PRINTED: 05/04/2016 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2)MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345306	B. WING			R-C 05/03/2016		
The second second second second second		345306	D. WING_			05/	03/2016	
	ROVIDER OR SUPPLIER MEMORIAL HOSPITALIN	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677				
(X4) ID PREFI X TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 000}	staff failed to notify th party after a resident abused. 483.13 (F 221) at J Immediate Jeopardy Nurse #1 restrained for the side rail with no make the side rail with a glastic make the side of the	began on 03/01/16 when e physician and responsible had been restrained and began on 03/01/16 when Resident #1's right arm to nedical symptoms to warrant began on 03/01/16 when NA #1 had tied Resident #1's ail with a towel that was nedical tape and Nurse #1 in sing body lotion due to his began on 03/01/16 when NA ely report to administrative had tied Resident #1's right th a towel that was taped tape and Nurse #1 stated to ed Resident #1 in the face of lotion due to his combative began on 03/01/16 when NA ely report when Nurse #1 s right arm to the bed rail taped with a plastic medical ated to NA #1 she had	{F 00	00)	Iredell Memorial Hospital (IMH) is compromoting and protecting patients' right developing and maintaining the skilled facility in a manner that ensures the sar patients, staff, and visitors. The following of Correction for each deficiency was developed by the Director of Nursing and Facility Administrator of the Skilled Nursacility with oversight by the Vice Presignation of Correction was developed ensure the Skilled Nursing Facility's full compliance with the Medicare Condition Participation, with all actions in the Plan Correction completed on or before April 2016. Ongoing compliance will be evaluatively as noted for deficiency, with monitoring results forward the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurant Committee.	s and nursing fety of ng Plan and sing dent of ning. to 1 27, luated each arded to ne		
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIERREPRESENTATIVE'SSIGNATUR	Ε .		TITLE	, ,	(X6) DATE	

Any deliciency 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 burvey 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.

Facility ID: 933284

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100			(X3) DATE COMP	SURVEY LETED
		345306	B. WING _			R-C 05/03/2016	
	ROVIDER OR SUPPLIER	ıc		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677		500000	
(X4) ID PREFI X TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	E	(X5) COMPLETION DATE
{F 000}	body lotion due to his 483. 20 (F 279) at J Immediate Jeopardy I Nurse #1 tied Resider rail with a towel and ta tape to secure it and I she had sprayed Res cleansing body lotion behavior during nursin 483.75 (F 490) at J Immediate Jeopardy I #1 witnessed Nurse # right arm to the bed ra taped with a plastic m stated to NA #1 she ha the face with a cleans combative behavior a immediately report the staff. The facility provided to Centers for Medicare acceptable allegation A revisit survey was overification of the facil compliance and to de ongoing Immediate Je Jeopardy was remove At the time of the exit remained out of comp 223, F 225, F 226, F 2 scope and severity of	in the face with a cleansing combative behavior. Degan on 03/01/16 when the strict with a plastic medical Nurse #1 stated to NA #1 ident #1 in the face with a due to his combative to his high with a towel that was edical tape and Nurse #1 and sprayed Resident #1 in the face with a high with a towel that was edical tape and Nurse #1 and sprayed Resident #1 in the face with a high with a high with a high with an of compliance on 04/29/16. Onducted on 05/03/16 for ity's allegation of termine the status of the expandy. Immediate and on 05/03/16 at 10:45 AM. on 05/03/16, the facility liance at F 157, F 221, F 179 and F 490 at a lower (D) isolated, no actual harm that is dy, while the facility	{F 0	000}			

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						R-C	
		345306	B. WING _			05/03/2016	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 7 BROOKDALEDRIVE		
IREDELL	IREDELL MEMORIAL HOSPITALING			ST	FATESVILLE, NC 28677		
(X4) ID PREFI X TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000} {F 157} SS=D	consult with the reside known, notify the resident or an interested family accident involving the injury and has the pot intervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a nexisting form of treatment); or a decist the resident from the §483.12(a). The facility must also and, if known, the resor interested family mechange in room or roos specified in §483.15(a) resident rights under regulations as specifithis section. The facility must record the address and phorn legal representative of this REQUIREMENT.	ir correction actions. Y OF CHANGES COOM, ETC) iately inform the resident; ent's physician; and if dent's legal representative y member when there is an ential for requiring physician cant change in the resident's sychosocial status (i.e., a mental, or psychosocial reatening conditions or); a need to altertreatment entited to discontinue an ment due to adverse commence a new form of ion to transfer or discharge facility as specified in promptly notify the resident ident's legal representative ember when there is a mmate assignment as	{F 00	557}	CORRECTIVE ACTION FOR AFFECTIRESIDENT 1. Upon learning of restraint application alleged abuse, Director of Nursing of Skilled Nursing Facility (DON) assess Resident #1 on March 25, 2016, not sign of injury. Review of the patient medical record by the DON and Face Administrator on March 25, 2016, reno documentation of any signs of inj Resident #1's eyes, face, arm, or wirduring subsequent shifts following the alleged events. 2. Resident's physician was notified or 25, 2016 at 12:45 pm. by the DON or restraint of patient and alleged spray Remedy Cleansing Body Lotion in patice. No new orders were received. 3. Resident #1's family member was compared by the DON on March 28, 2016, to restrain to discuss changes in the pocare. The family member requested schedule the meeting with the Direct Nursing for March 29, 2016 so additing family members could attend. On Mach 2016, three family members, including Resident #1's Healthcare Power of met with the DON and the Facility Administrator of the Skilled Nursing and the Vice President of Profession Services and Facility Planning. Dur meeting, the family was notified of the allegations and the complete investing with respect to Resident #1's care, family was provided complete detail	n and of the ssed ing no 's sility evealed jury to rists ne n March of ying of eatient's to tor of cional flarch 29, ng Attorney Facility nal ing this ne gation The	03/25/16
	This REQUIREMENT by:	is not met as evidenced					

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		345306	B. WING _			05/0	03/2016	
STORY STREET, VICTOR	ROVIDER ORSUPPLIER	ıc		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677				
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{F 157}	Based on record reviinterviews the facility the physician and res resident became comand a nurse restraine bed rail with a towel at tape and sprayed the cleansing body lotion (Resident #1). Immediate Jeopardy staff failed to notify the party after a resident abused. The immediate jeoparty facility provided to Centers for Medicare acceptable allegation 04/29/16. A revisit survey was determine the status Jeopardy. The facility for review of the following review of the following prohibition and use on the prohibition and use on the prohibition of the prohibition of the prohibition and use on the prohibition of the prohibition of the prohibition of the prohibition of the prohibition and use on the prohibition of the prohibition and use on the prohibition of the pr	ews and staff and physician failed to immediately notify ponsible party when a abative during nursing care and the resident's arm to the and secured it with a plastic resident in the face with a for 1 of 1 sampled for abuse began on 03/01/16 when e physician and responsible had been restrained and rdy is present and ongoing. The State Agency and the and Medicaid with an of compliance (AOC) on conducted on 05/03/16 to of the ongoing Immediate or provided documentation wing: In-servicing on abuse frestraints. If audits for abuse, use of ian notification. If care plans revised and idualized for residents' care no additional allegations of	{F 1	557}	incidents of March 1, 2016 and Marc 2016. Family members had multiple questions, which were answered as possible. Discussion ensued regard resident's ongoing care and status. did note that Resident #1's behavior status had improved over the past in and wished to have Resident #1 ren the Skilled Nursing Facility for ongoing care. The meeting was concluded woffer for additional meetings and/or discussions should other questions concerns arise after the family mem present discussed the events with a family member. 4. Resident's physician was again con on April 1, 2016 by the Vice Preside Professional Services and Facility Professional Servi	fully as ding Family and nonth nain in ing with an or bers nother tacted ent of planning in in it's idents e had eeded in in in ing in in in ing in in in in ing in in in in ing in	04/01/16	
	cognitively intact resi	dents and interviews with cility on 05/03/16, review of			Review of resident weekly skin assessments on March 2, 2016, Ma	irch 9	03/23/16	

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{F 157}	Director of Nursing pr support corrective ac the immediate jeopar scope and severity of with potential for mor not immediate jeopar continues the proces implementation of the The findings included Resident #1 was adn 09/24/15 with diagno failure, chronic obstru- dementia, psychosis A review of the admis (MDS) dated 10/01/1	cility's Administrator and rovided sufficient evidence to tion by the facility to remove dy at F- 157 at a lower f (D) isolated, no actual harm than minimal harm that is dy, while the facility s of monitoring the e corrective action.	{F 1:		2016, March 16, 2016, and March 2 by the DON revealed no documenta reports of any injuries or wounds posecondary to abuse or application or restraints. 3. Interviews were conducted with 18 Nursing Facility clinical staff member the DON and the Facility Administration March 24, 2016 – March 29, 2016 to whether any other instances of abuse restraint application or suspicious in been witnessed or observed with an residents. No concerns were identified. 4. Additionally, the DON or Facility Administrator interviewed 3 physicial have the majority of the residents of Skilled Nursing Facility, including the Medical Director, to inquire whether had any concerns about the care report of application for any of their residents.	Skilled ers by ator from o inquire se or njury had ny other fied. ans who in the e SNF they indered estraint	03/29/16
	behaviors. The MDS #1 required extensive bathing and hygiene staff for bed mobility extremity impairment A review of the most	further indicated Resident e assistance for transfers, but was totally dependent on and toileting and had upper t on one side. recent quarterly Minimum			5. Following resident, staff, and physic interviews and medical record reviewas determined that no other residewere affected by these events and events were identified.	ws, it ents	03/29/16
	and exhibited physical directed toward other on staff for activities of extremity impairment. A review of a nurse's AM by Nurse #1 revecombative during attemptions and spit	erely impaired in cognition al and verbal behaviors rs and was totally dependent of daily living and had upper			SYSTEMIC CHANGES 1. During the Root Cause Analysis, the of Command" policy was reviewed Director of Nursing and Facility Administrator and determined to be appropriate. The Chain of Comman specifies that staff may bypass their immediate supervisor when reporting event if their supervisor is unresportant unavailable. Because the Chain of Command was not enacted at the tithe March 1, 2016 and March 4, 20 events, it was determined that additional processing the command was determined that additional command was determined to the command was determined	nd policy r ng an nsive or ime of	03/30/16

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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IREDELL	MEMORIAL HOSPITALI	VC		STATESVILLE, NC 28677			
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{F 157}	shoot staff and atterm with the resident wern no documentation in physician or responsion. A review of a typed so Nurse #1 revealed in Resident #1 was diffi aggressive and combined revealed on one night while discussing Resoursing supervisor shad to secure Resident #1 and release them who document indicated I night (no dates indicated and release them who document indicated I night (no dates indicated supervisor who said thave time for that so situation for staff and pillowcase and some #1's left wrist to the strevealed Resident #1 he was not able to su document indicated to repositioned him, the pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase, all taking document indicated to the staff and pillowcase.	pts to redirect and reason e unsuccessful. There was the nurse's notes that the ble party were notified. tatement dated 03/28/16 by part that taking care of cult because he was very bative. The document further it (no date was indicated) ident #1 with the night shift he suggested we might want 1's wrists while cleaning him en we were finished. The ater that night or the next ated) Resident #1 was we and Nurse #1 called the to call security but we did not in an effort to provide a safe resident she took a soft tape and secured Resident ide rail. The document could still move his arm but wing his arm at them. The hey cleaned and in Nurse #1 released the less than 5 minutes. The Nurse #1 stated she was	{F 15	 staff education was indicated changes to Resident's physic Resident's legal representative March 24, 2016, working staf provided education prior to the on the policy of immediate normanagement staff of any sus witnessed abuse or neglect or restraint application. Upon normanagement staff notifies the responsible party and attending Any changes in the resident's physical condition must be repromptly to the resident's physical condition. On April 21, 2016, the Skilled Facility clinical and non-clinic annual competencies and the checklists were expanded to specific education on Proper Witnessed / Suspected Abus Application and Chain of Conemployees will receive this education on Proper Witnessed / Suspected Abus Application and Chain of Conemployees will receive this education on Proper Witnessed / Suspected Abus Application and Chain of Conemployees will receive this education on Proper Witnessed / Suspected Abus Application and Chain of Conemployees will receive this education on Proper Witnessed /	on of ian and ve, effective f was e start of shift diffication of pected or r any otification, e resident's ing physician. Is behavior or ported vician and Nursing owed to work education. Nursing al staff e orientation include Notification of e or Restraint mand. New ducation on to the ent ducation encies.	04/21/16	
	An attempt was mad 04/19/16 at 2:00 PM answer and no option During a phone interwith the night shift No	uring this incident and sibility for her judgment. e to contact Nurse #1 on by phone but there was no in to leave a message. view on 04/19/16 at 4:36 PM cursing Supervisor she stated d Nurse #1 to tie Resident		 Education was provided to al Nursing Facility clinical and n staff and ancillary staff that p treatment, or services to resic Skilled Nursing Facility via a based learning module from a 2016 on Proper Notification of Suspected Abuse or Restrair and Chain of Command. Afte 2016, no staff will be allowed 	on-clinical rovide care, dents of the computer-April 22 – 24, of Witnessed / at Application er April 24,	04/24/16	

