
	TO THE TOTAL OF TH			ı				
STANLEY	TOTAL LIVING CENTER				4 OLD MOUNT HOLLY ROAD			
			,	s	TANLEY, NC 28164			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
IAG		is a partition of the state of	140		DEFICIENCY)	AIE	DAIL	
			 					
F 225	Continued From page	. 15	_					
1 220	, ,			225	•	•		
		aily living and exhibited no	()	3) ˈ				
	behaviors,	- -	Т	he V	Vitness/Staff Statement form was re	vised for	r staff	
_			· u	se w	hen reporting witnessed events rela	ated to r	esident	
		it report dated 12/28/15 at	С	are.	including abuse. This form specifica	lly direc	ts staff	
	1	rse Aide (NA) # 5 reported			ly provide the written statement aft			
	l .	ident #6 had a 5 inch x 4			t has been given to the nurse on du			
		upper arm. The report			pecifically directs staff to place cond			
		was sleeping when the			es, to use full names, and to be as spe			
		ng the first round on the			rther investigation.	, , , , , ,	50001010	
		t further indicated the bruise oper front, inside and outside	1,)1 1U	THICK HITCHIGHTON			
		le in color and the possible		A 11 .	department managers were in-servi	cad by ti		
	causes were listed as				nistrator on 3/21/16 on the use of t	_		
		t revealed NA #5 called-for			e event they are the manager on dut			
		at #6 and upon assessment,			e be reported directly to them follow			
	there was a 5 inch x 4				-	mig uie.	ADUSE	
	Resident #6's upper le			olic	y.			
		ed Resident #6 if she was in		A 11 '	lineared margar will be in conviged b	er tha Ct	.cc	
		ed "yeah" and when Nurse			licensed nurses will be in-serviced b			
		, Resident #6 grimaced and			elopment Coordinator between 3/23		L I	
7		v of a handwritten witness			/16 on the use of this form as they w		,,	
	statement by NA #5 re				onsible for obtaining such statement		п 1	
		check and change her.			ediate steps have been taken followi	_	į į	
		ident #6 seemed to be in a			e Policy for protection of the resider	ntand		
		necked her over and noticed	r	epo	rting of the concern.		2/26/16	
	Resident #6's upper le			1	•		3/26/16	
		nd she notified Nurse #2. A						
	section for an explana	ition and detailed		}				
	circumstances surrou	nding the bruise revealed a				- , -	·	
	bruised area covered	most of Resident #6's left						
	upper arm (5 inches x	4 inches) and was swollen.					· <u>-</u> _	
		hen the bruise was touched				-		
	it was hard and knotte							
		ed sounds. The report			,		.	
	further revealed NA#	*** ****						
		ne hall where Resident #6						
		rom 3:00 PM until 11:00 PM						
		r, when NA #5 clocked in						
	and went to the nurse	's station for report NA #1						

PRINTED: 03/18/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 345264 B. WNG 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 OLD MOUNT HOLLY ROAD** STANLEY TOTAL LIVING CENTER STANLEY, NC 28164 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ΙD PROVIDER'S PLAN OF CORRECTION. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 16 (Xo) F 225 TE had left without telling anyone. NA #3 gave report A new "Abuse Investigation" form was created to assist the to NA #5 but did not report any bruising on licensed nurse or department manager on duty at the time Resident #6's left upper arm. abuse is reported on the required steps to be taken and the required timeframe. This form will act as a timeline A review of a nurse's note dated 12/28/16 at 7:34 for the investigation process and includes all immediate AM revealed NA #5 informed Nurse #2 that steps to be taken by the nurse/manager on duty upon the Resident #6 had "a huge bruise" on her left upper reporting of abuse as well as the detailed steps of the arm. The notes indicated Nurse #2 assessed the investigation process itself. The form more specifically area and Resident #6 had a bruise that was 5 inches tall and 4 inches wide and covered the addresses injuries of unknown origin to direct the licensed entire front of Resident #6's left upper arm. The nurse to: notes revealed Resident #6 was unable to state 1. complete a full body skin assessment to ensure no how the bruise was obtained and Nurse #2 asked other areas of concern Resident #6 if she was in pain, and she replied complete an Incident/Accident report "yeah" and when the left upper arm was touched follow all immediate reporting requirements or moved, Resident #6 grimaced, grunted and following the Abuse policy for timely investigation pulled away. The notes further revealed Nurse #2 gave Resident #6 Acetaminophen for pain and All department managers were in-serviced by the left a note in the physician's communication book Administrator on 3/21/16 on the use of this form for review. in the event they are the manager on duty should abuse be reported directly to them following the Abuse A review of a nurse's note dated 12/28/15 at Policy. All licensed nurses will be in-serviced by the Staff 10:02 AM indicated an X-ray was obtained of-Development Coordinator between 3/23/16 and Resident #6's left upper arm due to bruising, 3/25/16 on the use of this form as they will be swelling and was painful to touch. responsible for initiating this form if abuse is A review of x-ray results dated 12/28/15 revealed reported as well as the specific directions related 2 views of the left humerus (upper arm bone) and. to injuries of unknown source.

the impression was mild arthrosis (wear and tear on the joints) with moderate demineralization - (dissolving bone).

A review of a typed document dated 12/28/15 and signed by the Director of Nursing (DON) indicated it was brought to his attention that Resident #6 had bruising to her left arm 5 inches x 4 inches. The document revealed this was discovered according to an incident report dated 12/28/15 at 1:45 AM which had been presented to the DON

3/26/16

CENTER	OT OIL WEDIOTHE C.	MEDIONID BEITVIOLD				OMB MC	J, 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE		
		345264	B. WING				C (04/2016	
NAME OF PR	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	04/2016	
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STANLEY	TOTAL LIVING CENTER				14 OLD MOUNT HOLLY ROAD			
				S	TANLEY, NC 28164			
(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 APPROPR DEFICIENCY)	N SHOULD BE COMPLETION DATE		
F 225	Continued From page	: 17		225				
,			"	220			· 	
		ent Nurse for follow up.		_,				
	The document revealed				"Questions After A Bruise/Skin Tea			
{		vho indicated she had a			ompleted by the licensed nurse to a			
ĺ		then reviewed Resident			dent/Accident report was revised to			
		d noted she required a lift		Dire	ect the nurse in the event a bruise is			
	for transfers. The doc			orig	gin/source to:			
-		he DON observed Resident		_	1. report to the Nurse Manager of	r manage	er on duty 🗄	
		#6 who was assigned to and noted Resident #6 had	-		to begin the required investiga	ation and	reporting	
	her arms folded acros				process		- 1	
		ent revealed at that time the			2. obtain a statement from the re	sident if	he/she is	
		unrelated to any staff harm			able to do so		,	
		s it originated from any			3. indicate if abuse is suspected a	nd if so-	-report	
		ff member. The document			following Abuse policy and pro		•	
		s not established that NA #1	·	Δ11.1	licensed nurses will be in-serviced b			
		but if at any time any new			velopment Coordinator between 3/	-		
		inted that would indicate NA			5/16 on the use of this form as they		Iu	
	#1 caused the injury,				ponsible for initiating this form if ab			
	otherwise, a formal in				orted.	inde io		
		I to the licensure agency		rep	orteu.	i	3/26/16	
	per facility policy.	to the hophodie agency			*		, , ,	
	,	The second second		.				
	A review of handwritte	n notes on a sheet of		(4)		1	I	
		12/28/15 at 3:15 PM by the	}		Risk Management Coordinator will	ranianze	-11	
		s name at the top of the			dent/Accident reports within 24 ho		411	
		yellow highlighter and notes	1		reported abuse or by Monday for ar		- 0	
	revealed Resident #6	on lift properly may be of	II.					
***	concern" (NA #6 "did g	good"), "concerns related to			urring after 4:30pm on the previous			
		nd arm on 2 lift occasions."			injuries of an unknown source to en			
					estigations have been properly initia			
•	During an interview or	03/03/16 at 12:08 PM the			Incident/Accident policies. Any inc			
	Administrator explaine		I		njury of unknown origin that has no		* +	
		nytime an investigation of		inve	estigation initiated or any that is que	estionabl	le for the	
	abuse was started and			nee	d for a formal investigation will be i	mmediat	tely	
		ould assist as needed. The			orted to the Director of Nursing for			
		rith any investigation staff			Director of Nursing will assign this			
		plete a full investigation that			sing Manager in the absence of the			
		th all staff involved so a			rdinator.			
		would be completed and		330	~ ······················	,	3/26/16	

		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				CIVID INC	7. 0000000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345264	B. WING			03/	04/2016
NAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE		
STANI FY	TOTAL LIVING CENTER			5	14 OLD MOUNT HOLLY ROAD		
OIMILLI	TO THE ENTITO GENTER			s	TANLEY, NC 28164		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	Y	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 225	Continued From page	e 18	F	225			
	the incidents reported					ļ	
		el Registry on the initial 24					
	hour report and the 5				Nursing Supervisor on each shift, inc		
		. √-12			conduct (3) random full body skin as		
	_	n 03/04/16 at 9:32 AM the			n each unit) daily x 2 weeks, weekly x		
		rse stated it was her usual			ly monthly x 3 months beginning on ide oversight and ensure continued o		
	routine when she can	ne to the facility in the			rting of injuries of unknown origin.		
		lent reports from the day			be immediately investigated followin		
	before. She stated on	,			lent/Accident policies.	.6 6.10 110	
		k and sorted through them	-	iicic	terre receive por order		3/26/16
	and found Resident#	6 had a bruise on her left	า	'he	ADON will conduct (15) random full	body ski	in
		er stated it looked like a big 🕒 🥏			ssment audits weekly (5 on each uni		
	bruise so she reviewe				then monthly x 2 months beginning		
		dications and then she went			ride oversight and ensure continued		
		and looked at the bruise. ————————————————————————————————————	, I	rop	er Incident/Accident reporting and	subsequ	ent
·		as very purple and looked	i	nve	stigation procedures for those noted	as injur	ies of
		e further explained the	ι	ınkı	nown source. All concerns and corre	ctive act	ion will
		was purple and she knew	V.		eported to the QA&A Committee mor	ıthly for	
-	Resident#6 was tran	sferred with a lift but she did	f	urtl	ner discussion and review.		
		positioned Resident #6 in the				1	3/26/16
		nsfers. She stated she was	-			1	· <u>-</u> .
		ad caused the bruise and					:
		ed the DON to look into the from there. She stated she	-				
		any investigation related to	Ea	ich S	Social Services Coordinator will cond	uct rand	lom
	the bruise on Resider				riews on his/her assigned unit who a		
-	**.				ted to determine resident understand		
	During an interview o	n 03/04/16 at 11:04 AM,			Abuse policy for reporting concerns	~,	
		emembered the bruise on			se occurs or is witnessed. These inte		
	Resident 6's left uppe		đơ	ne	for (4) residents weekly x 1 month a	nd then i	monthly.
		explained NA#1 and NA			onths. All concerns and corrective ac		
		be sharing work on the			ported to the QA&A Committee mont	hly for	
		ere supposed to stay for	fu	rthe	er discussion and review.		2/26/46
		staff at 11:00 PM but NA #1					3/26/16
		one and didn't stay for				•	
		I the bruise had not been					

CENTER	S FOR WEDICARE &	MEDICAID SEKVICES				OMB NO). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345264	B. WING				C
MAME OF D	ROVIDER OR SUPPLIER				TOUT ADDRESS SITE OF THE CORE	03/	04/2016
MAINE OF F	ROVIDER OR SUFFLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER			5	14 OLD MOUNT HOLLY ROAD		
				S	STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	at shift change during explained NA #5 was the night shift on 12/2 noticed Resident #6's changed. She further removed Resident #6 bruising and swelling arm and reported it to Resident #6 had bruis and when she first sarm was really swolle huge. She stated the felt firm and hard and it was a new bruise. It was located above Reup in the center of her looked like the size of any fingerprints or ind stated it alarmed her I further explained Res could not move herse Resident #6 could not grunted and made a fit hurt her when they-reported the bruising the change of shift report and wr report and passed the gave report to the first no one from Administrit and she did not known vestigation.	3:00 PM to 11:00 PM nurse report on 12/27/15. She making her first round on 8/15 after 1:00 AM and gown needed to be explained when NA #5 is gown she saw the on Resident #6's left upper Nurse #2. She explained sing on her left upper arm wit Resident #6's left upper and further described it as area was warm to touch and was purple and looked like she explained the bruise esident #6's left elbow and upper arm and it kind of a hand but she did not see entions in the area. She because of the size. She ident #6 was immobile and If in bed. She stated everbalize anything but rown face and she could tell moved her left arm and she to the first shift nurse during port around 7:00 AM on med she completed the ote her statement on the paperwork on when she is shift nurse on 12/28/15 but ration had asked her about	F	Stire reference for the state of the state o		f abuse verator with aday for a previous a taken to serve a final distance of the Continuity on with the basence of the listeps of the listens of the listen	will be thin 24 any as Friday o protect dents from tailed or ursing the 3/26/16 or of the troller a ts 3/26/16 s and the of the
	DON explained he red Resident #6's bruise of	ceived the incident report for on her upper left arm from t Nurse on 12/28/15. He					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 5 5 1.25				С	
		345264	B. WING				/04/2016	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	.1 50.	0 11 20 10	
STANLEY	TOTAL LIVING CENTER	3		5	14 OLD MOUNT HOLLY ROAD			
	TOTAL ENTITO CENTER			s	TANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	been injured during a see her transferred in observed NA #6 tran not observe NA #1 o He stated during the her arms folded acro bruise was due to the lift when her arms when the lift was rais to Resident #6's familieasily. He confirmed further and did not in provided care to Res found on 12/28/15. Is submit a 24 hour or 5 state agency becaus consider the bruise w	rned her arm might have a lift transfer and wanted to the lift. He explained he sfer Resident #6 but he did to NA #3 transfer the resident. lift transfer Resident #6 had ss her chest and he felt the to position of the resident in to were pressed together. the explained he talked lift who stated she bruised lift he did not investigate	F	Ab the dis inc All of QA any	y staff member who fails to follow a use Policy as written, including the each abuse Investigation Form, will be scipline including unpaid suspensionable for the control of the control of the control of the control of National States and the control of National States are commendations to ensuring the control of National States are commendations to ensuring further recommendations to ensuring further recommendations.	completicubject to an up to an and resuth the mon	on of on of	
	PM, NA #5 explained on Resident #6's left December 2015. She shift report from NA # without telling anyone report anything abour arm but during her fir noticed Resident #6's she changed it she she changed it she she changed it upset her whomated to know what wondered how could explained she immediate to Resident #6's the bruising went downton.	it have happened. She liately notified Nurse #2 who Is room and looked at it and vn from her left arm under r chest and partially around						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED			
		345264	B. WING				(=
NAME OF P	ROVIDER OR SUPPLIER	040204	D. 11110	Sī	FREET ADDRESS, CITY, STATE, ZIP CODE		03/	04/2016
STANLEY	TOTAL LIVING CENTE	R			4 OLD MOUNT HOLLY ROAD TANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU' CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE		(X5) COMPLETION DATE
F 225	moaning and she co facial expression she Nurse #2 assessed statement and NA # statement. She comadministration called about Resident #6's so she assumed son On 03/04/16 at 3:43 contact NA #3 by ph A message was left however, NA #3 did On 03/04/16 at 3:55 contact NA #7 who veresident #6 on the cowas no answer and to leave a message On 03/04/16 at 4:23 #1 who no longer we by phone. There was was left for her to redid not return the phone During a follow up in PM the Administration of the bruise on Residuring the morning in further brought up to She stated it was he staff should assess it	ned Resident #6 was uld tell by Resident #6's was in pain. She stated Resident #6 and wrote a 5 stated she wrote a firmed no one from her or talked to her to ask bruise or what had happened neone took care of it. PM attempts were made to one but there was no answer. for her to return the call not return the phone call. PM attempts were made to vas assigned to care for lay shift on 12/27/15. There there was no voicemail option for her to return the call. PM an attempt to contact NA wrked at the facility was made s no answer and a message turn the call however, NA #1 one call. terview on 03/04/16 at 2:00 r stated she was made aware dent #6's left upper arm neeting but now had been speed about the incident. r expectation that nursing mmediately for possible	F	225				
	staff should assess it causes of an injury be information off to upp thorough investigation	mmediately for possible efore they handed the per management and a pen should be completed and prking day reports should be						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			С	
		345264	B. WING				04/2016
NAME OF P	ROVIDER OR SUPPLIER		<u></u>	8	STREET ADDRESS, CITY, STATE, ZIP CODE		04/2010
STANI EV	TOTAL LIVING CENTER	5		ε	14 OLD MOUNT HOLLY ROAD		
- OWNER I	TO IAL LIVING CENTER			8	STANLEY, NC 28164		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	<u>' </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 225	Continued From pag	e 22	F	225			
		admitted to the facility on	'	220			
		ses of multiple cerebral					
		Alzheimer's disease, and			· ·	_	
		the most recent quarterly					
		MDS) dated 02/09/16					
	revealed that Reside						
	cognitively impaired	with no behaviors identified.					
	The MDS further indi	icated that Resident#1	Ì				
		ssistance with activities of					
	daily living (ADLs).						
		g Assistant (NA) #4 on					
		A revealed that she had been	İ				·-
		Saturday 02/20/16 at				٠.	
		PM when she overheard NA 🐭					
	#1 yelling at Residen	t #1 to stop touching her and			-		
		A#4 stated that Resident #1					
		you were sitting beside her 🕝 🕡			· -		
		NA #1's leg and NA #1 got					·
		ling at Resident #1. NA #4	 				en e <u>.</u>
		finished feeding the resident	ļ -		·		
		e had reported it to a nurse			}		
		/hich one. No written	- .			٠.٠	
	statement by NA #4 a available.	about this incident was					
	Interview with NA #3	on 03/02/16 at 3:05 PM					
	revealed that she wa	s working in the dining room					
	on the evening of 02/	/20/16 and witnessed					· 1
	Resident #1 patting t	he leg of NA#1. NA#3					
	stated that NA #1 the	n stated "oh my God stop it,					_
	why do u keep patting	g me, stop touching me" and					
	then NA#1 leaned in	to the face of Resident #1		-			, <u></u> ,
	and grabbed her righ	t hand and slammed it into					
		1 grazing the edge of the				Ī	
	table. NA#3 describe	ed it like scolding a child, NA					
İ	#3 further stated that	Resident #1 had no reaction	-				
	except mumbling. NA	\#3 stated that she felt like					
		esident #1. NA #3 stated she			<u>-</u>		
	had reported the inci-	dent to Nurse #1 and had					
	wrote a statement ab	out the incident as instructed					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	<u> </u>	(X3) DATE SURVEY COMPLETED	
		345264	B. WING					04/2016
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		1 03/	0472016
STANLEY	TOTAL LIVING CENT	ER		İ	OLD MOUNT HOLLY ROAD NLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 225	written by NA #3 st slam Resident #1's patting her. Anothe witnessed the way and stated that it w NA #3 and dated 0'. Interview with NA # revealed that she won 02/20/16 assistin NA #1 get very irrita patting her leg and slammed it into Restable and heard NA F**king patting my she witnessed between was both physical a had just had manda were educated on that included examples and included examp	atement for Incident/Accident" ated that she witnessed NA #1 hand and told her to stop r family member also she was talking to the resident as inappropriate. Signed by 2/20/16. 2 on 03/02/16 at 4:13 PM res present in the dining room ng with supper and witnessed ated with Resident #1 who was grabbed her hand and sident #1's lap grazing the #1 state to Resident #1 "stop leg." NA #2 stated that what reen NA #1 and Resident #1 and verbal abuse because they atory training on abuse and he different types of abuse bles of each type. NA #2 bried the incident to the Nurse ten statement by NA #2 about railable. or #1 on 03/04/16 at 9:53 AM ras a sitter for another resident or #1 stated that on 02/20/16 in supper time she witnessed gr NA #1's leg and NA #1 got #1 she took her arm and her lap. Visitor #1 stated that	F	225				
	NA #1 was very and nose with Resident stop that" and "keep Visitor #1 further sta grab the wrist of Re lap at least 3 times room tending to the	#1 and got almost nose to #1 and stated "I told you to by your hand to yourself." ated that she witnessed NA #1 sident #1 and shove it into her while she was in the dining resident she worked for.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		2.500.					
		345264	B. WING	1		03/	04/2016
NAME OF PI	ROVIDER OR SUPPLIER			ı	STREET ADDRESS, CITY, STATE, ZIP CODE		1
STANLEY	TOTAL LIVING CENT	ER		ı	514 OLD MOUNT HOLLY ROAD		
		<u> </u>		1 3	STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	nge 24	F	225			
	incident to a nurse	and that later that evening the					·
	Nurse Supervisor of	ame and thanked her for				İ	_
		nt. No written statement by					
		s incident was available.					
	Interview with Nurs	e #1 on 03/02/16 at 3:20 PM -				.]	ear of the
	revealed that NA#	3 reported the incident with NA			-		
	#1 and Resident #1	I in the dining room on					
		imately 6:30 PM. Nurse #1			_		
		ipervisor was already aware.				٠٠.	
		NA#3 for reporting the incident	i		-		
		ed NA #3 to write a statement	-: -			• -	, e.e. pe
		nessed.Nurse#1 further			-		
		othing further because he took					
		se Supervisor was taking care	•			.:	
		written statement by Nurse #1			-		
	about this incident			-			
-		e Supervisor on 03/02/16 at	· · ·		-		
		hat NA #2 reported to him that	-	-; -	•	~ -	guille in the Line
		erbally aggressive and very.				-	
		#1. Nurse Supervisor stated	-			7.5	art person to
		g room and asked to speak	-		-		ಇತ್ತು
		ed what was going on. NA #1				`	This is a
***		t#1 was rubbing her leg near	-			ے	**
		d NA #1 stated that she had			-		
		1's hand way and told her not	}				A STORY TO STATE
		pervisor stated he asked NA					NATURA EL P
		verbally aggressive and NA.	-				ភព ៥៩
:		so Nurse Supervisor asked					
		tone of her voice could be					Arm of the state
		lly aggressive and NA #1			·.		Farma di Affi
		se supervisor again stated				•	-
		ned NA #1 to the 400 secure				.	
		or the remained of her shift. onfirmed that he had not			-		
		but had sent an email					···
		incidents that happened on					
		incidents that happened on ipervisor further stated that his					
		esides talking to NA #1 was to					
		ther unit for the remainder of					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
		345264	B. WING					C
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C			STATE, ZIP CODE	03/	04/2016
STANLEY	TOTAL LIVING CENTER				514 OLD MOUNT HOLLY STANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD I RENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 225	Continued From page	25		225				
	her shift. No written st		Г.	440	7		.'	-
		incident was available.						
	Review of email: dated	i 02/21/16 at 7:15 PM from			·			T +++
		Director of Nursing (DON)					5	_ `**
	read in part that a visi	tor had witnessed NA #1				•		14.01
	being rude to Residen	at #1 and shoving her arm				•	i	
		uld pat NA #1 on the leg.						
		A#1 about it she became				•		
	upset, defensive, and	with an aggressive attitude.					-	
ĺ	Nurse Supervisor talk	ed to NA #1 under the						
-	camera in the 100 me	dication unit so the DON	-					-
	could observe her boo	ly language an attitude. I						1
	moved her to the 400	secure memory care unit					-	- 24-
	for the remainder of he					-		
-	Interview with DON or					-		
	revealed that he was r	made aware of the incident						
		from Nurse Supervisor that 💠 🦈					٠.	
•		16 when he arrived at work. 🧺						
		NA #1 thought the staff did						
:		he was a Yankee, NA #1	. •					
.	told DON that Resider	nt #1 was putting her hand: 🗻 🛶					. ,	
	on NA#1's leg and NA	\#1 was placing it back on	1.	-				Mark of 1921
:		I confirmed that there was	J	-		:		Presidente
		eted on the incident with.						
İ	Resident #1 and had r	not been reported to the						_ = 14.
-	North Carolina Health	Care Personnel Registry						
		eport or the 5 working day		٠.				ere e eta e
.		er stated he had not talked						- 1
ĺ	to the sitter/visitor that	was present in the dining			•			
	room that day because							Service Services
.		er/visitor, and the DON					4.1.	₩ A.
		not spoken to the other	-	-				eri e i i i i i i i i
ļ		that evening. The DON					-	- <u> </u>
	Supervisor the expecta	d been reported to Nurse				-		* * * * * * * * * * * * * * * * * * * *
	Supervisor would cont					•		
	administrator immedia							
İ		inistrator on 03/03/16 at						ŀ
		it she was notified by the						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345264	B, WING				C
NAME OF P	ROVIDER OR SUPPLIER		.1		TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	04/2016
STANLEY TOTAL LIVING CENTER				51	14 OLD MOUNT HOLLY ROAD TANLEY, NC 28164		
(X4) 1D 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 225	Continued From page	⊋ 26	F	225			-
	· -	stigation of abuse was		220			-
	started and if the DO	N had any question then she					
	would assist as need	ed. The administrator also					
	stated that if abuse is		}		· · · · · · · · · · · · · · · · · · ·		
		immediately notify the DON				* - '	-
	and/or administrator.	The administrator went on					
	to say that with any in	vestigation staff is expected					
	to complete a full inve	estigation that included					
	interviews with all stat	ff involved and the nurse					
	supervisor was fully c		ł	i			
		ould have included the					
ĺ	immediate suspensio	n of NA #1 and immediately					
	notifying the DON so	a thorough investigation					
		nd the incidents reported to		İ			ν,
		onnel Registry via the initial				- 51	
	24 hour report and the	e 5 working day report.					1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
	Review of 24 hour init	ial report dated 03/03/16	, A.	:	•	i	1
,	was filed by DON stat	ed that report was given to	-				
		nember "slamming" resident	-				_ `.
.		/ee's knee and putting it					
		knee. On 03/02/16 during	· -	ĺ			- Marie San Grand
:		e surveyor it was asked if I		-			T = 1 - 1 - 1
	to which nothing had I	rbal abuse toward resident" been reported, prompting		*-	_		
	this investigation to be	peer reported, prompting popered: Signed by the				* •	garage and the second
	DON on 03/03/16.	s opened. Signed by the	<u> </u>			i. ·	- 1
		Imitted to the facility on				÷ * :	***
ĺ		es that included diabetes			· · · · · · · · · · · · · · · · · ·	_ n - in	2 - 2 - 2
		, Alzheimer's disease, and	_		•	-	
	dementia. Review of t	he most recent			·	•	Tarak amenda
.		sion Minimum Data Set					
		revealed that Resident #2		1	• • • • • • • • • • • • • • • • • • •	.	
[was severely cognitive					* •	
	behaviors were identif						
		nt #2 required extensive			•		
	assistance with ADLs.						
		on 03/02/16 at 5:09 PM					
		0/16 at approximately 5:00					
		n the dining room waiting		- 1			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	13 FOR MEDICARE &		т			<u>OMB NO</u>	<u>). 0938-0391 </u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
						C			
		345264	B, WNG	_		03/	04/2016		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	*****			
STANLEY	TOTAL LIVING CENTER				514 OLD MOUNT HOLLY ROAD				
O MILL I	TO THE LIVING GENTLIC				STANLEY, NC 28164				
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION	-	(76)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	ΊX			(X5) COMPLETION DATE		
F 225	Continued From page	ı 9 7	F:	22					
	for supper and had be		Γ,	22	20				
		ecome anxious and ed to leave the dining room.			•		-		
		took Resident #2 to see a					,-		
		Iso resided at the facility to					- •		
	see if that would calm	Resident #2 down. NA #2					:		
		lent #2 had visited with the							
		ew minutes he had calmed	•				· .		
		able to return Resident #2						•	
		A #2 further stated that when						-	
		t #2 to the dining room NA	-				= ++ 		
		t is his issue?" NA #2 stated				_			
		t #2 had delusions that his							
		led. NA#2 stated that NA	_	-					
		Resident #2 and got down in-				•			
		nat was a stupid reason to						•	
	hit me and you had no	reason to act like way" in a					-		
	very aggressive and the	nreatening tone. NA#2 also	_			:		-	
		very hateful in the way NA			•				
		#2 that evening in the							
;	dining room. NA #2 st	ated she reported this to the			·		. == 1.		
		pproximately 5:15 PM. The 🚉 🔍	Æ		~	-7.2			
	written statement obta	ined from NA #2 about this 💷 🖠			-	_		_	
	incident read in part th		-						
		en he became worried and	==		·				
		sions that his daughter had		-			- 1 " - 1:		
		cident. NA #2 stated she					- 1. 1		
		dent #1 down and NA #1		-		<u>.</u> '	Alignor and Comme		
		ent #2 and starting fussing							
		ated "he had no reason to							
	treat her that way."				·		·		
		upervisor on 03/02/16 at	•.		·		1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1		
		n 2/20/16 at approximately			***		5. 5. 5		
		ed to him that NA #1 had				2			
		esident #2 and was talking -			~				
		ly then she should have				i,			
		the dining room. Nurse							
		that he had not spoken to							
	the DON but had sent	an email notifying him of							