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{F 157}	rounds during the shift to call her when a res she would have expe immediately notify the party after Resident # bed rail. A review of a facility did Administrator titled Al	ail. She stated she made ft and was available for staff ident was out of control and cted Nurse #1 to e physician andresponsible ft's right arm was tied to the locument completed by the llegation of Resident	{F 1!	57}	the Skilled Nursing Facility until this education has been completed. 5. Proper Notification of Witnessed / Suspected Abuse or Restraint Appliand Chain of Command was added list of annual competencies required any staff providing care, treatment, a services to residents of the Skilled Naracility. MONITORING	to the I for or	04/21/16	
	summary of interview indicated on 03/01/16 when they provided m NA #1 assisted with p the room for a short p duties. When she fin	d 03/30/16 revealed a brief s of staff. The document S NA #1 assisted Nurse#1 norning care to Resident #1. providing peri care then left period of time to doother ished she noticed the door			 100% of working Skilled Nursing Facelinical and non-clinical staff will coneducation on the policy of immediate notification of management staff of a suspected or witnessed abuse or neany restraint application and Chain of Command. 	nplete e any eglect or	03/26/16	
	inside the room. When noticed Resident #1's bed with a towel and present in the room. I remove the tape and Nurse #1 asked what had applesauce on his face that was drip Nurse #1 stated she w #1 his meds but he w 03/24/16 the DON mereported the incident 03/01/16 and reported Resident #1's right had bed with a comparison of the room of the reported the sident #1's right had bed with a comparison of the room of th	et with NA #1 and she that had occurred on d Nurse #1 briefly restrained and to his bed rail witha			 100% of employees hired to the Skil Nursing Facility after 04/21/16 will re education on Proper Notification of Witnessed / Suspected Abuse or Re Application and Chain of Command. Orientation records for 100% of new to the Skilled Nursing Facility will be audited by the Facility Administrator months to ensure all employees rec training on proper notification. Audit will be reported to the Quality Coord Council and the Skilled Nursing Quant Assurance Committee. 100% of working Skilled Nursing Facilinical and non-clinical and ancillary 	eceive estraint hires for 3 eived t results linating ality	04/21/16	
	pillowcase/towel and resident while providi combative behavior. NA #2 were attemptin	tape to protect herselfand			will complete education on proper notification of witnessed / suspected or restraint application and Chain of Command.	l abuse		
		agitated and beganhitting			4. 100% of working Skilled Nursing Fa clinical and non-clinical and ancillary		04/24/16	

		IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED		
		345306	B. WING			1329	-C	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677			05/03/2016		
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{F 157}	in the face with clear spitting at her. NA #2 wiped Resident #1's 03/24/16 the DON m reported the incident 03/01/16. NA #1 represtrained Resident with a pillowcase/towand resident while p combative behavior. with NA #2 and she is occurred on 03/04/1 Resident #1 in the falotion. On 03/25/16 Inotified of the incide Resident #1's family meeting was reques and on 03/29/16 at 1 with Resident #1's faincidents. A review of facility in completed by the Ac Summary of Investig consistent with the fall		{F 1	57}	will complete the 2016 competence proper notification of witnessed / suspected abuse or restraint appli and Chain of Command.			

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		345306	B. WING _			R-C 05/03/2016		
	ROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677				
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{F 157}	03/04/16 to serve as kicking or spitting at h direction during medic During an interview of Director of Nursing (Ewitnessed Resident # early in the morning by 03/01/16. The DON ewas no restraint used #1 spraying a cleansi #1's face. She further longer employed by the An attempt was made contact Resident #1's unsuccessful. During an interview of the facility Medical Difference was a better was ituation instead of the polybed rail. He explained and on call 24 hours awas his expectation in physician if a resident or exhibited behaviors. He further stated he was about the incidents as they had occurred. An attempt was made contact Resident #1's unsuccessful. During a follow up interpolation of the DON verified notes there was no do the follow up interpolation.	punishment for hitting, her and/or not following her cation administration. on 04/19/16 at 11:08 AM the DON) confirmed NA #1 had with a sam tied to the bedrail before the end of the shift on explained on 03/04/16 there I but NA #2 observed Nurseing body lotion in Resident's riverified Nurse #1 was no	{F 1	57}				