the incidents that happened on 02/20/16. Nurse

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	OT OK MEDIOAKE &					OMR M	<i>J.</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		E CONSTRUCTION		SURVEY PLETED
		345264	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/04/2016
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1	514 OLD MOUNT HOLLY ROAD		
STANLEY	TOTAL LIVING CENTER				STANLEY, NC 28164		
	DI BALLA DV OT	ATTIMENT OF DEFICIENCES	1	<u>L</u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 225	Continued From page	28		225			
	, +			225	9		
		ted that his only other action #1 was to reassign her to					
-		mainder of her shift. No					
		Nurse Supervisor about this					<u>.</u>
	incident was available				·		
	1	on 02/21/16 at 7:15 PM					
		to Director of Nursing					
		Saturday evening 02/20/16 .					
		#1 being verbally aggressive	i				'
	to Resident #2 when I	Resident #2 had become _					
	combative. Nurse su	pervisor stated in the email	·				
		NA #1 and NA #1 stated she					
	was being picked on t						<u>. </u>
		ble with the DON. NA#1	-1				
		visor that she hated working 💎					= -
	at the facility and it wa	as the most pathetic place 🗓 📖					
		at before. NA #1 claimed	17		*	į	
		ke her because she was a	-			- :	eger in a
		language and attitude was	 -			- 2	
		defensive. NA #1 stated		٠	-		
		shifts because she could			-		
		coworkers and now she			•	-	· =
		th the staff that was there					
	the shift and I moved	greed to stay for the rest of	-		-	-	fu +5 1772 -
1		the remainder of her shift.					- ' - '
		n 03/02/16 at 3:37 PM				-4.	<u>.</u>
		t made aware of the incident	1 - "			, 1	· = ·
		S when he arrived at work		•	·		
		m Nurse Supervisor. The	-				
	DON confirmed that the	nere was no investigation			·		·
		nt #2 and the incident was	L		·		ļ .
		orth Carolina Health Care					,
		a the 24 hour initial report					·
-		ort. The DON also stated					
1		the NA's that where working				1	
	that evening about the		_				
		rom them regarding the					
		rther stated that he trusted					