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{F 157}	was notified during the and the family was unthe administrative stated a resident had a charnursing staff to notify should notify the respise had known the mand he had been spracleansing body lotion physician and responduring an interview of Administrator stated in nursing staff should he physician and responduring an interview of Administrator stated in the physician and responduring the physician a	nfirmed Resident #1's re of the incidents until he e investigation on 03/25/16 naware of the incidents until ff met with them on it was her expectation when age in status she expected the physician and they consible party. She stated if norning of 03/01/16that d been tied to the bed rail ayed in the face with the she would have notified the sible party immediately. n 04/20/16 at 4:23 PM the t was her expectation that ave reported immediately to ponsible party when as restrained to the bed rail 1 was sprayed in the face dylotion.	{F 1	57}				
{F 221} SS=D	483.13(a) RIGHT TO PHYSICAL RESTRAI		{F 2		CORRECTIVE ACTION FOR AFFECT RESIDENT	ED		
	physical restraints im discipline or convenie	right to be free fromany posed for purposes of ence, and not required to			 On March 1, 2016, NA #1 reported she promptly removed the restrain The Facility Administrator recalled 	nt.	03/01/16	
	This REQUIREMENT by:	edical symptoms. Γ is not met as evidenced			March 4, 2016, Nurse #1 had request with her and during that mee expressed frustration with Resident behavior. Nurse #1 reported bein	uested to eting nt #1's		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		345306	B. WING				03/2016
IREDELL MEMORIAL HOSPITALINC (X4) ID PREFI X TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	557 ST	REET ADDRESS, CITY, STATE, ZIP CODE TATESVILLE, NC 28677 PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
{F 221}	Based on observation interviews, police interviews,	ons, staff and physician erview and record reviews obtect a resident's right to be aint when staff restrained a ical symptoms. As a resultaresident's arm to the bedrail ured the towel with a plastice became combative during int sampled for abuse. began on 03/01/16 when Resident #1's right arm to inedical symptoms to warrant and Medicaid with an information of compliance (AOC) on conducted on 05/03/16 to of the ongoing Immediate by provided documentation wing: fin-servicing on abuse of audits for abuse, use of ian notification. Of care plans revised and oridualized for residents' care into additional allegations of	{F 2	221}	and crying during her shift the e before. When questioned, Nursidenied anything further happenis Facility Administrator asked Nurshe felt she needed to take som work, and Nurse #1 responded had only one more shift to work was going to be on vacation from March 13. The Facility Administrator asked Nurse #1 was experiencing and decided to immediately rem #1 from Resident #1's care. Nursh not assigned to provide care for #1 after this meeting and through duration of her employment. 3. Since the facility is committed to restraint-free and use of restraint tolerated, Nurse #1 was suspen March 24, 2016 at 4:45 p.m. 4. Upon learning of restraint applicalleged abuse, Director of Nursi Skilled Nursing Facility (DON) a Resident #1 on March 25, 2016 sign of injury. Review of the parmedical record by the DON and Administrator on March 25, 201 no documentation of any signs of Resident #1's eyes, face, arm, of during subsequent shifts following subsequent shifts following leged events. 5. Suspension of Nurse #1 continues the nurse's employment on M 2016 for application of restraint. did not return to work or provide resident care from March 24, 20 March 30, 2016.	e #1 ng. The se #1 if ne time off that she and then m March 5 istrator burn-out, nove Nurse rse #1 was Resident hout the being tts is not ded on ation and ng of the ssessed noting no ient's Facility 6, revealed of injury to or wrists ng the ed rmination larch 30, The nurse any	03/24/16 03/25/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(S) N	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345306	B. WING		05/03/2016	
	ROVIDER OR SUPPLIER	ıc		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677		
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{F 221}	all documentation to sinterviews with the factoriector of Nursing prosupport corrective act the immediate jeoparescope and severity of with potential for more	support the AOC and cility's Administrator and ovided sufficient evidence to tion by the facility to remove dy at F- 221 at a lower (D) isolated, no actual harm that is	{F 221	CORRECTIVE ACTION FOR OTHER RESIDENTS 1. Review of weekly skin assessment March 2, 2016, March 9, 2016, Mar 2016, and March 23, 2016 by the E revealed no documentation or repo any injuries or wounds potentially secondary to application of restrain	rch 16, DON orts of	
not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action.	s of monitoring the		Staff interviews and a root cause at were immediately initiated upon red NA #1's report of restraint application	ceiving		
				3. NA #1 was suspended on March 28 at 1:25 p.m. for failure to immediate notify management staff of the obsapplication of restraint. 3. NA #1 was suspended on March 28 at 1:25 p.m. for failure to immediate notify management staff of the obsapplication of restraint.	ely	
failure, chr dementia, A review of Data Set (Resident # and exhibit directed to on staff for extremity if further review of psychotrol receiving for	A review of the most of Data Set (MDS) dated Resident #1 was severand exhibited physical	andschizophrenia. recent quarterlyMinimum		 Education on the Statement of Res Free Facility and the importance of Immediately following the Chain of Command if application of restraint observed was provided to NA #1 at time of suspension and prior to her to work on April 2, 2016. 	is t the	
	on staff for activities of extremity impairment further revealed restrance. A review of a care plate psychotropic's revealed.	daily living and had upper on one side. The MDS ints were notused. In dated 02/15/16 titled and Resident #1 was Risperdal for behavior		 As of Friday, March 25, 2016, the Dand Facility Administrator have been rounding separately on all three shill least three times per week to confirm understanding of the restraint-free and to meet with staff regarding an questions or concerns. 	en ifts at rm the policy	
	behavior will be mana dose of medications. listed to observe for s as anxiety, somnolen or headaches and ob	aged by lowest possible The interventions were ide effects of Prozacsuch ce (drowsiness), dizziness serve for side effects of usea, constipation, sedation		 On March 29, 2016, interviews wer conducted by the DON with all aler oriented long-term residents who w residents of the facility during the ti the alleged events. All residents verbalized that they had no compla about the care they had received. 	t and vere me of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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{F 221}	02/17/16 tiled psycho was discontinued and Zyprexa and to continued behavior will be manadose of medications.	n with a revised date of tropic's indicated Risperdal I Resident #1 was started on the goal that resident's aged by lowest possible The interventions were ide effects of Zyprexa such	{F 22	21}	7. Interviews were conducted with 18 Nursing Facility clinical staff members the DON and the Facility Administ from March 24, 2016 – March 29, inquire whether any other instance restraint application or suspicious had been witnessed or observed wother residents. No concerns were identified.	pers by rator 2016 to es of injury with any	03/29/16	
	A review of a care plan with a revised date of 02/22/16 titled psychotropic's indicated Prozac and Zyprexa were discontinued. A review of a care plan with a revised date of 02/29/16 titled psychotropic's indicated Seroquel 25 milligrams was started for schizoaffective disorder and the goal indicated that resident's behavior will be managed by lowest possible dose of medications. The interventions were listed to observe for side effects of Seroquel such				8. Additionally, on March 25, 2016 at March 29, 2016, the DON or Facil Administrator interviewed 3 physic who have the majority of the resid the Skilled Nursing Facility, includi SNF Medical Director, to inquire withey had any concerns about the crendered or restraint application for their residents. No concerns were identified. SYSTEMIC CHANGES	ity sians ents on ing the whether care or any of	03/29/16	
	7:00 AM shift from 02 revealed Nurse #1 an assigned to care for F A review of a nurse's AM by Nurse #1 reve quietly off and on all r requests were verbali A review of a nurse's AM by Nurse #1 reve combative during attemedications and spit toward staff. The note	nedule for the 11:00 PM - //29/16 through 03/01/16 d Nurse Aide (NA) #1 were Resident#1. note dated 03/01/16 at 4:49 aled Resident #1 had slept hight and no complaints or zed.			1. To mitigate this type of event from reoccurring, on March 24, 2016, M 2016, and March 26, 2016, all Skil Nursing Facility clinical and non-cl staff was provided education by th prior to the start of shift on the polimmediate notification of manager staff of any suspected or witnesse restraint application. Specific disc points included the facility's comm maintaining a restraint-free environand the use of restraints for medic symptoms or convenience are not tolerated. Education included a discussion of restraint alternatives utilize in response to aggressive or combative residents, to include no of Nursing Supervisor, Resident's physician, and Responsible Party calling Security or transferring residents.	March 25, led inical e DON icy of ment d ussion itment to ment al	03/26/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2)MU IDENTIFICATION NUMBER: A. BUILI			DNSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
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{F 221}	shoot staff and attem with the resident were A review of a nurse's 9:57 PM revealed Re	pts to redirect and reason unsuccessful. notes dated 03/01/16 at sident #1 resting in bed with	{F 2:		No Skilled Nursing Facility staff m are allowed to work until they hav received this education. 2. On 3/29/16 and 3/31/16, Skilled N Facility staff was provided educat DON on managing challenging be	e lursing ion by the	03/31/16
	no complications. A review of nursing a through 03/31/16 review of a handwrewealed on Monday with Nurse #1 and Recombative. The state #1 helped NA #1 chaine was changed NA to other residents and a residents, NA #1 noti	ment further revealed Nurse nge Resident #1 and after #1 left the room to check on after she finished with other ced Nurse #1 was still in			and resident rights. 3. During the Root Cause Analysis, "Chain of Command" policy was reported by the Director of Nursing and Fa Administrator and determined to lappropriate. The Chain of Commandiate supervisor when reported event if their supervisor is unrespunavailable. Because the Chain Command was not enacted at the the March 1, 2016 and March 4, a events, it was determined that ad staff education was indicated.	the eviewed cility be and eass their ting an onsive or of etime of 2016	03/30/16
	#1 needed any help. when NA #1 opened Nurse #1 fighting with arm tied to the bed w wrapped around it. To revealed NA #1 immed and towel from Residual straightened him up it sideways in the bed. During an interview of NA #1 she confirmed written statement and she started her shift a worked until the end 03/01/16. She explain	ediately removed the tape			 The root cause analysis was com April 1, 2016. The investigation rethat Nurse #1 felt frustrated and a "wit's end" with resident's combat and she willfully violated the facili Restraint-Free policy. NA #1 received that the restraint application should been immediately reported, but on withhold the report due to person reasons. It was determined that additional education needed to be provided to Skilled Nursing Facility the facility's Restraint-Free policy examples of restraints, the importing mediate notification of restraint application, and methods of dealif frustration or burn-out. On 4/09/16, the Director of Nursing Facility the facility is restrainted to the importing mediate notification of restraints. 	evealed at her iveness ty's ognized ld have pted to al e ty staff on , tance of	04/01/16 Ongoing
		athered up the dirty linens			implemented "Daily Reminders" f		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		2)MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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finished disposing of the noticed Resident #1's concerned her because his door closed. NA # opened the door Nurseleft side of the bed and NA #1 stated she ther right arm near his write with a towel. She experies wrapped around the best wrapped around the best wrapped multiple times secure it. She verified #1's arm was restrain stated she was sure it a pillow case. She stated the resident and he wone side to the other the head of the bed and the bed. She explained pretty tight around his movement of his right Resident #1 was unal because of left sided he could not have renright arm. She stated the towel and started released his arm and applesauce with particular solution that looked lift face. She explained Not tried to give Resident but he was combative her. NA #1 stated she tied Resident #1's arr him more. She descriptions.	the linen and trash she door was closed and it se they did not usually leave 1 explained when she se #1 was standing on the d told her to close the door. In observed Resident #1's set was tied to the bedrail lained the towel was ledrail then around Resident se ends of the towel were clastic medical tape was set around the towel to a she observed Resident ed with a white towel and it was not sted she immediately went to as lying across the bed from instead of his head toward and his feet toward the foot of set the towel was wrapped arm and he had limited arm. She further explained ble to use his left arm weakness from a stroke so moved the towel from his a she immediately grabbed pulling the tape off and she noticed he had cles of medication in it and a ke body cleanser on his large #1 told her she had #1 his morning medications and was spitting themat e thought when Nurse#1 in to the bed rail itagitated	{F 2	21}	clinical staff. These reminders are printed document on a topic relateresident care selected by the Dire Nursing. Topics include challenging behaviors, care of the resident wit dementia, resident rights, and other pertinent topics. The reminders a posted for all staff members to revidaily seven days/ week. 6. On April 12, 2016, the Regional Ombudsman provided mandatory education to Skilled Nursing Facilic clinical and non-clinical staff regar resident rights, including the right free from restraints. A second traisession with the Regional Ombud scheduled for April 27, 2016. 7. On April 21, 2016, the Skilled Nurseacility clinical and non-clinical stannual competencies and the orie checklists were expanded to incluse Specific education on: Restraint-free Environment Managing Challenging Behave Chain of Command Proper Notification of Restrate Application Caregiver Fatigue New employees will receive this educing departmental orientation to Skilled Nursing Facility. Current employees will receive this education annually during staff competencies. On April 22, 2016, these same togaded to the list of annual competencies.	to to ctor of ang the ctor of ang the	04/27/16	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI		CONSTRUCTION	(X3) DATE:	SURVEY LETED
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{F 221}	going to be combative #1 sometimes made remarks and sometine staff during care but a stopped what she wad to provide his care ar cooperative. During an observation #1 provided a demone #1's arm was tied to resident room and the were present for the turned the bed diagon parallel with the wall up position on the rig requested the DON to side to side with her and NA #1 wrapped to then around the DON ends of the towel tog it with Transpore met hypoallergenic, trans tape that offers stron the tape was the san had been used to tap arm. A review of a typed so Nurse #1 revealed in	e. She explained Resident inappropriate verbal nes would hit and kick at she redirected him or s doing and went back later and then he usually was non 04/19/16 at 2:30 PM NA stration of how Resident the bedrail in an empty e DON and Administrator demonstration. NA #1 nally so that it was no longer and the side rails were in the ht side of the bed. NA #1 to lie across the bed from back resting on the side rail he towel around the side rail lt's right wrist and twisted the ether and taped it to secure dical tape (a latex-free, parent and perforated plastic g adhesion). NA #1 verified ne plastic medical tape that he towel on Resident #1's statement dated 03/28/16 by part that taking care of	{F 2:		required for any staff providing car treatment, or services to residents Skilled Nursing Facility. 9. Education was provided to all Skill Nursing Facility clinical and non-clistaff and ancillary staff that provide treatment, or services to residents Skilled Nursing Facility via a comp based learning module from April 2016 on the following topics: • Resident's Rights • Restraint-Free Environment • Proper Notification of Restra Application • Managing Challenging Beha • Chain of Command • Caregiver Fatigue After April 24, 2016, no staff will be allowed to work on the Skilled Nur Facility until this education has be completed. 10. Education was provided to all Skille Nursing Facility clinical and non-clistaff and ancillary staff that provide residents of the Skilled Nursing Facility's commitment to remain resfree and examples of restraints fro 22 – 24, 2016.	ed inical e care, of the uter-22 – 24, int viors	04/24/16
	aggressive and combine revealed on one night while discussing Resonursing supervisor slato secure Resident # and release them who document indicated lease.	cult because he was very pative. The document further at (no date was indicated) ident #1 with the night shift are suggested we mightwant 1's wrists while cleaning him are ne we were finished. The later that night or the next ated) Resident #1 was			1. 100% of working Skilled Nursing F clinical and non-clinical staff will concentration on the policy of immedian notification of management staff of suspected or witnessed abuse or or any restraint application, restraint environment, & restraint alternative.	omplete ate f any neglect nt-free	03/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			ECONSTRUCTION	COMPLETED R-C		
		345306	B. WING _				03/2016	
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{F 221}	cursing and combative supervisor who said to have time for that so is situation for staff and soft pillowcase and so Resident #1's left wrist document revealed Resident was not at them. The document	ontinued From page 16 prising and combative and Nurse #1 called the apervisor who said to call security but we did not exe time for that so in an effort to provide a safe muation for staff and resident Nurse #1 took a suff pillowcase and some tape and secured esident #1's left wrist to the side rail. The accument revealed Resident #1 could still move arm but was not able to swing his arm at earn. The document indicated we cleaned and positioned him, then Nurse #1 released the		21}	 100% of working Skilled Nursing F staff will complete education on m challenging behaviors and resider The Facility Administrator will mor weekly to ensure that seven "Daily Reminders" were posted by the D the staff. Monitoring will continue months and results will be reporte Quality Coordinating Council and Skilled Nursing Facility Quality As Committee. 	anaging at rights. iitor ON for for 3 d to the the	04/22/16 Ongoing	
	pillowcase, all taking document indicated N always in the room do	less than 5 minutes. The lurse #1 stated she was			100% of working Skilled Nursing Figure 100% of working Figure 100% of work		04/27/16	
	O4/19/16 at 2:00 PM is answer and no option. During a phone interview with the night shift Nushe had not instructed #1's arm to the bed rarounds during the shift to call her when a result She further stated it with #1 should have called tied Resident #1's arm explained staff should Resident #1 when he	iew on 04/19/16 at 4:36 PM rsing Supervisor she stated If Nurse #1 to tie Resident hil. She stated she made it and was available for staff ident was out of control. It was her expectation Nurse If her and should not have			 100% of employees hired to the S Nursing Facility after 04/21/16 will education during orientation on refree environment, managing chall behaviors, chain of command, pronotification of restraint application caregiver fatigue. Orientation rec 100% of new hires to the Skilled N Facility will be audited by the Facility will be received training on the items. Audit results will be reported Quality Coordinating Council and Skilled Nursing Quality Assurance Committee. 100% of working Skilled Nursing I clinical and non-clinical and ancilled. 	receive straint- enging per , and ords for Jursing lity ure all ese ed to the the ese establishment of the ese establishment of the ese establishment of the ese establishment of the establishment of	Ongoing 04/24/16	
	A review of facility inv completed by the Adr Summary of Investiga determined Nurse #1 consistent story. The	providecare. estigation dated 03/30/16 ninistrator titled Final			will complete the 2016 competend proper notification of witnessed / suspected abuse or restraint appl 7. 100% of working Skilled Nursing I clinical and non-clinical and ancilla will complete education on resider rights, restraint-free environment,	cy on ication. Facility ary staff nt's	04/24/16	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED R-C	
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{F 221}	hand that was restrain room, when the restrain a Nurse Supervisor of further indicated Nurse fact she restrained Repillowcase and tape of therefore, it was concrestrained Resident #A review of a facility of Administrator titled A Abuse/Restraint date summary of interview indicated on 03/01/16 when they provided resident #1's room for a short of the common for a short of the commo	aint was actually applied or if was notified. The report se #1 was consistent with the esident #1's hand with a to avoid being hit so cluded Nurse #1 intentionally #1. document completed by the allegation of Resident ed 03/30/16 revealed a brief ws of staff. The document 60 NA #1 assisted Nurse #1 morning care to Resident #1. providing peri care then left period of time to do other hished she noticed the door m was closed so she went en she entered the room she is right hand was tied to the was taped. Nurse #1 was NA #1 immediately began to towel to free his hand but it she was doing. Nurse #1 go to give Resident #1 his	{F 2	221}	notification of restraint application managing challenging behaviors, command, and caregiver fatigue. 8. During rounding 3 times per weel months, the DON and Facility Administrator will ensure that all rare free from restraints. Audit respected to the Quality Coordi Council and the Skilled Nursing FQuality Assurance Committee.	chain of k for six residents sults will nating	Ongoing	

	OF DEFICIENCIES FCORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{F 221}	witnessed Resident # early in the morning b 03/01/16. She further longer employed by the During an observation door of Resident #1's sitting calmly in a chadoor. An over bed tall he was moving items with his right hand an observed. During an observation the door of Resident #1 sitting up the over bed table in quietly and as staff sp calm voice and raised when staff walked by restraints observed. During an interview of Assistant Chief of Pol family reported the incarm to the bedrail to the department. He explainvestigation and issuarrest. He further exp the police station and she confessed to tying bed rail. He explained was taken to jail on 2 handicapped person a imprisonment. He fur been released from jail.	e also confirmed NA #1 had et's arm tied to the bedrail efore the end of the shift on verified Nurse #1 was no he facility. n on 04/19/16 at 1:00 PM the room was open and he was ir in his room facing the ble was in front of him and on top of the table around d there were no restraints n on 04/20/16 at 10:35 AM #1's room was open and in a chair in his room with front of him. He was sitting toke to him he replied in a if his right hand to wave his door and there were no n 04/19/16 at 1:15 with the ice he verified Resident #1's cident of tying Resident #1's he police at the police ined they conducted an ed a warrant for Nurse #1's blained Nurse #1 came to was taken into custody and g Resident #1's arm to the d after being processed she counts of assault on a and 1 count of false ther explained she had	{F 2	21}			