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATI	O. 0938-0391 E SURVEY PLETED
STANLEY TOTAL LIVING CENTER SUMMARY STATEMENT OF DETICIENCES (EACH DEFICIENCY MUST BE PRECEIPED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) F 225 Continued From page 29 the Nurse supervisor because he was present at the time and had a better idea of what happened. The DON. The DON again confirmed this incident was not investigated and was not reported to the Health Care Personnel Registry. Interview with the Administrator on 03/03/16 at 12:08 PM revealed that she was notified by the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON and/or administrator. The administrator went on to say that with any investigation staff is expected to complete a full investigation that included interviews with all staff involved and the nurse supervisor was fully capable of starting this investigation or ON No a through investigation could be started and the incidents reported to the Health Care Personnel Registry-via the initial:24 hour report and the 5 working day-report.			345264	B. WING				
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 29 the Nurse supervisor because he was present at the time and had a better idea of what happened. The DON stated if any abuse was reported to Nurse Supervisor he should immediately notify the DON. The DON again confirmed this incident was not investigated and was not reported to the Health Care Personnel Registry. Interview with the Administrator on 03/03/16 at 12:08 PM revealed that she was notified by the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON and/or administrator. The administrator went on to say that with any investigation staff is expected to complete a full investigation that included interviews with all staff involved and the nurse supervisor was fully capable of starting the investigation which should have included the immediate suspension of NA #1 and immediately notifying the DON so a thorough investigation could be started and the incidents reported to the Health Care Personnel Registry via the initial:24 hour report and the 5 working day report.					Đ	514 OLD MOUNT HOLLY ROAD		104/2016
the Nurse supervisor because he was present at the time and had a better idea of what happened. The DON stated if any abuse was reported to Nurse Supervisor he should immediately notify the DON. The DON again confirmed this incident was not investigated and was not reported to the Health Care Personnel Registry. Interview with the Administrator on 03/03/16 at 12:08 PM revealed that she was notified by the DON anytime an investigation of abuse was started and if the DON had any question then she would assist as needed. The administrator also stated that if abuse is reported to Nurse Supervisor he would immediately notify the DON and/or administrator. The administrator went on to say that with any investigation staff is expected to complete a full investigation that included interviews with all staff involved and the nurse supervisor was fully capable of starting the investigation which should have included the immediate suspension of NA #1 and immediately notifying the DON so a thorough investigation could be started and the incidents reported to the Health Care Personnel Registry via the initial:24 hour report and the 5 working day report.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	D BE	(X5) COMPLETION DATE
O3/03/16 at 2:30 PM of immediate jeopardy. The administrator provided acceptable credible allegation of compliance on 03/04/16 at 6:45 PM. Credible Allegation of Compliance F 225: (1) On 12/28/15, Resident #6 had a bruise of unknown origin with no 24 hour report or 5 day working report submitted to the NC Health Care Personnel Registry and a thorough investigation was not completed. On 2/20/16 at 11:00pm, Nursing Assistant (NA)		the Nurse supervisor the time and had a be The DON stated if an Nurse Supervisor he the DON. The DON a was not investigated Health Care Personn Interview with the Adr 12:08 PM revealed th DON anytime an investanted and if the DON would assist as needstated that if abuse is Supervisor he would and/or administrator. to say that with any into complete a full investigation which shirmmediate suspension notifying the DON so could be started and the 1th Care Personne hour report and the 5 The administrator provided allegation of compliant Credible Allegation of (1) On 12/28/15, Resider unknown origin with n working report submit Personnel Registry ar was not completed.	because he was present at letter idea of what happened. It is a provided to should immediately notify again confirmed this incident and was not reported to the el Registry. In ministrator on 03/03/16 at let she was notified by the stigation of abuse was. In had any question then she let. The administrator also reported to Nurse immediately notify the DON. The administrator went on evestigation staff is expected estigation that included and the nurse apable of starting the mould have included the electron of NA #1 and immediately at thorough investigation the incidents reported to the lef Registry via the initial 24 working day report. I DON were notified on of immediate jeopardy. The diacceptable credible acceptable credible acceptable credible on 03/04/16 at 6:45 PM. Compliance F 225: It #6 had a bruise of o 24 hour report or 5 day ted to the NC Health Care and a thorough investigation	F	225			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
345264 В.	. WNG _		C 03/04/2016	
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 OLD MOUNT HOLLY ROAD STANLEY, NC 28164	30,0112010	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
Residents #1 and #2 on 02/20/16, left the facility after working her entire shift. On 2/22/16 at 3:23pm, the accused CNA was suspended (she had not returned to work since leaving on 2/20/16 @ 11:00pm) and was ultimately terminated from employment on 2/26/16 at 1:20pm. On 02/22/16 an investigation was initiated on the abuse of Resident #2 by the Director of Nursing which resulted in termination of NA #1 on 2/26/16 at 1:20pm. On 02/22/16 the family of Resident #2 was involved in the investigation and was made aware of the investigation initiated on 2/22/16 as well as of the outcome of the investigation on 2/26/16 by the Director of Nursing. On 03/03/16, the Nursing Supervisor was placed on suspension pending further investigation of his role in the allegations of abuse for Residents #1 and #2, which occurred on 02/20/16, for failure to protect residents and properly report resident abuse. As of 03/04/16, The results of this investigation are pending and the Nursing Supervisor will remain on suspension until the investigation is complete. On 03/03/16 at 2:19 pm The 24 hour Health Care Personnel Registry (HCPR) abuse/neglect investigation report form for Resident #1 was completed by the Director of Nursing and faxed to HCPR for further investigation report form for Resident #1 was completed abuse.	F 2.	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		345264	B. WING			ľ	C
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER				51	REET ADDRESS, CITY, STATE, ZIP CODE 4 OLD MOUNT HOLLY ROAD TANLEY, NC 28164	03/04/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	#2 and Nursing Assis immediately report al Resident #1 and Res pending further inves	om, Nursing Assistant (NA) stant (NA) #3 who failed to legations of abuse towards ident #2 were suspended tigation of their actions	F.	225		-	
	to immediately report according to the Abus	sciplinary actions for failure allegations of abuse _		-			- 77 - 52 - 54
	completed the NC Bo Evaluation Tool to de requirements for the obtained a score of 1 of Nursing consultation reporting. The Direct NC Board of Nursing on 03/04/16 at 10:00: was given a phone as	Nursing Supervisor and ! which indicated NC Board on but no requirement for or of Nursing contacted the for the required consultation am. The Director of Nursing oppointment for further review					
	Personnel Registry (Investigation report for completed by the Direction of	m, the 24 hour Health_Care HCPR) abuse/neglect form for Resident #6 was ector of Nursing and faxed to estigation of alleged abuse.		-	·		
1	100 unit Social Service for any residual effect	d #6 were assessed by the ses Coordinator on 03/03/16 ss from the alleged with no concerns noted.	- • ·			. : -	
	for all staff on duty on abuse. The in-service	nducted by the Administrator 03/03/16 regarding resident agenda included:					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		DISTRUCTION	(X3) DATE	SURVEY PLETED
		245004			•		С
345264			B. WING			03/	04/2016
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER				514 (EET ADDRESS, CITY, STATE, ZIP CODE DLD MOUNT HOLLY ROAD NLEY, NC 28164		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	abusive situation by t	a 32 al of the resident from the he employee who witnesses	F	225			-
	by the employee who direct supervisor or a			ı		-	
	management				 		
	by the direct supervis- management to the D Administrator 2. Definitions of phy	or or member of irector of Nursing or the sisted and verbal abuse					
	towards any resident physical and verbal al 3. Definition of how	including scenarios of both ouse to make the immediate	-u -			* =	
	verbally.	allegations and the allegations will be reported the immediate protection of	-			·	esynt, en
	any resident in which suspected.	abuse/neglect.are					Alphana i right Galan Jung Mi Marius ai sa m
	work-related duties un In-service has been of On 03/04/16 all reside oriented were interview Services Coordinator	ompleted. Ints who are alert and wed by the 100 unit Social and MDS Coordinators to e any reports of abuse	-	-			
	completed on all resid	oe skin assessments were ents (including Residents ess for possible signs of Supervisors, MDS	-				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345264	B. WING				04/2046
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	04/2016
STANLEY TOTAL LIVING CENTER				ı	14 OLD MOUNT HOLLY ROAD STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pag Coordinators, and R Coordinator. Skin a signs of potential ab	isk Management ssessments revealed no	F	225			
	in-serviced the Directorole and responsibility any allegations of abuse/neglect includerigin and beginning	required timeframe per policy	-				
	completed the NC B Evaluation Tool to de requirements for the his role in the failure reporting and investi abuse for Resident # which indicated NC but no requirement f Administrator contact for the required cons 5:28pm and was ma	Director of Nursing based on to complete the required gations of allegations of second by a score of 11 source of Nursing consultation for reporting. The sted the NC Board of Nursing sultation on 03/04/16 at second by a score of Nursing sultation on 03/04/16 at second by a score of Nursing sultation on 03/04/16 at second by a score of Nursing sultation on 03/04/16 at second by a score of Nursing sultation on 03/04/16 at second by a score of Nursing sultation on 03/04/16 at second by a score of Nursing sultation on 03/04/16 at second by a score of Nursing substitution on 03/04/16 at second by a score of Nursing substitution on 03/04/16 at second by a score of Nursing substitution on 03/04/16 at second by a score of Nursing substitution on 03/04/16 at second by a score of 11 second by a sc					
	on 03/04/16 @ 5:40g appointment with the Monday 03/07/16 for On 03/04/16 @5:45g in-serviced all Nursin all shift supervisors, immediately reportin appropriate investigated of potential abuse are bruising of unknown	NC Board of Nursing for further direction. om, the Administrator games and selection includes on their specific role in		-			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/18/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES	,		O	MB NO. 0	938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(3) DATE SUP COMPLET	
		345264	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	340204	B. WING			03/04/	2016
THE OF THE VIDER OR GOT LIET			l	STREET ADDRESS, CITY, STATE, ZIP CODE			
STANLEY	TOTAL LIVING CENTER			l l	14 OLD MOUNT HOLLY ROAD		
	,				STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) OMPLETION DATE
F 225	Continued From page	9 34	f F:	225			<u>.</u> .
·	7:05 PM when staff in administrative staff, a confirmed that they ha training on the immed situation to the direct	ad received in service iate reporting of the abusive supervisor or any other					
F 226 SS=J		IMPLMENT -	F	226	-		
	policies and procedure mistreatment, neglect and misappropriation This REQUIREMENT by: Based on record revisionally falled to operat	, and abuse of residents	ī.	pr ph Su Ph res fur on 2/2	sidents #1 and #2 were immediately otected from any further verbal and/or ysical abuse by NA#1 by the Nursing pervisor on 2/20/16 when NA#1 was ysically removed from their unit. All sidents were further protected from any ther abuse by NA#1 upon her suspensi 2/26/16 and subsequent termination of 26/16 by the Director of Nursing.	y ion on	2/26/16
	24 hour and 5 working Carolina Health Care agency) for a resident origin (Resident #6). immediately stop verb (Resident #1 and Res witnessed physical abremove the perpetrato to immediately notified the facility fails verbal and physical at Health Care Personne	day reports to the North Personnel Registry (state with a bruise of unknown The facility also failed to al abuse when observed		on Sup to p Res 100 det	ull body skin assessment was complete Residents #1, #2, and #6 by Nursing pervisors with no concerns noted relate potential abuse. Sidents #1, #2, and #6 were assessed by Dunit Social Services Coordinator to ermine any residual effects of physical Jor verbal abuse with no concerns note	ed 3/ y the	3/16

FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	345264	B. WING _		03/04/2016
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HEAPPROPRIATE DATE
Immediate jeopard facility failed to rep (Resident #6) with Personnel Registry thorough investigatin the 5 working data began on 02/20/16 the facility also fail incident of physical incidents of verbal Resident #2) within Personnel Registry thorough investigatin the 5 working data was removed on 0 facility provided an allegation of compliance at a (isolated with no accommon than minimal jeopardy) to compliance at a (isolated with mediate abusive situation a witnessed abuse to Findings included: A review of a facility pand abuse of resident's property, staff members to resident's property.	ampled residents for abuse and #2). By began on 12/28/15 when the port a bruise of unknown origin in 24 hours to the Health Care by and failed to conduct a ation and report those findings are report. Immediate Jeopardy 5 for Residents #1 and #2 when ed to report a witnessed all abuse (Resident #1) and 2 abuse (Resident #1) and 2 abuse (Resident #1 and in 24 hours to the Health Care of and failed to conduct a ation and report those findings are report. Immediate jeopardy 3/04/16 at 7:05 PM when the id implemented a credible liance. The facility remains out a clower scope and severity of Dectual harm with potential for the harm that is not immediate ete education and ensure as put into place are effective are moval of residents from and the immediate reporting of the management staff.	re iii sii v	the Director of Nursing who face quired 24 hour and 5 day represented investigation for Residents #1 uspended on 3/4/16 with distequired by the NC Board of Novork on 3/8/16. A full investigation of the verphysical abuse of Resident #2 with all required reporting to Care Personnel Registry by the on 3/8/16. A full investigation of bruise of Resident #6 was completed with the NC Health Care Person Administrator on 3/9/16. A full investigation of the verphysical abuse of Resident #6 was completed with all result investigation of the NC Health Care Personnel Resident #1 and #2 find also failed to immediately and also failed to immediately	ailed to complete the ports with a complete , #2, and #6 was ciplinary action as ursing upon return to 3/8/16 bal and 1 was completed of the NC Health he Administrator of unknown origin of with all required reporting nel Registry by the bal abuse of Resident quired reporting to the gistry by the 3/11/16 failed to immediately rom reported abuse y report the abuse to suspended on 3/4/16 3/12/16 equired by the NC Board

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		E CONSTRUCTION	(X3) DATE :	
							;
		345264	B. WING				04/2016
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		2010
CTABLE OF	TOTAL LIMBIO OFFITED			5	14 OLD MOUNT HOLLY ROAD		
SIANLET	TOTAL LIVING CENTER			s	STANLEY, NC 28164		i
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.	L	PROVIDER'S PLAN OF CORRECTION	— т	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI - TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	∄ Œ	(X5) COMPLETION DATE
F 226	Continued From page	36	-	226			
	any resident in the fac			220			i
	ensure that all alleged			(2)	•	ı	
	mistreatment, neglect				l body skin assessments were conduc	cted on	
	unknown source, and	misannropriation of		all 1	residents by Nursing Managers to ass	sess for	
		reported immediately to			signs of potential physical abuse wit		* .
	the Administrator and				ncerns noted.		
		he facility shall investigate					3/4/16
		and will protect the resident		All	residents who are alert and oriented	were	
	from further potential			inte	erviewed by the MDS Coordinators to)	
-	investigation is in prog	ress. The results of all		det	ermine any concerns related to abus	e with	
	investigations will be r	eported to the Administrator -			negative responses. Each resident w		- [
		certification agency within			ninded /educated at that time on the		3/4/16
	five working days of th				oorting procedures if abuse occurs.	• •	
	labeled identification r				0.1		
		Iful infliction of injury,	•	The	e Administrator conducted an in-serv	ice for	
	unreasonable confiner				staff between 3/3/16 - 3/4/16 on re		. 1
		n physical harm, pain, or			de to the Abuse Policy & Procedures		gr <u>.</u>
•		document indicated any			efinitions, examples, and scenarios o		ο,
		ted to identify any known		abı			3/4/16
·		e of abuse and/or neglect			nmediate steps required when abuse	ic	<u> </u>
:	and to report those su	spicions to their supervisor			spected and/or reported including th		· .
	or any other member of	or management			mediate removal of the resident from		
	immediately. This may		7 -		uation, immediate verbal reporting o		
.	that may constitute ab	ences, patterns, and trends			its as witnessed to the direct supervis		·
-		ctor of Nursing and/or the	- ***				
	Administrator is to be	notified of suspicious			rse on duty, immediate removal of th	e -	
	events or allegations of				cused employee from all duties, and		
	immediately for the sa				mediate verbal reporting to the DON		
		gation/Protection indicated	-		d Administrator for timely investigat	ıng	
	if an individual employ			pro	ocedures	i	
	abuse/neglect, he or s						
	suspension pending th						
	investigation to ensure	the safety of residents. If					
		le to determine that there is					to .
	a clear suspect, all sta	ff assigned to the resident					-
	prior to the incident/inj	ury will be interviewed in an					
	effort to identify who m	ay be responsible. A					
	section labeled Report	ing indicated the Director		1			

00,110		I				<u>OMB NO</u>	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		345264	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER			1 8	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	/04/2016
				1			
STANLEY	TOTAL LIVING CENTER			1	14 OLD MOUNT HOLLY ROAD		
				S	STANLEY, NC 28164		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E IATE	COMPLETION DATE
F 226	Continued From page	37	F	226			
		onsible for completing all					
	steps of the investigat	ion process, reviewing with	(3				.
	the Administrator daily	/ until the investigation is			Vitness/Staff Statement form was re		
	complete. The Directo	or of Nursing and the			hen reporting witnessed events rela		
	Administrator will review	ew all investigations upon			including abuse. This form specifica		
		accuracy, timeliness, and			y provide the written statement afte		
		red information prior to	re	por	t has been given to the nurse on dut	y. This f	orm
	making the final decis	ion and/or faxing the final	_ al	so s	pecifically directs staff to place conc	erns in d	lirect
	report to the state age		q	uote	s, to use full names, and to be as spe	cific as p	ossible
	- **	-	- fo	r fu	rther investigation.		
	 Resident #6 was a 	dmitted to the facility on	-				
	11/02/11 with diagnos	es listed on the diagnosis		All d	lepartment managers were in-servi	ed by th	ie
		edical record of congestive	- A	dmi	nistrator on 3/21/16 on the use of t	his form	
	heart failure, high bloc				event they are the manager on duty		
		disease, dementia, anxiety			be reported directly to them follow		Abuse -
	and depression.	-		olicy		J	
	A review of the most n	ecent annual Minimum		A 31 Y	2	.1 0.	cc
	Data Set (MDS) dated				icensed nurses will be in-serviced b		
	Resident #6 had short	and long term memory			lopment Coordinator between 3/23		-
	problems and was sev	rerely impaired in cognition			/16 on the use of this form as they w		
	for daily decision maki				nsible for obtaining such statement		1
	indicated Resident #6	was totally dependent on			diate steps have been taken following		
-		ily living and exhibited no			e Policy for protection of the residen	ıt and	3/26/16
İ	behaviors.	· ·	re	por	ting of the concern.	_	3/20/10
	A was dans at 200				•	. 79	e :
		report dated 12/28/15 at			•		t
		se Aide (NA) # 5 reported			•		
	bruige on her left upon	#6 had a 5 inch x 4 inch	-	ļ			
	Booldoot #6 was also	r arm. The report indicated					
İ	found during the first re	ing when the bruise was					* #
	found during the first re						
		cated the bruise was on the outside left arm and was				٠.	" - .
ŀ	purple in color and the	bossible course were		i			t
	listed as unknown. Nu				•		
		x #5 called for her to look at					
		assessment, there was a 5]	
	inch x 4 inch purple bri	Jise on Resident #6's				1	
	ווס שנסומים וויבוווו	COMONENOS	1				

O LITTLE	O TOIT MEDIOTAL G	MEDIONID OFWICES		.,,		OMR MC). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTI A. BUILDIN	PLE CONSTRU	CTION	(X3) DATE COME	SURVEY PLETED
		245204	D MANO			'	С
NUIS OF D	BOURDED AD ALIGNUES	345264	B. WING_			03/	04/2016
NAME OF P	ROVIDER OR SUPPLIER]	STREET ADD	RESS, CITY, STATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER		i		OUNT HOLLY ROAD		
				STANLEY,	NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 226	Resident #6 if she wa "yeah" and when Nurs Resident #6 grimaced of a handwritten wither revealed she went into check and change he Resident #6 seemed if #5 checked her over a upper left arm was ve swollen and she notifican explanation and desurrounding the bruise covered most of Residenches x4 inches) and indicated when the bruinard and knotted and vocalized sounds. The and NA#3 were assigned where Resident #6 living and went to the nursident without telling but did not report any left upper arm. A review of a nurse's in AM revealed NA#5 in Resident #6 had "a huarm. The notes indicate and Resident #6 inches tall and 4 inches entire front of Resident notes revealed Resident was on Resident if she was in "yeah" and when the lor moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved, Resident #6 or moved.	#2 documented she asked in any pain and she stated se #2 touched the bruise, and pulled away. A review assistatement by NA #5 or Resident #6's room to r. She documented to be in a lot of pain so NA and noticed Resident #6's ry badly bruised and ed Nurse #2. A section for estailed circumstances are revealed a bruised area clent #6's left upper arm (5 was swollen. The notes uise was touched it was Resident #6 grimaced and e report revealed NA #1 ned to work on the hall ed but when NA #5 clocked se's station for report NA #1 anyone. NA #3 gave report bruising on Resident #6's	lice ab the for ste rep inv ad nu Al Ac in ab Po 2 7 re re	dew "Abuse ensed nursuse is reported investigation dresses injurse to: 1. compothe 2. compothe 2. compothe department ministrate the event to the event force be reported as sponsible forted as sponsible foorted as sponsible foorted as sponsible f	e Investigation" form was cresse or department manager of orted on the required steps to timeframe. This form will actigation process and includes alouse as well as the detailed a process itself. The form more plete a full body skin assessor areas of concern plete an Incident/Accident row all immediate reporting rowing the Abuse policy for the ent managers were in-service for on 3/21/16 on the use of they are the manager on duty orted directly to them followers directly to them followers of this form as they well as the specific directions funknown source.	n duty and be taked taked as a tiles all immon duty in steps of ore speculirect the ment to deport equiremently investigation and will be see is a related	t the time en and meline nediate upon the the ifically e licensed ensure no ents estigation Abuse the Staff d
		Acetaminophen for pain and					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	NO MILI	7101 5	COMPTENDE		i —	2. 0930-03 .	91
	F CORRECTION	IDENTIFICATION NUMBER;	A. BUILD		E CONSTRUCTION		(X3) DATE COMP	SURVEY	
			"				 ,	С	
		345264	B. WING	_				04/2016	
NAME OF P	PROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP C	ODE		0-1120.0	
STANLEY	TOTAL LIVING CENTER	,		5	14 OLD MOUNT HOLLY ROAD				
VIAILE !	TOTAL LIVING OLNILIS		!	s	STANLEY, NC 28164				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF (CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACT)	ON SHOULD BE		COMPLETION	Ŋ
		DO NOTE THE PARTY	IAG	ļ	CROSS-REFERENCED TO TI DEFICIENC		IIE	DAIE	
			 		/				_
F 226	Continued From page	39	F	226					
!	1 -	sician's communication book							
	for review.	Joint o communication book		- !	ļ			j	-
			T	he "	"Questions After A Bruise/	Skin Tear"	form, w	/hich	
	A review of a nurse's	note dated 12/28/15 at			mpleted by the licensed nu				
	10:02 AM indicated ar	n X-ray was obtained of			lent/Accident report was r				
		er arm due to bruising,			ct the nurse in the event a l	oruise is of	unknov	wn	
	swelling and was pain		. 0		n/source to:				
	-			1	 report to the Nurse Ma 	nager or n	ıanager	on duty	
	A review of x-ray resu	ults dated 12/28/15 revealed	1		to begin the required i	nvestigatio	on and r	eporting	
l	2 views of the left hum	nerus (upper arm bone) and			process	_		r	
	the impression was m	nild arthrosis (wear and tear 🕒 🥏		2	2. obtain a statement from	m the resid	ent if h	e/she is	
	on the joints) with mod	derate demineralization			able to do so	-		-,	7
ļ	(dissolving bone).		· · ·	3	3. indicate if abuse is sus	nected and	if so—	renort	
ļ		ue *		-	following Abuse policy				İ
	A review of a typed do	ocument dated 12/28/15 by	A	all lic	censed nurses will be in-se			f ·	٠,
J		g (DON) indicated it was			elopment Coordinator bety				2
1		n that Resident #6 had-			/16 on the use of this form				٠.
,		n 5 inches x 4 inches. The			onsible for initiating this fo				-
,	document revealed thi				rted.	IIII II GOGS	C 13		- i
-		ent report dated 12/28/16 at	•	opor 	r teu.			3/26/16	,
1	1:45 AM and had beer	n presented to the DON by	<u> </u>	-			-		
1		Nurse for follow up. The	1 .	Ì	• -		- 1	in the second	
1		e DON spoke to Resident		Ì	İ		1	=	
. [#6's ramily who indicate	ited she had a history of		Ì	İ	-	-	-	
.]		ewed Resident #6's clinical	İ	Ì	İ		1		
1		required a lift for transfers.		Ì	İ			24, 2	
ļ	the DON shoomed Be	ed on 12/28/15 at 3:15 PM esident #6's lift transfer by	,]	1			- ·- ·	
		ned to care for Resident #6		1	<u>-</u>	-	1		
	and noted Resident #6			1		_			- 1
	across her chest durin				•	-	[
		41-44:					. [•	
		that time it was determined	·				-		
	harm and that the resident					•			
	indications that it origin								
		nber. The document further							
	revealed it was not es	tablished that NA #1 had							
	caused the injury but if						1		
		in at any time any new							

PRINTED: 03/18/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 345264 B. WNG 03/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY TOTAL LIVING CENTER STANLEY, NC 28164 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 226 Continued From page 40 F 226 #1 caused the injury, either intentionally or (4) otherwise, a formal investigation would be The Risk Management Coordinator will review all opened and submitted to the licensure agency Incident/Accident reports within 24 hours of per facility policy. the reported abuse or by Monday for any reports occurring after 4:30pm on the previous Friday specifically A review of handwritten notes on a sheet of notebook paper dated 12/28/15 at 3:15 PM by the for injuries of an unknown source to ensure all DON revealed NA #1's name at the top of the investigations have been properly initiated per the Abuse page highlighted with yellow highlighter and notes and Incident/Accident policies. Any incident report with revealed Resident #6 "on lift properly may be of an injury of unknown origin that has not had the proper concern" (NA #6 "did good"), "concerns related to ... investigation initiated or any that is questionable for the bruises on both legs and arm on 2 lift occasions." need for a formal investigation will be immediately reported to the Director of Nursing for further review. During an interview on 03/03/16 at 12:08 PM the The Director of Nursing will assign this review to another Administrator explained she was notified by the Nursing Manager in the absence of the Risk Management DON anytime an investigation of abuse was = ---Coordinator. started and if the DON had any question then she would assist as needed. The Administrator stated The Nursing Supervisor on each shift, including weekends. with any investigation staff was expected to will conduct (3) random full body skin assessments per shift complete a full investigation that included (1 on each unit) daily x 2 weeks, weekly x 4 weeks, and then interviews with all staff involved so a thoroughfinally monthly x 3 months beginning on 3/25/16 to investigation would be completed and the incidents reported to the North Carolina Health provide oversight and ensure continued compliance with Care Personnel Registry on the initial 24 hour reporting of injuries of unknown origin. Any concerns noted report and the 5 working day report. will be immediately investigated following the Abuse and Incident/Accident policies. During an interview on 03/04/16 at 9:32 AM the 3/26/16 Risk Management Nurse stated on 12/28/15 she The ADON will conduct (15) random full body skin

Risk Management Nurse stated on 12/28/15 she reviewed an incident report which indicated Resident #6 had a bruise on her left upper arm. She further stated she looked at Resident #6's skin assessments and medications and then she went to Resident #6's room and looked at the bruise. She described the bruise was on Resident #6's left upper arm which covered the whole upper arm and was very purple and looked like a new bruise. She stated she was at a loss as to what had caused the bruise and recalled she had

asked the DON to look into the bruise and he

The ADON will conduct (15) random full body skin assessment audits weekly (5 on each unit) x 1 month and then monthly x 2 months beginning on 3/25/16 to provide oversight and ensure continued compliance with proper Incident/Accident reporting and subsequent investigation procedures for those noted as injuries of unknown source. All concerns and corrective action will be reported to the QA&A Committee monthly for further discussion and review.