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\$10000\$0000\$0000\$0000\$	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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{F 221}	the facility Medical I facility was a restrai thought there was a the situation instead the bed rail. He explresident exhibited by them to monitor them. During a follow up in PM the DON stated facility and there she for use of physical reconvenience and the for restraints to be used the form to be used on interventions to han behaviors. She expless have had a care plainterventions for state behaviors. She state included for staff to help from coworkers resident exhibited by when they exhibited members because swould calm the resident in the face and the fac	Director he confirmed the nt free facility. He stated he better way to have handled of tying the resident's armto ained usually when a chaviors someone sat with m. Atterview on 04/20/16 at 2:58 they were a restraint-free bould be absolutely no reason estraints or restraints used for ere were no medical reasons used for Resident #1. She her expectation that staff ther least restrictive dle Resident #1's combative ained Resident #1 should in for behaviors with specific ff to use when he exhibited end interventions should have step away or reach out for so r supervisors when a chaviors or redirect residents to behaviors or change staff sometimes different staff	{F 22	21}				

Facility ID: 933284

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(X4) ID PREFI X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 221}	Continued From page 4:02 PM.	e 20	{F 22	21}			
{F 223} SS=D	483.13(b), 483.13(c)(ABUSE/INVOLUNTAR		{F 22	50	CORRECTIVE ACTION FOR AFFECT RESIDENT	ED	
	The resident has the sexual, physical, and punishment, and invo	right to be free from verbal, mental abuse, corporal luntary seclusion.			 On March 1, 2016, NA #1 reported she promptly removed the restrain cleaned Resident #1's face and repositioned him in bed. 	17	03/01/16
		use verbal, mental,sexual, orporal punishment, or			 On March 4, 2016, NA #2 reported immediately cleaned Resident #1' remove the lotion. 		03/04/16
	by: Based on observation interviews, police into the facility failed to pure free from physical abbecame combative durse restrained the with a towel and sect sprayed the resident with a cleansing bod sampled for abuse (for the immediate Jeopardy #1 witnessed Nurse right arm to the bed taped with a plastic right arm to the bed taped with a plastic right arm to the bed taped with a clean combative behavior.	began on 03/01/16 when NA #1 had tied Resident#1's rail with a towel that was medical tape and Nurse#1 had sprayed Resident #1 in sing body lotion due to his			 The Facility Administrator recalled March 4, 2016, Nurse #1 had requested with her and during that mee expressed frustration with Resider behavior. Nurse #1 reported bein and crying during her shift the even before. When questioned, Nurse denied anything further happening Facility Administrator asked Nurse she felt she needed to take some work, and Nurse #1 responded the had only one more shift to work, a was going to be on vacation from — March 13. The Facility Administ Nurse #1 was experiencing burned decided to immediately remove N from Resident #1's care. Nurse #1 not assigned to provide care for R #1 after this meeting and throughed duration of her employment. Since the facility is committed to be restraint-free and use of restraints tolerated, Nurse #1 was suspendent. 	nested to being nt #1's g upset ning #1 g. The e #1 if time off at she and then March 5 trator felt but, and urse #1 1 was desident but the being is not eed on	03/04/16
		ardy is present and ongoing.			March 24, 2016 at 4:45 p.m. pend investigation of the alleged abuse		
		the State Agency and the e and Medicaid withan			Upon learning of restraint applicate alleged abuse, the Director of Nur	ion and sing of	03/25/16

Facility ID: 933284

	DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	On Section Association and Control of Contro				R-	c
	345306	B. WING _			05/0	03/2016
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
IREDELL MEMORIAL HOSPITALING		557 BROOKDALEDRIVE				
SENSORS CONSULTED VISION CONSULTABLES CONTRACTOR CONTRA			ST	ATESVILLE, NC 28677		
(X4) ID SUMMARY STATEMENT PREFI (EACH DEFICIENCY MUST X TAG REGULATORY OR LSC IDE		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	C. Constant	(X5) COMPLETION DATE
F 223} Continued From page 21 acceptable allegation of cor 04/29/16. A revisit survey was conductermine the status of the Jeopardy. The facility provifor review of the following: - Evidence of staff in-se prohibition and use of restration of auditestraints and physician notes and phys	ucted on 05/03/16 to e ongoing Immediate rided documentation ervicing on abuse raints. lits for abuse, use of otification. e plans revised and zed for residents' care ditional allegations of 6. are, interviews with and interviews with on 05/03/16, review of ort the AOC and a Administrator and ad sufficient evidence to by the facility to remove F-223 at a lower scope II, no actual harm with himal harm that is not the facility continues the implementation of ety Data Sheet (MSDS) he body cleanser used Remedy, 4-in-1 body appearance as a thin heet further indicated it a skin irritant but with	{F 22	CFF	the Skilled Nursing Facility (DON) assessed Resident #1 on March 25 noting no sign of injury. Review of patient's medical record by the DO Facility Administrator on March 25, revealed no documentation of any injury to Resident #1's eyes, face, a wrists during subsequent shifts follathe alleged events. 6. Nurse #1 was terminated by the Di Nursing for allegation of abuse and improper application of restraint. CORRECTIVE ACTION FOR OTHER RESIDENTS 1. Review of resident weekly skin assessments on March 2, 2016, Ma 2016. March 16, 2016, and March 2 2016 by the DON revealed no documentation or reports of any inj wounds potentially secondary to ab 2. Staff interviews and a root cause a were immediately initiated on Marc 2016 by the Director of Nursing and Facility Administrator. 3. As of Friday, March 25, 2016, the D and Facility Administrator have bee rounding separately on all three shi least three times per week to confir understanding that there is no toler abuse in the facility and to meet wit regarding any questions or concern 4. Interviews were conducted with 18 Nursing Facility clinical staff memb the DON and the Facility Administra from March 24, 2016 – March 29, 2	the N and 2016, signs of arm, or owing rector of l arch 9, 23, uries or ouse. nalysis h 24, d OON en ifts at m ance of th staff ns. Skilled ers by ator	03/30/16 03/23/16 03/24/16 Ongoing

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPL	ETED .				
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			ID PREFI	55 S1	TREET ADDRESS, CITY, STATE, ZIP CODE TATESVILLE, NC 28677 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	ULD BE COMPLETION	
X TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
{F 223}	Resident #1 was adm 09/24/15 with diagnor failure, chronic obstrudementia, psychosis A review of the admis (MDS) dated 10/01/15 severely impaired in behaviors. The MDS #1 required extensive bathing and hygiened staff for bed mobility extremity impairment. A review of the most Data Set (MDS) date Resident #1 was severed and exhibited physical directed toward other.	ninutes and seek medical ersists. nitted to the facility on ses which included heart ctive lung disease, stroke, and schizophrenia. sion Minimum Data Set indicated Resident #1 was cognition and exhibited no further indicated Resident erassistance for transfers, but was totally dependent on and toileting and had upper on one side.	{F 2	223}	inquire whether any other instance restraint application or suspicious had been witnessed or observed wother residents. No concerns were identified. 5. On March 29, 2016, interviews we conducted by the DON with all also oriented long-term residents who residents of the facility during the the alleged events. All residents verbalized that they had no compliabout the care they had received. 6. Additionally, on March 25, 2016 at 29, 2016, the DON or Facility Adminterviewed 3 physicians who have majority of the residents on the Sk Nursing Facility, including the SNF Medical Director, to inquire whether had any concerns about the care for any of their residents. No concerns identified.	injury with any e ere ert and were time of laints and March hinistrator e the killed er they rendered	03/29/16
	A review of a staff sci 7:00 AM shift from 02 revealed Nurse #1 ar assigned to care for I A review of a handwr revealed on Monday with Nurse #1 and Re combative. The state #1 helped NA #1 cha he was changed NA so other residents and a	nedule for the 11:00 PM - 2/29/16 through 03/01/16 ad Nurse Aide (NA) #1 were Resident#1. itten statement by NA#1 night 02/29/16 sheworked			 To mitigate this type of event from reoccurring, on March 24, 2016, M 2016, and March 26, 2016, all Ski Nursing Facility clinical and non-c staff was provided education by the prior to the start of shift on what is considered abuse and types of ab Skilled Nursing Facility staff member allowed to work until they have rethis education. On 3/29/16 and 3/31/16, Skilled N Facility staff was provided education resident abuse by the Director of Indiana. 	March 25, Illed Ilinical ne DON souse. No bers are ceived	03/26/16

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF- PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SUF- COMPLET						
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		345306	B. WING			0000	03/2016
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{F 223}	Resident #1's room so #1 needed any help. when NA #1 opened to Nurse #1 fighting with arm tied to the bed wi wrapped around it. The revealed NA #1 imme and towel from Reside straightened him up in sideways in the bed. During an interview of NA #1 she confirmed in	o she went to see if Nurse The document indicated the door she witnessed Resident #1 and had his th a bath towel and tape ne document further diately removed the tape ent #1's arm and n bed because he was lying 104/19/16 at 2:08 PM with she worked the night shift	{F 223	3.	During the Root Cause Analysis, the "Chain of Command" policy was reby the Director of Nursing and Fac Administrator and determined to be appropriate. The Chain of Command policy specifies that staff may bypa immediate supervisor when report event if their supervisor is unrespound available. Because the Chain of Command was not enacted at the the March 1, 2016 and March 4, 20 events, it was determined that add staff education was indicated.	eviewed ility e and ass their ng an nsive or f time of 016 itional	03/30/16
	03/01/16. She explain 03/01/16 Nurse #1 he #1. She stated she ga and trash and left the finished disposing of the noticed Resident #1's concerned her because his door closed. NA # opened the door Nurseleft side of the bed and NA #1 stated she ther right arm near his wrise with a towel. She explored wrapped around the be #1's wrist and then the twisted together and purapped multiple times secure it. She verified #1's arm was restrain stated she was sure it a pillow case. She sta	te #1 was standing on the d told her to close the door. In observed Resident #1's st was tied to the bedrail lained the towel was edrail then around Resident e ends of the towel were blastic medical tape was		5.	on April 1, 2016 by the Director of and Facility Administrator. Following resident, staff, and physician intervand medical record reviews, it was determined that no other residents affected by these events and no networks were identified. The investigation revealed that Nurse #1 felt frustrate at her "wit's end" with resident's combativeness and she willfully violate facility's Restraint-Free policy. did not recognize that spraying Refull in the face with cleansing lotion form of abuse even if it was immediated addressed and did not result in har was determined that additional eduneded to be provided to Skilled N. Facility staff on the definition of abuse examples of abusive behavior, main challenging behaviors, and method dealing with frustration or burn-out.	were ew igation ed and blated NA #2 sident was a diately rm. It ucation ursing use and naging ds of	Ongoing
	one side to the other i	as lying across the bed from nstead of his headtoward nd his feet toward the foot of id the towel was wrapped		5.	On 4/09/16, the Director of Nursing implemented "Daily Reminders" for clinical staff. These reminders are printed document on a topic related	r all a	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED				
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NAME OF PROVIDER ORSUPPLIER IREDELL MEMORIAL HOSPITALINC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL X TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	5! S X	TREET ADDRESS, CITY, STATE, ZIP CODE 57 BROOKDALEDRIVE TATESVILLE, NC 28677 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
pretty move Resid because he countries and a front of face work are turned parall up poor eque side to face work and a front of face work and a fr	ment of his rightent #1 was unause of left sided uld not have rearm. She stated wel and started sed his arm. She yed the towel from the solution was also for his gown. She was yellow in consert they used a care. She explains #1 spray Reside #1 had told he with the body class not able to ruise his right harm was tied to the present for the did the bed diagonal with the wall as sitted to the present for the did the bed diagonal with the wall as sitted to the present for the did the bed diagonal with the wall as sitted the DON to side with her last #1 wrapped the pround the DON to for the towel tog. Transpore meallergenic, trans hat offers stron pe was the same	s arm and he had limited t arm. She further explained ble to use his left arm weakness from a strokeso moved the towel from his she immediately grabbed pulling the tape off and e explained after she om his arm she noticed he pieces of medication init I over his face and on the e stated the solution on his olor and looked like body is a lotion/cleanser during ned she did not witness dent #1 in the face but that in she sprayed him in the eanser. She stated Resident is the lotion off his face and was tied to the bed rail. In on 04/19/16 at 2:30 PM NA stration of how Resident the bedrail in an empty e DON and Administrator demonstration. NA #1 nally so that it was no longer and the side rails were in the ht side of the bed. NA#1 to lie across the bed from back resting on the side rail I's right wrist and twisted the ether and taped it to secure dical tape (a latex-free, parent and perforated plastic g adhesion). NA #1 verified ne plastic medical tape that e the towel on Resident #1's	{F 2	223}	resident care selected by the Direct Nursing. Topics include challenging behaviors, care of the resident with dementia, resident rights, and other pertinent topics. The reminders are posted for all staff members to revidaily seven days/ week. 6. On 4/12/16, the Regional Ombuds provided mandatory education to cand non-clinical Skilled Nursing Fastaff regarding resident rights, include right to be free from abuse. The training session will be repeated by Regional Ombudsman on 4/27/16. 7. On April 21, 2016, the Skilled Nursing Facility staff annual competencies orientation checklist were expanded include specific education on: Managing Challenging Be Caregiver Fatigue Chain of Command New employees will receive this education during departmental oriet to the Skilled Nursing Facility. Curemployees will receive this education during staff competencies. 8. On April 22, 2016, these same top added to the list of annual competer required for any staff providing cartreatment, or services to residents Skilled Nursing Facility. 9. Education was provided to all Skill Nursing Facility clinical and non-clistaff and ancillary staff that provide treatment, or services to residents Skilled Nursing Facility via a competencies.	man dinical cility uding his y the ing and the doto haviors entation rrent ion s. ics were encies e, of the ed inical e care, of the	04/27/16 04/21/16 04/22/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 2	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{F 223}	Administrator titled A Abuse/Restraint data revealed a brief sum. The document indica assisted Nurse #1 w care to Resident #1. providing peri care the period of time to do finished she noticed room was closed so When she entered the #1's right hand was and was taped and Noroom. NA #1 immeditape and towel to free asked what she was revealed Resident #	document completed by the illegation of Resident ed 03/24/16-03/30/16 mary of interviews of staff. ated on 03/01/16 NA#1 hen they provided morning	{F 223	based learning module from Apri 2016 on the following topics: Resident's Rights Managing Challenging B Caregiver Fatigue, include access to EAP Program Chain of Command 10. Additionally all clinical and non-constitution of Skilled Nursing Facility staff were education from April 22 -24, 2016 actions to be taken in response to event where resident or staff safe jeopardy ("5 Rights of Duty To Rown These actions include providing a environment for the resident, speabout the event, documenting the enlisting help from co-workers, a ensuring staff safety. After April no staff will be allowed to work of Skilled Nursing Facility until this chas been completed. MONITORING	dehaviors ding dinical e provided 3 on o a safety ety are in eport"). a safe eaking up e event, and 24, 2016 on the	04/24/16
	down the front of hin trying to give Reside was not listening. Or NA #1 and she repo occurred on 03/01/10	n. Nurse #1 stated shewas int #1 his medications buthe n 03/24/16 the DON met with red the incident thathad 3. NA #1 reported Nurse #1 sident #1's right hand tohis		100% of working Skilled Nursing clinical and non-clinical staff will education on what is considered and types of abuse.	complete	03/26/16
	bed rail with a pillow protect herself and recare due to combative indicated on 03/04/1 attempting to get Resit to stand lift and of became agitated and continuously and aft chair NA #2 turned as she sprayed Reside cleansing lotion due	case/towel and tape to esident while providing peri we behavior. The document 6 Nurse #1 and NA #2 were sident #1 up out of bed with a ver to a chair. Resident#1 d began hitting and spitting er he was transferred to his and observed Nurse #1 as		 100% of working Skilled Nursing staff will complete education on abuse. The Facility Administrator will moweekly to ensure that seven "Da Reminders" were posted by the I the staff. Monitoring will continue months and results will be report Quality Coordinating Council and Skilled Nursing Facility Quality A Committee. 	esident onitor illy DON for e for 3 ed to the	04/22/16 Ongoing