3/26/16

PRINTED: 03/18/2016 FORM APPROVED

	CO T OIL MEDIOAILE &				· · · · · · · · · · · · · · · · · · ·	OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		345264	B MANG				С
NAME OF B	DOLUDED OD OLUDELIED	343204	B. WING			03.	/04/2016
IVAIVIE OF P.	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER			5	14 OLD MOUNT HOLLY ROAD		
				S	STANLEY, NC 28164		
(X4) ID		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION	 I	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE IATE	COMPLETION DATE
F 226	Continued From page	41		226			
		e confirmed she did not		220		•	-
	participate in any inve	etigation related to the		_			1
	bruise on Resident #6	's left upper erm	İ	Eac	th Social Services Coordinator will c	onduct ra	andom 📑
	and on recipent no	o lott apper ann.	"	inte	erviews on his/her assigned unit wh	o are ale	rt and 🔝
	During an interview or	03/04/16 at 11:04 AM		orie	ented to determine resident unders	anding/:	awareness
	Nurse #2 stated she re	emembered the bruise on		of tl	he Abuse policy for reporting conce	rns and v	what to do
	Resident 6's left uppe			if al	buse occurs or is witnessed. These i	nterview	s will be
	December 2015. She	explained NA #5 was	-	don	ne for (4) residents weekly x 1 mont	h and the	en monthly
	making her first round	on the night shift on			months. All concerns and correctiv		
	12/28/15 after 1:00 AM	I and noticed Resident #6's		be r	reported to the QA&A Committee m	onthly fo	r
	gown needed to be ch			furt	ther discussion and review.	7	1
	explained when NA #5	removed Resident #6's				3	3/26/16
	gown she saw the bru	ising and swelling on			•		
.	Resident #6's left upper	er arm and reported it to		All A	Abuse Investigation forms and Witn	ess/Staf	r I
	Nurse #2. Nurse #2 c	onfirmed the bruise had not	-	Stat	tements initiated upon the report of	abuse w	rill be
	been reported to her b	y the nurse at shift change		rev	riewed thoroughly by the Administr	ator with	in 24
	during report on 12/27	/15. She explained when		hou	ars of the reported abuse or by Mon	day for a	nv
	she assessed Resider	it #6 she had bruising on	-	rep	orts occurring after 4:30pm on the	nrevious	Friday
	her left upper arm and	described it as huge and	-	to e	ensure all required steps have been	taken to	protect
- 1		e area was warm to touch		the	resident(s) involved as well as other	re racida	ante from
İ	and felt firm and hard	and was purple and looked		pote	ential abuse in a timely manner and	that date	ailed
	like it was a new bruis	e. She explained the bruise		ster	os of the investigation have been in	riated in	the
		sident #6's left elbow and		reai	uired timeframe by the Director of I	Jurcina c	une -
	up in the center of her	upper arm and it kind of		his a	designee. The Controller (also a lice	na sing c	noina
	one financerists as inde	a hand but she did not see		han	ne Administrator) will act in the abs	ango of t	ha I
	etated it clarmed her h	entions in the area: She		non Adn	ninistrator to review these forms.	ence or t	ne
	further evaluined Posic	ecause of the size. She lent #6 was immobile and	1	LLLII	ministrator to review these forms.	. :	3/26/16
-	could not move herself	in had Shaetated		Thr	oughout an abuse investigation, the		
1	Resident #6 could not	verbalize anything but		Maar	oughout all abuse livestigation, the	Director	ot
		own face and she could tell		nul'	sing will review all steps taken thus	iar in th	e
	it hurt her when they m	loved her left arm and she	,	յո +յ։ Իւ Օ(cess daily with the Administrator (t	ie Contro	oller
	reported the bruising to	the first shift nurse during		uu U baa	ne absence of the Administrator) inc	ruding a	1
	the change of shift rep			uioï alat	rough review of all witness/staff sta	tements	
	12/28/15. She explaine		· [SIGU	ained for further direction.		
+	incident report and wro	te her statement on the			:		3/26/16
- 1	report and passed the	paperwork on when she			1]	
		shift nurse on 12/28/15 but					
		ition had asked her about					ł

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION	(X3) DATE	SURVEY
				_		ŀ	С
		345264	B. WNG			1	/04/2016
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	, 0-1, 2010
STANLEY	TOTAL LIVING CENTER			5	14 OLD MOUNT HOLLY ROAD		
	- TO THE LIVE OF THE R		!	S	STANLEY, NC 28164		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x 	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 226	Continued From page	. 42	[200			
	it and she did not kno		「	226			
•	investigation.	w anything about an	}	The	e Director of Nursing will review all	findings	and
	mreddigador.			cor	nclusions of the detailed investigatio	n with th	he -
	During an interview or	1 03/04/16 at 12:36 PM the		Ada	ministrator (the Controller in the ab	sence of	the
	DON explained he red	ceived the incident report for		Adı	ministrator) prior to final submissio	n of the	
:	Resident #6's bruise of	on her upper left arm from		fina	al report to ensure completion of all	steps of	
	the Risk Management	Nurse on 12/28/15. He		the	investigation process and determin	ation of	the
	stated he was concern	ned her arm might have		fina	al outcome related to the accused en	iplovee.	
	been injured during a	lift transfer and wanted to				1 .7	3/26/16
		the lift so he observed NA		Any	y staff member who fails to follow ar	ıv step o	of the
	#6 transfer Resident #	6 with a lift. He confirmed		Abı	use Policy as written, including the c	ompletic	on of 📑
	NA#3 transfer the ros	further or observe NA #1 or ident and he did not submit		the	Abuse Investigation Form, will be si	ubiect to) - 5-1
	a 24 hour or 5 working	day report to the state		dis	cipline including unpaid suspension	up to an	id ===
		time he did not consider	_	inc	luding termination.	-	}
		by an injury of unknown					3/26/16
	origin.	and any or annatomy.		All	reports of abuse including findings a	ınd resu	lts .
				of t	he investigation will be reported to	the mon	thly
-	During a telephone int	erview on 03/04/16 at 3:30	:	QA_i	&A Committee by the Director of Nu	rsing for	
	PM, NA #5 explained s	she remembered the bruise		any	further recommendations to ensure	e contini	ued
	on Resident #6's left u	pper arm at the end of	-	con	opliance.		
	December 2015. She	stated during her first				ı	
ĺ	round of the shift she	noticed Resident #6's gown			-	. – .	
	was solled and when s	she changed it she saw the			-		3/26/16
	bruise on Resident #6	s left upper arm, chest-and					
.	Murco #2 who come to	she immediately notified					
	looked at it and the bri	Resident #6's room andising went down from her			· · · · · ·		7#77 : -
	left arm under her arm	pit and on her chest and			·		
	partially around her bro	east and the color of the			en en en en en en en en en en en en en e	+	.: 6
	bruise was purplish. S	the explained Resident #6				[]	- 1
	was moaning and she	could tell by Resident #6's					
	facial expression she v	vas in pain. She stated			. •	-	
	Nurse #2 assessed Re	esident #6 and wrote a					-
	statement and NA #5 s	stated she wrote a				"]	
	statement. She confire					1	
	administration called h	er or talked to her to ask				İ	
		uise or what had happened					
- 1	so she assumed some	one took care of it		- 1			1

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	ROVIDER OR SUPPLIER	345264	B. WING					
STANLEY .			D. WILLO		-	ĺ		С
	TOTAL LIVING CENTER			STRE	ET ADDRESS, CITY, STATE, Z	IP CODE	03,	/04/2016
(X4\ ID				514 O	OLD MOUNT HOLLY ROAD NLEY, NC 28164	5002		į
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT		(X6) COMPLETION DATE
F 226	Continued From page	43	F 2	226				
	contact NA #3 by phor and a message was le	M attempts were made to ne but there was no answer ft for her to return the call ot return the phone call;						
	contact NA #7 who wa Resident #6 on the day was no answer and the	M attempts were made to s assigned to care for y shift on 12/27/15. There ere was no voicemail option her to return the call.		-			-	
# k r	On 03/04/16 at 4:23 Pf #1 who no longer work by phone but there was message was left for ho nowever, NA #1 did no	er to return the call 👢	-	-		4- 4-		
F c fi S iii a	PM the Administrator si of the bruise on Reside during the morning med urther brought up to sp She stated it was her e investigation to be com and 5 working day repo equired.	view on 03/04/16 at 2:00 tated she was made aware int #6's left upper arm eting but now had been need about the incident. expectation for a thorough pleted and the 24 hour ints to be submitted as			 			
0 V d N re c T re d	finimum Data Set (MD evealed that Resident ognitively impaired witl he MDS further indical	s of multiple cerebral neimer's disease, and most recent quarterly S) dated 02/09/16 #1 was severely n no behaviors identified. red that Resident #1 stance with activities of	-				-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		I				OMB M	<u>), 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY
		245004	5 ,,,,,,,				c
MANEGER	DOMBED OF MICHAEL	345264	B. WING			03.	/04/2016
MAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER				514 OLD MOUNT HOLLY ROAD		
				1	STANLEY, NC 28164		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD) BE	COMPLETION
			,,,,,	,	CROSS-REFERENCED TO THE APPROP	RIAIE	DATE
F 226	Continued From page	44	F	226			
	in the dining room on	Saturday 02/20/16 at	1		1		
		M when she overheard NA					
i	#1 yelling at Resident	#1 to stop touching her and	,				-
	to leave her alone. NA	A#4 stated that Resident #1					
	would pat your leg if y	ou were sitting beside her					
	and she was patting N	IA #1's leg and NA #1 got			-		
	angry and began yelli	ng at Resident #1. NA #4					
	stated that when she	finished feeding the resident					
ı	she was assisting she	had reported it to a nurse					
	but could not recall wh						
	statement by NA #4 al	bout this incident was				-	
	available.						· 1
		on 03/02/16 at 3:05 PM					2.5
	revealed that she was	working in the dining room					
	on the evening of 02/2						
	Resident #1 patting th						
1	stated that NA#1 then	stated "oh my God stop it,			· -		
	why do you keep patti	ng me, stop touching me"					
.		d into the face of Resident			_		
	#1 and grabbed her rig	tht hand and slammed it			·		: .
	into the lap of Residen	t#1 grazing the edge of the			·		11 - 41 L
٠.	table. NA #3 described	it like scolding a child, NA					·
	#3 further stated that F	Resident #1 had no reaction =				İ	
	MA#1 had abused Dec	#3 stated that she felt like					
	had reported the incide	sident #1. NA #3 stated she ent to Nurse #1 and had					
		ent to Nurse #1 and had ut the incident as instructed	-			뒫	·
	by Nurse #1.	at the incident as instructed			·	·421	•
-		ment for Incident/Accident"			•		,=* [*] *
	written by NA #3 states	that she witnessed NA #1					
	slam Resident #1's ha	nd and told her to eton			-		
	patting her. Another fa			ļ			_ ` `] ·
		was talking to the resident		ĺ			
	and stated that it was i	nappropriate. Signed by					
	NA #3 and dated 02/20						9
	Interview with NA #2 o					Ì	· · ·
		present in the dining room					·
Ì	on 02/20/16 assisting v	with supper and witnessed					
	NA#1 get very irritated	with Resident #1, who					