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII			RUCTION	(X3) DATE S	
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{F 223}	met with NA #1 and s	off. On 03/24/16 the DON he reported the incident that	{F 2	23}		100% of working Skilled Nursing Facilinical and non-clinical staff will retraining on resident rights.	acility ceive	04/27/16
had occurred on 03/01/16. NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tapeto protect herself and resident while providing peri care due to combative behavior. On 03/25/16 the DON met with NA #2 and she reported the incident that had occurred on 03/04/16 when Nurse #1 sprayed Resident #1 in the face with cleansing lotion. A review of a typed statement dated 03/26/16 at 1:15 AM by NA #2 revealed she was in Resident #1's room on 03/04/16 with Nurse #1 to get Resident #1 out of bed. The document indicated					100% of employees hired to the Sk Nursing Facility after 04/21/16 will education during orientation on ma challenging behaviors, caregiver fa and chain of command. Orientatio records for 100% of new hires to the Skilled Nursing Facility will be audithe Facility Administrator for 3 morensure all employees received traithese items. Audit results will be reto the Quality Coordinating Councithe Skilled Nursing Quality Assurance Committee.	receive naging tigue, n neted by other to ning on eported I and	Ongoing	
	Resident #1 was con trying to spit on staff) transferred to a chair several times to assis	ed. The document indicated hbative (hitting, kicking and and after Resident #1 was NA #2 asked Nurse#1 st her to get Resident back in In't slide off the edge but			6.	100% of working Skilled Nursing F clinical and non-clinical and ancilla will complete the 2016 competence managing challenging behaviors, caregiver fatigue, and chain of con	ry staff y on	04/24/16
	instead Nurse #1 pro in the face with some which made Residen document further ind	ceeded to spray Resident #1 e lotion base cleansingspray t #1 more aggressive. The icated NA #2 immediately washed the resident's face.			7.	100% of working Skilled Nursing F clinical and non-clinical and ancilla will complete education on residen rights, managing challenging beha caregiver fatigue, and chain of con	ry staff t's viors,	04/24/16
	with NA #2 she expla Resident #1 up to a 0 6:00 AM and 6:30 AN with a sit to stand lift	view on 04/19/16 at 3:02 PM ined Nurse #1 wanted to get chair on 03/04/16 between M and they transferred him from his bed to the chair. #1 was trying to hit them and			8.	100% of working clinical and non-on-on-on-on-on-on-on-on-on-on-on-on-	mplete n resident	04/24/16
	kick them and he wa stated she kept askir position Resident #1 sliding forward but N grabbed a spray bott	s spitting at them. NA #2 ng Nurse #1 to help her in the chair because he was urse #1 ignored her and le of cleansing lotion and times in the face. She			9.	During rounding 3 times per week months, the DON and Facility Administrator will ensure that all reare free from abuse. Audit results reported to the Quality Coordinatin Council and the Skilled Nursing Faquality Assurance Committee.	esidents will be	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3)	COMPLETED R-C		
		345306	B. WING			05/03/2016		
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{F 223}	she got a washcloth a explained when Nurs it startled him and may stated she felt she had washing the lotion of the time did not think. A review of a typed so Nurse #1 revealed in Resident #1 was difficated and revealed on one night while discussing Resolution nursing supervisor shad to secure Resident #1 and release them who document indicated I night (no dates indicated unight (no dates indicated unight (no dates indicated in the supervisor who said thave time for that so situation for staff and soft pillowcase and soft pillowcase and soft pillowcase and soft pillowcase and soft pillowcase, all taking document indicated in always in the room daccepted full responsions. An attempt was mad 04/19/16 at 2:00 PM	on his face at his running down his face so and wiped the lotion off. She e #1 sprayed him in the face ade his agitation worse. She ad taken care of it by f Resident #1's face and at	{F 2	223}				

AND DI AN OECOPPECTION IDENTIFICATION NUMBER:		A. BUILDI		COMPLETED			
	*	345306	B. WING		<u></u>	1500	I-C 103/2016
	ROVIDER ORSUPPLIER	NC		557 E	EET ADDRESS, CITY, STATE, ZIP CODE BROOKDALEDRIVE TESVILLE, NC 28677		
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{F 223}	with the night shift Nushe had not instructed #1's arm to the bed rarounds during the shift to call her when a ress. She further stated it w #1 should have called tied Resident #1's arm not have spayed the face. During an interview of Assistant Chief of Polfamily reported the informarm to the bedrail to department. He explainvestigation and issuarrest. He further explainvestigation and issuarrest. He further explained was taken to jail on 2 handicapped person imprisonment. He further explained was taken to jail on 2 handicapped person imprisonment. He further explained was taken to jail on 2 handicapped person imprisonment. He further explained was taken to jail on 2 handicapped person imprisonment. He further explained was taken to jail on 2 handicapped person imprisonment. He further explained was taken to jail on 2 handicapped person imprisonment. He further explained was taken to jail on 2 handicapped person imprisonment. He further explained was moving items with his right hand. During an observation the door of Resident #1's sitting up the over bed table in	view on 04/19/16 at 4:36 PM ursing Supervisor she stated di Nurse #1 to tie Resident ail. She stated she made ft and was available for staff ident was out of control. was her expectation Nurse di her and should nothave in to the bed rail and should cleansing body lotion in his in 04/19/16 at 1:15 with the lice he verified Resident #1's cident of tying Resident #1's cident of tying Resident #1's the police at the police ained they conducted an ared a warrant for Nurse #1's plained Nurse #1 came to was taken into custody and and Resident #1's arm to the differ being processed she counts of assault on a and 1 count of false other explained she had	{F 2	23}			

PRINTED: 05/04/2016 FORM APPROVED OMB NO. 0938-0391

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calm voice and raised when staff walked by During an interview of the facility Medical Did DON had informed his the incidents that had 03/04/16. He stated hoteler way to have had of tying the resident's During a follow up interpolate a facility Resident #1's spraying him in the facility and interview of Administrator stated is staff to treat residents residents was not told. The facility Administrator and hoteless and the staff to treat residents.	It his right hand to wave his door. In 04/20/16 at 2:24 PM with rector he confirmed the m during the investigation of occurred on 03/01/16 and he thought there was a andled the situation instead arm to the bed rail. Berview on 04/20/16 at 2:58 he considered the incidents arm to the bed rail and he with the cleansing lotion explained there was a zero in the facility. In 04/20/16 at 4:23 PM the transfer was her expectation of a respectfully and abuse of the erated in the facility. In DON, hospital spital Vice President were	{F 2	223}			
4:02 PM. 483.13(c)(1)(ii)-(iii), (ii), (ii), (iii), (iiii), (iii), (iii), (iii), (iiii), (iii), (iii), (iii), (iiii), (iiii), (iiii), (iiii),	c)(2) -(4) ORT VIDUALS employ individuals who have abusing, neglecting, or by a court of law; or have linto the State nurse aide abuse, neglect, mistreatment propriation of their property;	{F :		 On March 1, 2016, NA #1 reported she promptly removed the restraction of the Resident #1's face, a repositioned him in bed. On March 4, 2016, NA #2 reported 	ed that int, and	03/01/16
	DUTING a follow up into post tying the resident's praying him in the fact abuse. The DON stated is staff to treat residents residents was not tolerance for abuse in the facility Administrator stated in the facility Administrator stated in the facility Administrator stated in the facility Administrator and honotified of immediate 4:02 PM. 483.13(c)(1)(ii)-(iii), (iii), (iii), (iii) and in the facility must not expense for a finding entered a finding entered and a finding entered and fresidents or misaper of residents or misaper or misaper or misaper or	DUIDER ORSUPPLIER EMORIAL HOSPITALINC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 calm voice and raised his right hand to wave when staff walked by his door. During an interview on 04/20/16 at 2:24 PM with he facility Medical Director he confirmed the DON had informed him during the investigation of he incidents that had occurred on 03/01/16 and 03/04/16. He stated he thought there was a better way to have handled the situation instead of tying the resident's arm to the bed rail. During a follow up interview on 04/20/16 at 2:58 PM the DON stated she considered the incidents of tying Resident #1's arm to the bed rail and spraying him in the face with the cleansing lotion has abuse. The DON explained there was a zero colerance for abuse in the facility. During an interview on 04/20/16 at 4:23 PM the Administrator stated it was her expectation of residents was not tolerated in the facility. The facility Administrator, DON, hospital Administrator and hospital Vice President were notified of immediate jeopardy on 04/19/16 at	A BUILDI 345306 B. WING WIDER ORSUPPLIER EMORIAL HOSPITALINC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 calm voice and raised his right hand to wave when staff walked by his door. During an interview on 04/20/16 at 2:24 PM with he facility Medical Director he confirmed the DON had informed him during the investigation of he incidents that had occurred on 03/01/16 and 03/04/16. He stated he thought there was a petter way to have handled the situation instead of tying the resident's arm to the bed rail. During a follow up interview on 04/20/16 at 2:58 PM the DON stated she considered the incidents of tying Resident #1's arm to the bed rail and spraying him in the face with the cleansing lotion as abuse. The DON explained there was a zero colerance for abuse in the facility. 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(c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	A BUILDING 346306 DIVIDER ORSUPPLIER BMORIAL HOSPITALINC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BY YELL REGULATORY ORLSC IDENTIFYING INFORMATION) Continued From page 29 calm voice and raised his right hand to wave when staff walked by his door. During an interview on 04/20/16 at 2:24 PM with he facility Medical Director he confirmed the DON had informed him during the investigation of he incidents that had occurred on 03/01/16 and 33/04/16. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 225}	indicate unfitness for other facility staff to the or licensing authorities. The facility must ensure involving mistreatment including injuries of unisappropriation of reimmediately to the add to other officials in act through established process that it is survey and cert. The facility must have	n employee, which would service as a nurse aide or ne State nurse aide registry s. ure that all alleged violations nt, neglect, or abuse, nknown source and esident property are reported ministrator of the facility and cordance with State law procedures (including to the tification agency). e evidence that all alleged phly investigated, and must tial abuse while the	{F 2	225}	3. The Facility Administrator recalled March 4, 2016, Nurse #1 had required meet with her and during that mee expressed frustration with Residen behavior. Nurse #1 reported being and crying during her shift the ever before. When questioned, Nurse #1 denied anything further happening Facility Administrator asked Nurse she felt she needed to take some the work, and Nurse #1 responded that had only one more shift to work, and was going to be on vacation from 1 — March 13, 2016. The Facility Administrator felt Nurse #1 was experiencing burn-out, and decide immediately remove Nurse #1 from Resident #1's care. Nurse #1 was assigned to provide care for Resident #1 meeting and throughout the duration of her employment.	ested to ting t #1's pupset hing #1 . The #1 if ime off t she hd then March 5	03/04/16
	to the administrator or representative and to with State law (include certification agency) vincident, and if the all appropriate corrective. This REQUIREMENT by: Based on staff interviacility staff failed to in incidents of physical report placed other retrieved.	estigations must bereported or his designated other officials in accordance ling to the State survey and within 5 working days of the leged violation is verified e action must be taken. T is not met as evidenced iews and record reviews the mmediately report witnessed abuse and the failure to esidents at risk for abuse. It to immediately report when ombative during nursing care			 Since the facility is committed to be restraint-free and use of restraints tolerated, Nurse #1 was suspende March 24, 2016 at 4:45 p.m. pendi investigation of the alleged abuse. Upon learning of restraint applicating alleged abuse, Director of Nursing Skilled Nursing Facility (DON) asses Resident #1 on March 25, 2016, no sign of injury. Review of the patient medical record by the DON and Factorial and the patient medical record by the DON and the patient medical record by the	is not d on ng on and of the essed oting no nt's acility revealed njury to wrists the	03/24/16 03/25/16
	and a nurse restraine	ed the resident's arm to the and secured it with a plastic			of the nurse's employment on Mar 2016 for alleged abuse and restrai	ch 30,	

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{F 225}	tape and sprayed the cleansing body lotion resident sampled for a limit of the cleansing body lotion resident sampled for a limit of the bed rail wit with a plastic medical NA #1 she had spraye with a cleansing body behavior. The immediate jeopar The facility provided to Centers for Medicare acceptable allegation 04/29/16. A revisit survey was determine the status of Jeopardy. The facility for review of the follow Evidence of staff prohibition and use of Documentation or restraints and physici Documentation of developed to be individuated. There had been reabuse made since 04 Observations of nursi cognitively intact residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews with the facility of the clean residual documentation to sinterviews w	resident in the face witha on 2 occasions for 1 of 1 abuse (Resident#1). began on 03/01/16 when NA ely report to administrative had tied Resident #1's right the atowel that was taped tape and Nurse #1 stated to ed Resident #1 in the face lotion due to his combative rdy is present and ongoing. the State Agency and the and Medicaid with an of compliance (AOC) on conducted on 05/03/16 to of the ongoing Immediate provided documentation ving: in-servicing on abuse frestraints. If audits for abuse, use of an notification. If care plans revised and dualized for residents' care no additional allegations of /20/16. Ing care, interviews with dents and interviews with cility on 05/03/16, review of	{F 225	application. The nurse did not retu work or provide any resident care in March 24, 2016 – March 30, 2016. CORRECTIVE ACTION FOR OTHER RESIDENTS 1. Review of resident weekly skin assessments on March 2, 2016, Mit 2016. March 16, 2016, and March 2016 by the DON revealed no documentation or reports of any inj wounds potentially secondary to alt 2. Staff interviews and a root cause a were immediately initiated on March 2016 by the Director of Nursing and Facility Administrator. 3. NA #1 and NA #2 were suspended March 25, 2016 for failure to immediately interviews and application of restraint. 4. As of Friday, March 25, 2016, the Eand Facility Administrator have been rounding separately on all three shieast three times per week to confirm understanding that there is no toler abuse in the facility and to meet with regarding any questions or concerns. 5. Interviews were conducted with 18 Nursing Facility clinical staff membithe DON and the Facility Administrator from March 24, 2016 – March 29, 2 inquire whether any other instances suspicious injury or abuse had bee witnessed or observed with any oth residents. No concerns were identified to the surface of the suspicious injury or abuse had bee witnessed or observed with any oth residents. No concerns were identified to the suspicious injury or abuse had bee witnessed or observed with any oth residents. No concerns were identified to the suspicious injury or abuse had bee witnessed or observed with any oth residents. No concerns were identified to the suspicious injury or abuse had bee witnessed or observed with any oth residents. No concerns were identified to the suspicious injury or abuse had bee witnessed or observed with any oth residents.	on on diately pected OON Ongoing en ifts at rm rance of th staff ns. Skilled ers by ator 2016 to s of neer

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{F 225}	continued From page 32 support corrective action by the facility to remove the immediate jeopardy at F- 225 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action. The findings included: Resident #1 was admitted to the facility on 09/24/15 with diagnoses which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/27/16 indicated Resident #1 was severely impaired in cognition and exhibited physical and verbal behaviors directed toward others and was totally dependent		{F 22		 On March 29, 2016, interviews we conducted by the DON with all ale oriented long-term residents who residents of the facility during the the alleged events. All residents verbalized that they had no compl about the care they had received Additionally, on March 25, 2016 at 29, 2016, the DON or Facility Adminterviewed 3 physicians who have majority of the residents on the Sk Nursing Facility, including the SNF Medical Director, to inquire whether had any concerns about the care for any of their residents. No concerns identified. 	rt and were time of aints aints ad March hinistrator e the tilled er they rendered	03/29/16
	directed toward other on staff for activities of extremity impairment further revealed restr A review of a staff sch 7:00 AM shift from 02 revealed Nurse #1 ar assigned to care for h A review of a handwr revealed on Monday with Nurse #1 and Recombative. The state #1 helped NA #1 challed he was changed NA to other residents and a residents, NA #1 notin Resident #1's rooms	s and was totally dependent of daily living and had upper on one side. The MDS aints were notused. nedule for the 11:00 PM - 2/29/16 through 03/01/16 nd Nurse Aide (NA) #1 were Resident#1. ritten statement by NA#1 night 02/29/16 she worked			 To mitigate this type of event from reoccurring, on March 24, 2016, M 2016, and March 26, 2016, all Ski Nursing Facility clinical and noncstaff was provided education by the prior to the start of shift on the new immediately notify managements any suspected or witnessed abuse restraint application. Any changes resident's behavior or physical comust be reported promptly to the physician and responsible party. Skilled Nursing Facility staff memballowed to work until they have rethis education. During the Root Cause Analysis, "Chain of Command" policy was reby the Director of Nursing and Fac Administrator and determined to be 	March 25, lled linical are DON ed to taff of e or in the ndition resident's No pers are ceived the eviewed bility	03/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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{F 225}	Nurse #1 fighting with arm tied to the bed w wrapped around it. The revealed NA #1 immediately went to the bed. During an interview on NA #1 she confirmed from 11:00 PM on 02 03/01/16. She explain 03/01/16 Nurse #1 he #1. She stated she gand trash and left the finished disposing of noticed Resident #1's concerned her becauth is door closed. NA # opened the door Nurse with the ends of the bed are near his wrist was tied. She explained the towel plastic medical tape of a white towel and state towel and it was not a simmediately went to the towel was wrapped and he had limited medical the she further explained the towel was wrapped and he had limited medical the she further explained the towel was wrapped and he had limited medical the she further explained the foot of the towel was wrapped and he had limited medical the she further explained.	the door shewitnessed Resident #1 and hadhis ith a bath towel andtape he document further ediately removed thetape	{F 2:	3	appropriate. The Chain of Comma policy specifies that staff may bypa immediate supervisor when report event if their supervisor is unresponsive unavailable. Because the Chain of Command was not enacted at the the March 1, 2016 and March 4, 2 events, it was determined that additional staff education was indicated. 3. The root cause analysis was compon April 1, 2016. This investigation revealed that Nurse #1 felt frustrated their "wit's end" with Resident #1 combativeness, and she independent chose to inappropriately restrain Resident #1. NA #1 recognized that the resident application should have been immore ported, but opted to withhold the due to personal reasons. NA #2 or recognize that spraying Resident #1 face with cleansing lotion was a for abuse even if it was immediately addressed and did not result in ha was determined that additional edineded to be provided to Skilled Neaddressed and did not result in ha was determined that additional edineded to be provided to Skilled Neaddressed and methods of dealing frustration or burn-out. 4. On 4/12/16, the Regional Ombuds provided mandatory education to and non-clinical Skilled Nursing Fastaff regarding resident rights, include the right to be free from abuse and North Carolina Elder Abuse Act. training session will be repeated be Regional Ombudsman on 4/27/16.	ass their ing an onsive or of time of 016 litional oleted on ed and 's lently desident of the firm of	04/01/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 225}	towel from his right at immediately grabbed the tape off and releated he had applesauce wit and a solution that I his face. She explain the cleanser they use cleaning them and it the front of his gown yellow in color. She sable to rub the lotion hand was tied to the did not observe Nurse on Resident #1's face had sprayed Resident She confirmed she goon 03/01/16 who was she did not report the been tied to the bed is she knew Resident # been tied to the bed incident at the time be get anyone in trouble concerned she would co-workers if she rep worked with Nurse # 03/01/16 but they wo explained when the I 03/23/16 to talk about an opportunity to should be a solution of the she would be a she would concerned the worked with she would concerned the would concerned the worked with she would concerned the worked with she work	ould not have removed the rm. She stated she the towel and started pulling sed his arm and she noticed ith particles of medication in coked like body cleanser on led the solution looked like do na resident's skin while was all over his face and on and stated the cleanser was tated Resident #1 was not off his face because his right bed rail. She explained she was all over the day shift NA assigned to Resident #1 but the Resident #1's arm had rail with a towel. She stated 1's arm should not have all but she did not report the ecause she did not want to she further stated she was be treated differently by her orted it. She explained she after the incident on rked on different halls. She don't some things she saw it as we her the handwritten	{F 22		 On April 21, 2016, the Skilled Nurs Facility staff annual competencies orientation checklist were expande include specific education on Prope Notification of Witnessed / Suspect Abuse or Restraint Application, Ca Fatigue, and Chain of Command. employees will receive this educati during departmental orientation to Skilled Nursing Facility. Current employees will receive this educati annually during staff competencies On April 22, 2016, these same topi added to the list of annual compete required for any staff providing carteatment, or services to residents Skilled Nursing Facility. Education was provided to all Skille Nursing Facility clinical and non-clistaff and ancillary staff that provide treatment, or services to residents Skilled Nursing Facility via a compibased learning module from April 2 2016 on the Proper Notification of Witnessed / Suspected Abuse or Application, Caregiver Fatigue, and of Command. After April 24, 2016, will be allowed to work on the Skille Nursing Facility until this education been completed. Additionally all clinical and non-clin Skilled Nursing Facility staff were page to the staff and non-clin Skilled Nursing Facility staff were page to the staff were page to the staff and non-clin Skilled Nursing Facility staff were page to the staff were page to the staff and non-clin Skilled Nursing Facility staff were page to the staff and non-clin Skilled Nursing Facility staff were page to the staff and non-clin skilled Nursing Facility staff were page to the staff and non-clin skilled Nursing Facility staff were page to the staff and non-clin skilled Nursing Facility staff were page to the staff and non-clin skilled Nursing Facility staff were page to the staff and non-clin skilled Nursing Facility staff were page to the staff and non-clin skilled Nursing Facility staff were page to the staff and non-clin skilled Nursing Facility staff were page tor	and the d to er ted regiver New ion the ion ics were encies e, of the ed inical e care, of the uter-22 - 24, Restraint d Chain , no staff ed in has inical provided	04/21/16 04/22/16 04/24/16	
	1:15 AM by NA #2 ret #1's room on 03/04/1 Resident #1 out of be Resident #1 was con	tatement dated 02/29/16. tatement dated 03/26/16at vealed she was in Resident 6 with Nurse #1 to get ed. The document indicated hbative (hitting, kicking and and after Resident #1 was			education from April 22 -24, 2016 of actions to be taken in response to event where resident or staff safety jeopardy ("5 Rights of Duty To Rep These actions include providing a environment for the resident, spea about the event, documenting the enlisting help from co-workers, and	a safety y are in port"). safe king up event,		