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OTATE	OF PERIODICATE						OMR MC	<i>).</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUI A. BUILD		E CONSTRUCTION	_	(X3) DATE COME	SURVEY
		345264	B. WNG	i				C
NAME OF P	ROVIDER OR SUPPLIER			T :	STREET ADDRESS, CITY,	STATE ZIP CODE	1 03/	04/2016
					514 OLD MOUNT HOLLY			
STANLEY	TOTAL LIVING CENTER			1	STANLEY, NC 28164	NOAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.			DIO DI ANI OE DODDECENSIONI		···········
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	ΊX	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	45		000				
. 220			F	226				-
	was pauing ner leg, a	nd NA #1 grabbed her hand	İ			-		
	table and board NA #	lesident #1's lap grazing the 1 state to Resident #1 "stop					<u> </u>	
	E**king natting my les	"." NA #2 stated that what						÷
i	she witnessed between	en NA #1 and Resident #1	_					· •
		verbal abuse because they	1			0		•
		ry training on abuse and					٠	
	were educated on the	different types of abuse						
	and included example	es of each type. NA#2	1					
		ed the incident to the Nurse						·
		n statement by NA #2 about					-	
	this incident was avail	able			_		٠	
		#1 on 03/04/16 at 9:53 AM	-			,	· · ·	
		a sitter for another resident			_	٠ ٤		
	at that facility. Visitor	#1 stated that on 02/20/16 in				•		
	the dining room at sup	pper time she witnessed	-					
	Resident #1 rubbing N	IA#1's leg and NA#1 got						<u> </u>
		1 she took her arm and						· · · · · · · · · · · · · · · · · · ·
	forced it down onto he	er lap. Visitor #1 stated that	-		-			
		and got almost nose to				•		7 LL 1 L -
:		and stated "I told you to						
	stop that" and "keep y	our hand to yourself."					•	
*		d that she witnessed NA #1			ļ			1 -0.0
	lan of least 3 times with	dent #1 and shove it into her tile she was in the dining	-					÷
}	room tending to the re							
İ	Visitor #1 stated that s						- 1	
		that later that evening the	-				-	1.1 = 1.1
	Nurse Supervisor cam		1			-		-
	reporting the incident	No written statement by	-				-	- "
	Visitor #1 about this in	cident was available	. _			•		
		1 on 03/02/16 at 3:20 PM _]				.	<u> </u>
		eported the incident with NA				·		-1.
ĺ	#1 and Resident #1 in	the dining room on						
		tely 6:30 PM. Nurse #1						
		rvisor was already aware.						·
	Nurse #1 thanked NA	#3 for reporting the incident						
		NA #3 to write a statement						
	about what she witnes	sed Nurse #1 further					İ	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		B) DATE	SURVEY PLETED
		345264	B. WNG					C
NAME OF P	ROVIDER OR SUPPLIER	·		s	TREET ADDRESS, CITY, STATE, ZIP CODE		U3/	04/2016
STANLEY	TOTAL LIVING CENTER			ı	14 OLD MOUNT HOLLY ROAD TANLEY, NC 28164			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 226	it for granted the Nurse care of the situation. In Nurse #1 about this in Interview with Nurse \$2:34 PM revealed that NA #1 was being verb hateful to Resident #1 he went to the dining with NA #1 and asked stated that Resident # her private area and Nurse supe #1 if she was being verb 1 if she was being verb 1 if she was being verb 1 if she was being verb 1 if maybe the toler perceived as verbally replied "maybe." Nurse that he had reassigned memory care unit for the Nurse Supervisor contispoken to the director sent an email notifying happened on 02/20/16 stated that his only oth NA #1 was to reassign remainder of her shift. Nurse Supervisor about available. Review of email dated Nurse Supervisor to Divisitor had witnessed Nesident #1 and shovi	ning further because he took se Supervisor was taking No written statement by scident was available. Supervisor on 03/02/16 at t NA #2 reported to him that sally aggressive and very . Nurse Supervisor stated room and asked to speak what was going on. NA #1 **T was rubbing her leg near NA #1 stated that she had hand away and told her not ervisor stated he asked NA erbally aggressive and NA o Nurse Supervisor asked he of her voice could be aggressive and NA #1 e supervisor again stated of NA #1 to the 400 secure he remainder of her shift. firmed that he had not of nursing (DON) but had of hursing (DON) but had of him of the incidents that S Nurse Supervisor further her action besides talking to a her to another unit for the No written statement by ut this incident was 02/21/16 at 7:15 PM from ON read in part that a NA #1 being rude to ng her arm when Resident	F	226	DEFICIENCY)			
	#1 would pat NA #1 or questioned NA #1 abo defensive, and with an Nurse Supervisor talke	nthe leg. "When I ut it she became upset, aggressive attitude."						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONST	RUCTION				(X3) DATE	SURVEY PLETED
		345264	B. WING		<u>.</u>						C
	ROVIDER OR SUPPLIER TOTAL LIVING CENTER			5	14 OLD		CITY, STAT COLLY ROA 8164		DE	03/	04/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH	OVIDER'S P I CORRECT REFERENC DE	IVE ACTIO	N SHOULD I EAPPROPR	BE	(X5) COMPLETION DATE
F 226	Continued From page	47 dy language an attitude. I secure memory care unit	F	226			· · · · · · · · · · · · · · · · · · ·				
į	for the remainder of h Interview with the DO				٠.						-
į	on 02/20/16 via email he received on 02/22/ NA #1 told DON that F	from Nurse Supervisor that 16 when he arrived at work. Resident #1 was putting her			·, ·		·	-			
	back on Resident #1% there was no investiga	nd NA #1 was placing it The DON confirmed that ation completed on the-		ļ							
`	incident with Resident reported to the North (Personnel Registry via	Carolina Health Care a the initial 24 hour report or					••			· -	
-	he had not talked to the present in the dining re-	ort. The DON further stated be sitter/visitor that was from that day because he								 	
	and the DON confirme to the other NAs that v	ation for that sitter/visitor, ad that he had not spoken were working that evening. If abuse had been reported			ş. ·			٠.		~	
		e expectation is that Nurse act the DON or the			· ,			-			
	Interview with the Adm	inistrator on 03/03/16 at it she was notified by the									en a sitte is tek tila til til se a tila tegre e se
-	started and if the DON would assist as neede	had any question then she						٠.			remiku ya 1 1802 - Aristo Remikus
}	incident with NA #1 an Care Personnel Regist a full investigation. The	d Resident #1 to the Health try and had not completed Administrator also stated			÷						
	that if a NA had witnes 02/20/16 at supper in t investigation should ha administrator also state to Nurse Supervisor he										

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		NSTRUCTION	(X3) DATE	SURVEY PLETED
		345264	B. WING				С
NAME OF D	ROVIDER OR SUPPLIER	340204	D. WING _			03,	04/2016
	TOTAL LIVING CENTER		į	514 O	ET ADDRESS, CITY, STATE, ZIP CODE LD MOUNT HOLLY ROAD ILEY, NC 28164		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From page	48	F 2	26			
	-	aff is expected to complete		.20		. •	
		t included interviews with all			•		r was set you
		ministrator stated that nurse					3-11
	supervisor was fully c						77.7
		ould have included the					TOP WAS
	immediate suspension					÷ '	
		stated nurse supervisor				* 1=	
		tely notified the DON sora					index Toronto and the second of the second
		could be completed and					The state of the s
		to the Health Care		1			en nest in 100 en ese fin ne gyennini 1919
		a the initial 24 hour report			<u>-</u>		
	and the 5 working day	report as stated in the			•		
		ninistrator stated, after					The second of th
		DON yesterday, he felt like					
	he should have done	something so he filled out					
ļ		initial report to the Health	- -, · · ·		-		
. }	Care Personnel Regis	itry.	=-				
· .	3. Resident #2 was ac	lmitted to the facility on	.,				
	10/17/15 with diagnos	es that included diabetes	1				
	mellitus, hypertension	, Alzheimer's disease, and			• • • • • • • • • • • • • • • • • • •		
ŀ	dementia. Review of the	he most recent					, e Pagareta d
· ·		sion minimum data set					
	(MDS) dated 10/26/15	revealed that Resident #2	-		·		
Ì	was severely cognitive	ely impaired and no		-			
		ied. The MDS also 🚐 👢				=	
	indicated that Residen	it #2 required extensive				4 + 1	
.	assistance with ADLs.						
		on 03/02/16 at 5:09 P.M				- 1	
		0/16 at approximately 5:00 🔑 💎		-			
		n the dining room waiting 😇 💎	F		1		
.	for supper and had be						2 - 1 - A-
		d to leave the dining room.	:				
		took Resident #2 to see a					
ŀ	family member who als	so resided at the facility to					· 1 7 7 = 5
		Resident #2 down. NA #2					
		ent #2 had visited with the				-	
		w minutes he had calmed					-
		able to return Resident #2					
i	to the dining room. NA	#2 further stated that when			•		

		I DIONIE CENTIOLO	· · · · · ·				OMR MC	<i>).</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		(X3) DATE COMF	SURVEY
		345264	B. WNG				1	С
NAME OF P	PROVIDER OR SUPPLIER				EET ADDRESS SIEW DELVE		03/	04/2016
77 1112 01 1	TO THE TOTAL OF TH			i	EET ADDRESS, CITY, STATE,			
STANLEY	TOTAL LIVING CENTER				OLD MOUNT HOLLY ROAD	•		
	1		,	STA	ANLEY, NC 28164			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	, l	PROVIDER'S PLA	N OF CORRECTION	_	(X5)
TAG		SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED	E ACTION SHOULD E TO THE APPROPRI	BE ATF	COMPLETION DATE
			<u> </u>			CIENCY)		
F 600]							
F 226				226				
	she returned Residen	t #2 to the dining room NA:	-	.				
	#1 asked NA #2 "Wha	t is his issue?" NA #2 stated		-				
	to INA #1 that Resider	It #2 had delusions that his	- -					
	#1 then engresshed !	led. NA #2 stated that NA					٠.	
	his face and stated "44	Resident #2 and got down in 💄 👵 nat was a stupid reason to						(a) (a)
	hit me and you had no	reason to act like way" in a				•	•	
	Very addressive and t	hreatening tone. NA #2 also	· 				• • •	
٠	stated that NA #1 was	very hateful in the way NA	- : 				"	1.00
		#2 that evening in the	-		•	•	- '	
		ated she reported this to the-		ĺ				
		pproximately 5:15 PM,		İ		-		* * * * * * * * * * * * * * * * * * * *
İ	Interview with the Nur	se supervisor on 03/02/16	. =		•			
٠. ا	at 2:34 PM revealed to	nat on 2/20/16 at						- ·
		M NA #2 reported to him					* -	
	that NA #1 had been v	rery hateful to Resident #2						
		oudly, more loudly than she			-			
	should have been to F	Resident #2 in the dining- :	- <u></u>					
	room. Nurse Supervis	sor confirmed that he had	-0 gradus	-				
•	not spoken to the DO	l but had sent an email 👚 🚊 📑	:-	-	·			a la la la la la la la la la la la la la
	notifying him of the inc	cidents that happened on 🗤 😑					-:	
•	02/20/16. Nurse Supe	ervisor further stated that	· · · · · · ·					
· · ·	his only other action b	esides talking to NA #1-was - 🗻 🍃	·	•			. 1	
ĺ	to reassign her to ano	ther unit for the remainder.						
	of her shift. No written	statement by Nurse					· · · · · · · · · · · · · · · · · · ·	
		ncident was available:						er e lægisk
	Interview with DON or					. •		
	stated that he was not	made aware of the incident						
	until Monday 02/22/16	when he arrived at work	F	·	-	-		
	and read the email fro	m Nurse Supervisor. The	. 577	-				
		ere was no investigation					·	·
		t #2 and the incident was	Ser				-	
,	Personnal Pagistra via	rth Carolina Health Care	'					7.29
		the 24 hour initial report		-				··· -
		ort. The DON also stated = - : he NAs that were working						12 1-
	that evening about the							
		om them regarding the						*
		ther stated that he trusted					ļ	

		T OCTORIO OCTAVIOLO	-		· · · · · · · · · · · · · · · · · · ·	<u> </u>	<u>O. 0938-</u> 0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345264	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER			一	STREET ADDRESS, CITY, STATE, ZIP CODE		/04/2016
				ĺ			
STANLEY	TOTAL LIVING CENTER			ı	514 OLD MOUNT HOLLY ROAD		
	01,000,000			٠	STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ΊX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	Continued From page	50	F	226	6		
		because he was present at	'	2,21	0		
	the time and had a be	etter idea of what happened.	İ		·	,	
		y abuse was reported to					
		should immediately notify			·		
	the DON. The DON a	gain confirmed this incident				4.5	-
		and was not reported to the				•	
ĺ	Health Care Personne	el Registry.		-	-		
	Interview with the Adri	ninistrator on 03/03/16 at	-			_	
		at she was notified by the					-
		stigation of abuse was -					1 2 4
	started and if the DON	I had any question then she			-		
		ed. The administrator also			-		gran garan
	stated that if abuse is						atu in a leasterance
1		mmediately notify the DON -					1 12 2
		The administrator went on					
	investigation that inclu	ected to complete a full	- '		•		} · · · ·
,	investigation that inclu-	ided interviews with all staff trator stated that nurse		••	-	4.	<u></u>
	supervisor was fully ca						Entrance Company
	investigation which ch	ould have included the					- 1
	immediate suspension	of NA #1. The	_			-	}
	administrator further s	tated nurse supervisor					17 Th 17 4 5
.	should have immediate	ely notified the DON so a					A 111 44
	thorough investigation	could be completed and					78 1474
	the incidents reported						
		the initial 24 hour report					
		report as stated in the		-			4 1 4 4 4 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4
	facility policy. The Adn					_	
	conversations with the	DON yesterday, he felt like					7.1
		something so he filled out					
		initial report to the Health					
	Care Personnel Regis						12 2 2
	The administrator and						
		fimmediate jeopardy. The					-
	administrator provided						
	allegation of compliand	ce on 03/04/16 at 6:45 PM					
	Credible Allegation of	Compliance F226					!

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONS	TRUCTION	(X3) DAT	E SURVEY PLETED		
					,		С		
		345264	B. WNG			03	/04/2016		
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 OLD MOUNT HOLLY ROAD STANLEY, NC 28164					
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 226	working report submit Personnel Registry at was not completed. On 2/20/16 at 11:00p #1, who physically and Residents #1 and #2 after working her entil 3:23pm, the accused had not returned to we 11:00pm) and was employment on 2/26/16 an investigation of the investigation at 1:20pm. On 02/22/16 the famit was involved in the investigation are pendit investigation are pendit investigation is completed.	nt #6 had a bruise of no 24 hour report or 5 day ted to the NC Health Care and a thorough investigation m, Nursing Assistant (NA) ad/or verbally abused on 02/20/16, left the facility re shift. On 2/22/16 at NA was suspended (she ork since leaving on 2/20/16 ultimately terminated from 16 at 1:20pm. Itigation was initiated on the by the Director of Nursing nination of NA #1 on 2/26/16 Ity member of Resident #2 vestigation and was made atton initiated on 2/22/16 as e of the investigation on or of Nursing. Ising Supervisor was placeding further investigation of his of abuse for Residents #1 ed on 02/20/16, for failure to properly report resident 6. The results of this ding and the Nursing non suspension until the ete.	F	226					
	On 03/03/16 at 2:19 p Personnel Registry (F	om The 24 hour Health Care ICPR) abuse/neglect							

TAGE DECLIFIATION OF LIGHT PROPERTY ACCORDS THE FOLL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO COMPLETE TO COMPLET			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			USURVEY PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164 (X4) ID PREFIX TAG (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From page 52 investigation report form for Resident #1 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164 PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE COMPLE DATE) F 226 F 226 On 03/03/16 at 2:19pm the 24 hour abuse/neglect investigation report form for Resident #1 was completed and faxed for further investigation of alleged abuse.			345264	B. WING				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From page 52 investigation report form for Resident #1 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. On 03/03/16 at 2:19pm the 24 hour abuse/neglect investigation report form for Resident #1 was completed and faxed for further investigation of alleged abuse.				STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD				
investigation report form for Resident #1 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse. On 03/03/16 at 2:19pm the 24 hour abuse/neglect investigation report form for Resident #1 was completed and faxed for further investigation of alleged abuse.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
#2 and Nursing Assistant (NA) #3 who falled to immediately report allegations of abuse towards Resident #1 and Resident #2 were suspended pending further investigation of their actions related to the allegations. NA #2 and NA #3 received written disciplinary actions for fallure to immediately report allegations of abuse according to the Abuse/Neglect policy on 03/04/16 and will return to work as of 03/05/16. On 3/4/16 at 9:00 am, the Director of Nursing completed the NC Board of Nursing Complaint. Evaluation Tool to determine reporting requirements for the Nursing Supervisor and — obtained a score of 11 which indicated NC Board of Nursing consultation but no requirement for reporting. The Director of Nursing consultation on 03/04/16 at 10:00am. The Director of Nursing was given a phone appointment for further review on Monday, 3/7/16 at 1:30pm. On 03/04/16 at 5:19pm, the 24 hour Health Care Personnel Registry (HCPR) abuse/neglect investigation report form for Resident #6 was completed by the Director of Nursing and faxed to HCPR for further investigation of alleged abuse.	F 226	investigation report for completed by the Dire HCPR for further investigation report for completed and faxed alleged abuse. On 03/03/16 at 3:20pi #2 and Nursing Assist immediately report alleged abuse related to the allegation received written discip immediately report alleged to the Abuse/Neglect preturn to work as of 03 of 3/4/16 at 9:00 am, completed the NC Bos Evaluation Tool to deter requirements for the Nobtained a score of 11 of Nursing consultation reporting. The Director NC Board of Nursing for 03/04/16 at 10:00a was given a phone ap on Monday, 3/7/16 at On 03/04/16 at 5:19pm Personnel Registry (Hinvestigation report for completed by the Director NC Board of Pursing for 03/04/16 at 5:19pm Personnel Registry (Hinvestigation report for completed by the Director NC Board of Pursing for 03/04/16 at 5:19pm Personnel Registry (Hinvestigation report for completed by the Director NC Board of Pursing for 03/04/16 at 5:19pm Personnel Registry (Hinvestigation report for completed by the Director NC Board of Pursing	orm for Resident #1 was ector of Nursing and faxed to estigation of alleged abuse. In the 24 hour abuse/neglect rem for Resident #1 was for further investigation of In, Nursing Assistant (NA) tent (NA) #3 who failed to egations of abuse towards dent #2 were suspended igation of their actions ons. NA #2 and NA #3 _ polinary actions for failure to egations of abuse according policy on 03/04/16 and will 8/05/16. Ithe Director of Nursing and of Nursing Complaint ermine reporting Jursing Supervisor and — which indicated NC Board in but no requirement for or of Nursing contacted the for the required consultation in. The Director of Nursing pointment for further review 1:30pm. In, the 24 hour Health Care CPR) abuse/neglect rem for Resident #6 was cotor of Nursing and faxed to	- F	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		345264	B. WING			l .	C	
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD					
——————————————————————————————————————			s	TANLEY, NC 28164				
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	Continued From page	53	F:	226				
,	100 unit Social Servic for any residual effect	#6 were assessed by the es Coordinator on 03/03/16 s from the alleged with no concerns noted.						
	for all staff on duty on abuse. The in-service 1. Revised Abuse & 	ducted by the Administrator 03/03/16 regarding resident eagenda included: Neglect policy/procedure to: al of the resident from the eemployee who witnesses						
	the abuse Immediate report	ng of the abusive situation witnesses the abuse to the						
						 -		
-	management Immediate reporti	ng of the abusive situation						
· · · · · · · · · · · · · · · · · · ·	Administrator	rector of Nursing or the					- -	
-	 Definitions of phy- including tone of voice towards any resident i physical and verbal ab 	and temperament used ncluding scenarios of both				-	.2 · · · · ·	
-	3. Definition of how anotification of abuse a	o make the immediate		-				
4		ne immediate protection of abuse/neglect are						
- `	No staff member will b work-related duties un completed.	e allowed to perform any til the In-service has been						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			DNSTRUCTION	(X3) DATE COM	SURVEY PLETED		
		345264	B. WING				C		
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164					
(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 CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE		
F 226	oriented were intervied Services Coordinator determine if there we and/or neglect with normal completed on all resident, #2, and #6) to assabuse by the Nursing Coordinators, and Ris Coordinator. Skin as signs of potential abuse of potential abuse of potential abuse and responsibility any allegations of abuse/neglect including origin and beginning to	ents who are alert and ewed by the 100 unit Social and MDS Coordinators to re any reports of abuse on egative responses. It is skin assessments were dents (including Residents sess for possible signs of Supervisors, MDS sk. Management sessments revealed no se. In, the Administrator or of Nursing on his specific in immediately reporting use/neglect or suspicions of the appropriate equired timeframe per policy	F	226					
	Evaluation Tool to det requirements for the I his role in the failure t reporting and investig abuse for Resident #6 which indicated NC B but no requirement fo Administrator contact for the required consu 5:28pm and was mad closed. The Director on 03/04/16 @ 5:40pt	ard of Nursing Complaint ermine reporting Director of Nursing based on o complete the required ations of allegations of and obtained a score of 11 oard of Nursing consultation or reporting. The ed the NC Board of Nursing ultation on 03/04/16 at e aware that the office is of Nursing was suspended on with a pending NC Board of Nursing for							

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		İ				С	
NING OF T		345264	B. WING			03/	04/2016
NAME OF PROVIDER OR SUPPLIER STANLEY TOTAL LIVING CENTER			514	REET ADDRESS, CITY, STATE, ZIP CODE OLD MOUNT HOLLY ROAD ANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	55	F	226			
	all shift supervisors, o immediately reporting appropriate investigat	g Managers, which includes n their specific role in and beginning the ion for all reported concerns			. · · · -	-	
	will be allowed to perf until this in-service ha	rigin. No nursing manager orm any work-related duties s been completed.		-			
	7:05 PM when staff in administrative staff, an confirmed that they had training on the immed situation to the direct emember of the manage immediate start of a fur reported abusive situation to the Health Care Personal reported abusive situation to the Health Care Personal reported abusive situation of the Health Care Personal reported abusive situation of the Health Care Personal reported abusive situation of the Health Care Personal reported abusive situation of the Health Care Personal reported abusiness and the Health Reported abusiness and the Health Reported abusiness and the Health Reported a	ras removed on 03/04/16 at terviews with nursing staff, and non-nursing staff and received in service interpretation of the abusive supervisor or any other ement team on duty, the all investigation of the attorn, and the reporting to onnel Registry in 24 hours indings in the 5 working day					
	÷						· · · · · · · · · · · · · · · · · · ·