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several times to back in the chair but instead Nurse Resident #1 in the cleansing spray aggressive. The #2 immediately gresident's face. During a phone with NA #2 she expected with a sit to stan She stated Resident #1 up to 6:00 AM and 6:3 with a sit to stan She stated Resident with a sit to stan She stated she kept position Resider sliding forward by Nurse #1 grabber lotion and spray She stated the locheekbones and she got a washod explained when it startled him are stated after they she left the room NA but did not resprayed Resident cleansing lotion, and didn't report further stated she washing the lotion the time did not realized she she immediately. She	chair NA #2 asked Nurse #1 assist her to get Resident #1 so he wouldn't slide off the edge we #1 proceeded to spray he face with some lotion base which made Resident #1 more document further indicated NA got a washcloth and washed the anterview on 04/19/16 at 3:02 PM explained Nurse #1 wanted to get to a chair on 03/04/16 between and lift from his bed to the chair. dent #1 was trying to hit them and we was spitting at them. NA #2 asking Nurse #1 to help her at #1 in the chair because he was but Nurse #1 ignored her and we do a spray bottle of cleansing wed him multiple times in the face. So to hand wiped the lotion off. She Nurse #1 sprayed him in the face and made his agitation worse. She was got him positioned in his chair and gave report to the first shift we port to her that Nurse #1 had ant #1 in the face with the body she stated she left the facility at the incident to anyone. She we felt she had taken care of it by an off Resident #1's face and at think it was abuse but nowshe build have reported the incident we confirmed she met with the 6 and reported the incident that	{F 225	ensuring staff safety. After April 2- no staff will be allowed to work on Skilled Nursing Facility until this echas been completed. MONITORING 1. 100% of working Skilled Nursing F clinical and non-clinical staff will co- education on the need to notify management staff of any suspecte witnessed abuse or restraint applic 2. 100% of working Skilled Nursing F clinical and non-clinical staff will re training on resident rights and Nor Carolina Elder Abuse Act. 3. 100% of employees hired to the S Nursing Facility after 04/21/16 will education during orientation on pro notification of witnessed/suspected or restraint application, caregiver f and chain of command. Orientatic records for 100% of new hires to the Skilled Nursing Facility will be aud the Facility Administrator for 3 more ensure all employees received traithese items. Audit results will be r to the Quality Coordinating Counc Skilled Nursing Quality Assurance Committee. 4. 100% of working Skilled Nursing F clinical and non-clinical and ancilla will complete the 2016 competence proper notification of witnessed/su abuse or restraint application, care fatigue, and chain of command. 5. 100% of working Skilled Nursing F clinical and non-clinical and ancilla will complete education on proper	the ducation Facility omplete ad or cation. Facility octive th Cacility or cation. Cacility of control of cacility of abuse attigue, on the ited by on reported il and the Facility on reported egiver Facility of cacility of cacil			

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{F 225}	had occurred on 03/0 DON requested she wincident that occurred she wrote the statement and emailed it to the I A review of a typed sincident #1 was difficated and emailed it to the I A review of a typed sincident #1 was difficated and revealed on one night while discussing Resident #2 and release them who document indicated Is night (no dates indicated supervisor who said thave time for that so situation for staff and soft pillowcase and sincident #1's left writed document revealed Finds arm but was not at them. The document repositioned him, the pillowcase, all taking document indicated for always in the room diaccepted full responsions. An attempt was made 04/19/16 at 2:00 PM I answer and no option.	4/16. She explained the write a statement about the I on 03/04/16 so that night ent that was dated 03/26/16 DON. Itatement dated 03/28/16 by part that taking care of cult because he was very eative. The document further it (no date was indicated) ident #1 with the night shift he suggested we might want I's wrists while cleaning him en we were finished. The eater that night or the next eater that night or the night or the next eater that night or the night or	{F 225	6.7.	notification of witnessed/suspected or restraint application, caregiver fand chain of command. 100% of working clinical and non-office skilled Nursing Facility staff will consider the constant of the const	clinical mplete n resident Rights of for six esidents will be	04/24/16 Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	COMPLETED R-C		
		345306	B. WING			-	03/2016	
	ROVIDER ORSUPPLIER	INC		557 B	ET ADDRESS, CITY, STATE, ZIP CODE BROOKDALEDRIVE TESVILLE, NC 28677			
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{F 225}	rounds during the set to call her when a result of the stated in the sta	rail. She stated she made hift and was available for staff esident was out of control. It was her expectation Nurse led her and should not have arm to the bed rail orsprayed Nurse #1, NA #1 and NA #2 ed the incidents immediately could have been completed. al 24 hour report that was sent has Health Care Personnel le (fax) was dated 03/24/16 at our revealed it was completed e allegation description orted to the DON on 03/24/16 urse #1 had briefly restrained hand to the bed rail with a per to protect herself and peri care due to combative orking day report that was sent has Health Care Personnel so dated 03/30/16 at 1:00 PM. It was completed by the DON description revealed Nurse #1 at Health Care Personnel so dated 03/30/16 at 1:00 PM. It was completed by the DON description revealed Nurse #1 at #1's right hand to the bottom administer medication and on further revealed Resident rained with a towel/pillowcase around the restraint to avoid sitting Nurse #1. The ed NA #1 entered the room, restrained by Nurse #1 and ached Resident #1 and began elease restraint. The licated NA #1 noticed Resident pplesauce and some form of	{F 2	25}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2)MULTIPLE CONSTRUCTION A. BUILDING				
		245000			R-C			
		345306	B. WING		05/03/2016			
NAME OF P	ROVIDER ORSUPPLIER		1 1	TREET ADDRESS, CITY, STATE, ZIP CODE				
IREDELL	MEMORIAL HOSPITALIN	ıc	5	57 BROOKDALEDRIVE				
	MEMORINE HOOF TIZE		8	STATESVILLE, NC 28677				
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{F 225}	Continued From page substance on his face	e 38 e and she cleaned it up. The	{F 225}					
	when she entered the spray bottle of cleans	licated NA #1 later stated e room that Nurse #1 hada ing lotion in her hand and ayed it in Resident #1's face erate.						
	A review of a facility of titled Allegation of Recompleted by the Adrrevealed a brief summ. The document indicat assisted Nurse #1 who care to Resident #1. #1 assisted with proviroom for a short perio and when she finished Resident #1's room. The when she entered the #1's right hand was tight and was taped and North Resident #1.	document dated 03/30/16 sident Abuse/Restraint ninistrator and DON nary of interviews of staff. ded on 03/01/16 NA#1 en they provided morning The document revealed NA ding peri care then left the d of time to do other duties d she noticed the door of has closed so she went documents further revealed room she noticed Resident ded to the bed with a towel urse #1 was present in the						
	to free his hand and R on his face and a substitution of the document revealed trying to give Resident was not listening. The on 03/24/16 the DON reported the incident to 03/01/16. The document reported Nurse #1 brief right hand to his bed rand tape to protect here.	remove the tape and towel desident #1 had applesauce stance on his face that was a face onto the front of him. He was that has been decided in the face of the fac						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED				
		345306	B. WING				03/2016
	ROVIDER ORSUPPLIER	NC		557 B	ET ADDRESS, CITY, STATE, ZIP CODE ROOKDALEDRIVE FESVILLE, NC 28677		
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{F 225}	and over to a chair. The Resident #1 became and spitting continuous transferred to his characteristic observed Nurse #1 as in the face with clean at her. The document wash cloth and wiped the lotion off. The document further the policy of the document further policy of the document further policy off. The document further off. The document further policy off. The document further off. The docu	f bed with a sit to stand lift The document revealed agitated and began hitting usly and after he was ir NA #2 turned and s she sprayed Resident #1 sing lotion due to his spitting t indicated NA #2 got a wet d Resident #1's face to get cument further indicated on et with NA #1 and she that had occurred on	{F 2	25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCT	COMPLETED R-C		
		345306	B. WING			05/03/2016	
	ROVIDER ORSUPPLIER	NC		557 BROOKD	ESS, CITY, STATE, ZIP CODE ALEDRIVE .E, NC 28677	33/33/2012	
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{F 225}	face because he did indicated therefore, intentionally restrain intentionally sprayed 03/01/16 and intentio or around the face opunishment for hittin and/or not following medication administrated buring an interview the Director of Nursi Nurse #1 and NA #1 Resident #1 on the return through 03/01/16. Si witnessed Resident early in the morning 03/01/16 but NA #1 cincident. She explained document by NA #1 her on 03/24/16 whe come in and meet with meeting NA #1 show document and stated The DON stated she not reported the incident personal reasons are what she was going explained on 03/04/15 spraying a cleansing but did not report the stated she met with her why she had not NA #2 stated at the fine of the stated at the	sprayed Resident #1 in the not listen. The report it was concluded Nurse #1 ed Resident #1 and I him in or around the face on onally sprayed Resident #1 in n 03/04/16 to serve as 19, kicking or spitting at her her direction during ration. on 04/19/16 at 11:08 AM with 19 (DON) she confirmed were assigned to care for 19 night shift from 02/29/16 he also confirmed NA #1 had #1's arm tied to the bedrail before the end of the shift on did not immediately report the	{F 2	25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTITUTION NUMBER: A. BUILDING				COMPLETED		
		345306	B. WING _			R-C 05/03/2016
	ROVIDER ORSUPPLIER	NC		STREET ADDRESS, CITY, STATE, ZIP CO 557 BROOKDALEDRIVE STATESVILLE, NC 28677	DE	33/33/2010
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{F 225}	facility. She further ve longer employed by the longer employed longer employ	was still present in the erified Nurse #1 was no he facility. In 04/19/16 at 3:00 PM the ed Nurse #1 had requested the morning of 03/04/16 after king the night shift. She in and met with Nurse #1 and upset and told her in hitting, kicking and spitting the asked Nurse #1 ything else had happened in nothing else had instrator stated she felt encing burnout and but was at that point the incidents of on 03/01/16 and 03/04/16. Berview on 04/20/16 at 2:58 it was her expectation that should have immediately on 03/01/16 so an ave been started on further stated it was her mould have immediately on 03/04/16 when NA#2 spray the body cleansing is face. Berview on 04/20/16 at 4:23 is stated it was her when Resident #1's arm bed rail and when Resident the face with the body	{F 2:	25)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER MEMORIAL HOSPITALIN	ıc				
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{F 225}		spital Vice President were jeopardy on 04/19/16at	{F 225		ED	
SS=D	ABUSE/NEGLECT, E		ų 22C	RESIDENT		
	policies and procedur	t, and abuse ofresidents		 On March 1, 2016, NA #1 reported she promptly removed the restraint cleaned Resident #1's face, and repositioned him in bed. 		
		Tie net met ee ovideneed		 On March 4, 2016, NA #2 reported immediately cleaned Resident #1's remove the lotion. 	she 03/04/16 s face to	
	This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility staff failed to operationalize policy and procedure when staff failed to immediately notify administrative staff of 2 witnessed incidents of physical abuse when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face with a cleansing body lotion on 2 occasions. The facility staffalso failed to assess the resident for physical injury after both of these instances of staff abuse for 1 of 1 resident sampled for abuse (Resident#1). Immediate Jeopardy began on 03/01/16 when NA #1 failed to immediately report when Nurse#1 had tied Resident #1's right arm to the bedrail			3. The Facility Administrator recalled March 4, 2016, Nurse #1 had required meet with her and during that meet expressed frustration with Residen behavior. Nurse #1 reported being and crying during her shift the ever before. When questioned, Nurse # denied anything further happening. Facility Administrator asked Nurse she felt she needed to take some to work, and Nurse #1 responded that had only one more shift to work, and was going to be on vacation from March 13. The Facility Administr Nurse #1 was experiencing burnodecided to immediately remove Nufrom Resident #1's care. Nurse #1 not assigned to provide care for Reference with the surface was provided to the meeting and throughoduration of her employment.	ested to ting t #1's g upset ning #1 . The #1 if ime off tt she nd then March 5 rator felt ut, and urse #1 I was esident	
	tape and Nurse #1 st sprayed Resident #1 body lotion due to his	taped with a plastic medical ated to NA #1 she had in the face with a cleansing combative behavior. rdy is present and ongoing.		 Since the facility is committed to be restraint-free and use of restraints tolerated, Nurse #1 was suspende March 24, 2016 at 4:45 p.m. pendi investigation of the alleged abuse. 	is not d on	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		COMPLETED			
		345306	B. WING _			R- 05/	-C 03/2016
	ROVIDER ORSUPPLIER MEMORIAL HOSPITALIN	ıc	STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677				
(X4) ID PREFI X TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 04/29/16. A revisit survey was conducted on 05/03/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:				 Upon learning of restraint applicating alleged abuse, Director of Nursing Skilled Nursing Facility (DON) asson Resident #1 on March 25, 2016, no sign of injury. Review of the patient medical record by the DON and Factorial Administrator on March 25, 2016, no documentation of any signs of it Resident #1's eyes, face, arm, or with during subsequent shifts following alleged events. The full investigation was complete. 	of the essed oting no nt's acility revealed njury to vrists the	03/25/16
	 Evidence of staff in-servicing on abuse prohibition and use of restraints. Documentation of audits for abuse, use of 				the nurse's employment was termi 3/30/16		03/30/10
	developed to be indiv areas There had been a abuse made since 04 Observations of nursi cognitively intact resid	of care plans revised and idualized for residents' care no additional allegations of			 Resident #1's care plan was updat April 20, 2016 to include interventic staff to utilize to protect Resident # staff from Resident #1's sexual bel inappropriate touching, and verbal physical aggression. CORRECTIVE ACTION FOR OTHER RESIDENTS 	ons for 1 and havior,	04/20/16
	all documentation to interviews with the far Director of Nursing prosupport corrective active immediate jeopar scope and severity of				Review of resident weekly skin assessments on March 2, 2016, M 2016. March 16, 2016, and March 2016 by the DON revealed no documentation or reports of any in wounds potentially secondary to a	23, juries or	03/23/16
	not immediate jeopar continues the process implementation of the	dy, while the facility s of monitoring the			 Staff interviews and a root cause a were immediately initiated on 3/24 the Director of Nursing and Facility Administrator. 	/16 by	03/24/16
	Policy with a reviewe	olicy titled Abuse Prohibition d date of October 2014 buse of residents will not be			3. The Skilled Nursing Facility policie "Statement on Restraint-Free Faci "Abuse Prohibition Policy", and "Re Rights" were reviewed by the DON Facility Administrator on March 24	lity", esident I and	03/24/16

	DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER)MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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		345306	B. WING			05/	03/2016	
	ROVIDER OR SUPPLIER	ıc	STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677					
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{F 226}	be suspended immediterminated after compressidents shall be ex Nursing (DON) or by designated by the DO of abuse or neglect expears to have result thoroughly investigate appropriate authorities to, the police, the Divinurse Aide Registry at The Director of Nursin investigate all complate by speaking with the and any staff member knowledge of the occus suspected of being alfrom work until the investigate are assess monitored to identify might lead to abuse, in This may include those behavior, aggressive Resident #1 was admonary of the most Data Set (MDS) date Resident #1 was severand exhibited physical directed toward other on staff for activities of	s or neglects a resident will liately and ultimately pletion of investigation. Itamined by the Director of supervisory personnel as the polygon of the distance of the supervisory personnel as the polygon of the distance of the supervisory personnel as the polygon of the distance of the supervisory personnel as the polygon of the distance of the supervisory personnel as the polygon of the distance of the supervisor of the s	{F 2	226}	and it was determined that had the policies been followed, Resident would have been protected. 4. NA #1 and NA #2, who failed to immediately report either witness application of restraint or resident were suspended on 3/25/16. 5. To ensure ongoing reinforcement policies, as of Friday, 3/25/16, the Director of Nursing and Facility Administrator have been roundin separately on all 3 shifts at least times per week to monitor the weand safety of each resident, to constaff understanding of the facility restraint-free policy and to meet a regarding any questions or concess. 6. The Director of Nursing was cound on 3/25/16 by the Facility Adminion the importance of immediately assessing the resident for potent or harm regardless of timing of residents of the facility during the the alleged events. All residents were sidents of the facility during the the alleged events. All residents verbalized that they had no compabout the care they had received. 8. Interviews were conducted with a Skilled Nursing Facility clinical st members by the DON and the Facility during the standard from March 24, 20 March 29, 2016 to inquire wheth other instances of suspicious injuicabuse had been witnessed or obwith any other residents. No conwere identified.	#1 ded t abuse, t of e g three ell-being onfirm s with staff erns. nseled strator ial injury eport. rere ert and were etime of blaints l. 18 aff acility 16 — er any ury or served	03/25/16 Ongoing 03/25/16 03/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
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{F 226}	7:00 AM shift from 02 revealed Nurse #1 ar assigned to care for R A review of a handwr revealed on Monday with Nurse #1 and Recombative. The state #1 helped NA #1 cha he was changed NA a other residents and a residents, NA #1 noti Resident #1's room s #1 needed any help. when NA #1 opened Nurse #1 fighting with arm tied to the bed w	nedule for the 11:00 PM - 2/29/16 through 03/01/16 and Nurse Aide (NA) #1 were Resident#1. itten statement by NA#1 night 02/29/16 she worked resident #1 was very ment further revealed Nurse nge Resident #1 and after #1 left the room to check on ofter she finished with other ced Nurse #1 was still in o she went to see if Nurse The document indicated the door she witnessed of Resident #1 and had his ith a bath towel and tape	{F 22		10.	Additionally, on March 25, 2016 at March 29, 2016, the DON or Fact Administrator interviewed 3 physis who have the majority of the resist the Skilled Nursing Facility, include SNF Medical Director, to inquire they had any concerns about the rendered for any of their resident concerns were identified. As a component of the root cause analysis, the process for screening upon hire was reviewed and felt that appropriate. No staff is employed Skilled Nursing Facility without fir having an in-person interview, rechecks, drug screen, and a nation criminal record background check Additionally, licensed or certified staff is primary source verified premployment. EMIC CHANGES	ility icians dents on ding the whether care s. No e ng staff to be d to the est ference nal k. clinical	03/29/16
	and towel from Residestraightened him up is sideways in the bed. During an interview of NA #1 she confirmed from 11:00 PM on 02 03/01/16 and wrote to the She explained aroun Nurse #1 helped her stated she gathered and left the room and disposing of the liner Resident #1's door wher because they did closed. NA #1 explait door Nurse #1 was sident #1 w	ediately removed the tape				To mitigate this type of event from reoccurring, on March 24, 2016, 125, 2016, and March 26, 2016, all Nursing Facility clinical and non-contact the start of shift on facility related to a restraint-free environment resident abuse, and resident right Education included strategies for with residents when frustrated, in removing oneself from the reside with appropriate notification of supervisory staff. Skilled Nursing staff was counseled to immediate intervene in the event of witnesses to ensure the safety of the reside action must be followed by promy notification of management staff suspected or witnessed abuse, in	March Il Skilled clinical he DON policies ment, ts. dealing cluding nt's care g Facility ely ed abuse nt. This ot of any	03/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFI X TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 226}	Continued From page was tied to the bed ra explained the towel we bedrail then around R the ends of the towel plastic medical tape waround the towel to so observed Resident #7 a white towel and state towel and it was not a immediately went to the across the bed from of his head toward the feet toward the some shall be further explained use his left arm becaute from a stroke so he could from his right and immediately grabbed the tape off and release he had applesauce with and a solution that he his face. She explain the cleanser they use cleaning them and it was the front of his gown a yellow in color. She sable to rub the lotion of hand was tied to the lotion of his gown and the lotion of hand was tied to the lotion of hand was tied to the lotion of his gown and the lotion of hand was tied to the lotion of hand was tied to the lotion of his gown and the lotion of hand was tied to the lotion of his gown and the lotion of hand was tied to the lotion of his gown and the lotion of hand was tied to the lotion of his gown and the lotion of h	il with a towel. She as wrapped around the esident #1's wrist and then were twisted together and was wrapped multiple times ecure it. She verified she I's arm was restrained with ted she was sure it was a pillow case. She stated she he resident and he was lying one side to the other instead the head of the bed and his of the bed. She explained d pretty tight around his arm ovement of his right arm. Resident #1 was unable to use of left sided weakness ould not have removed the	{F 22			ges in I they to onsible staff il they and non-if was nanaging hts, and the eviewed cility be and ass their ting an onsive in of a time of 2016 ditional pleted on ted and iolated. NA #1 cation ported,	03/31/16
	had sprayed Residen She confirmed she ga on 03/01/16 who was she did not report tha been tied to the bed r she knew Resident #	but Nurse #1 told hershe t #1's face with the cleanser. ave report to the day shiftNA assigned to Resident #1 but t Resident #1's arm had ail with a towel. She stated 1's arm should not have			personal reasons. NA #2 did not recognize that spraying Resident face with cleansing lotion was a for abuse even if it was immediately addressed and did not result in hawas determined by the Facility Administrator and the Director of I	#1 in the orm of arm. It	
	been tied to the bed r	ail but she did not report the					

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	COMPL	
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		345306	B. WING_			05/0	03/2016
	ROVIDER OR SUPPLIER MEMORIAL HOSPITALIN	ıc		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677			
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{F 226}	incident at the time be get anyone in trouble. concerned she would co-workers if she repworked with Nurse #1 03/01/16 but they wo explained when the D 03/23/16 to talk abou an opportunity to sho statement she had wr. A review of a typed s 1:15 AM by NA #2 rev. #1's room on 03/04/1 Resident #1 out of be Resident #1 was contrying to spit on staff) transferred to a chair several times to assis back in the chair so h but instead Nurse #1 Resident #1 in the factleansing spray which aggressive. The docu #2 immediately got a resident's face. During a phone interv. with NA #2 she explain Resident #1 up to a ce 6:00 AM and 6:30 AM with a sit to stand lift. She stated Resident #1 shiding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position Resident #1 sliding forward but No Nurse #1 grabbed as stated she kept askin position R	ecause she did not want to . She further stated she was be treated differently by her orted it. She explained she I after the incident on rked on different halls. She ON called her in on It some things she saw it as wher the handwritten iitten dated 02/29/16. Itatement dated 03/26/16 at wealed she was in Resident 6 with Nurse #1 to get ad. The document indicated abative (hitting, kicking and and after Resident #1 was NA #2 asked Nurse #1 of the to get Resident #1 e wouldn't slide off the edge	{F 2:	5	implemented "Daily Reminders" fo clinical staff. These reminders are printed document on a topic relate resident care selected by the Direct Nursing. Topics include challenging behaviors, care of the resident with dementia, resident rights, and other pertinent topics. The reminders are posted for all staff members to revidially seven days/ week. On 4/12/16, the Regional Ombuds provided mandatory education to cand non-clinical Skilled Nursing Fastaff regarding resident rights, inclute right to be free from abuse and North Carolina Elder Justice Act. training session will be repeated by Regional Ombudsman on April 27,	collicies ement of cohibition was an alursing use and end and end and end and end are in the collinical acility and in the collinical acility acility acility in the collinical acility acilit	Ongoing 04/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(X2)MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345306	B. WING			05/	-C 03/2016	
	ROVIDER ORSUPPLIER	NC	STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677			1 00	00/2010	
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{F 226}	cheekbones and was she got a washcloth a explained when Nurs it startled him and ma stated after they got I she left the room and NA but did not report sprayed Resident in a cleansing lotion. She and didn't report the further stated she felt washing the lotion of the time did not think realized she should himmediately. She cor DON on 03/25/16 and had occurred on 03/0 DON requested she incident that occurred she wrote the statem and emailed it to the A review of a typed so Nurse #1 revealed in Resident #1 was diffi aggressive and comb revealed on one night while discussing Resolution number of the secure Resident #1 and release them who document indicated I night (no dates indicated I night (no dates indicated I)	was on his face at his arunning down his face so and wiped the lotion off. She was a situation worse. She him positioned in his chair I gave report to the first shift to her that Nurse #1 had the face with the body stated she left the facility incident to anyone. She is she had taken care of it by face and at it was abuse but nowshe have reported the incident infirmed she met with the directed the incident had a statement about the directed on 03/04/16 so that night ent that was dated 03/26/16 DON. It attement dated 03/28/16 by part that taking care of cult because he was very pative. The document further in the suggested we might want 1's wrists while cleaning him en we were finished. The later that night or the next ated) Resident #1 was	{F 2	26}	following process revisions and state education: In order to provide guidar staff in addressing challed behavior, any such behavior aggression, sext behavior disinhibitions) wincorporated into the resist care plan and appropriate notified if such behavior or exacerbates. 8. On April 21, 2016, the Abuse Prohipolicy was revised to incorporate the timeframes for reporting suspected witnessed abuse as specified in the Justice Act. 9. On April 21, 2016, the Skilled Nurse Facility clinical and non-clinical state annual competencies and the oriest checklists were expanded to include specific education on: Restraint-free Environme Proper Notification of With Suspected Abuse or Rest Application Managing Challenging Beach Abuse Prohibition policy Elder Justice Act Chain of Command Caregiver Fatigue New employees will receive this education departmental orientation to Skilled Nursing Facility. Current employees will receive this education annually during staff competencies.	nce for nging vior (for ual ill be dent's e parties develops libition he don's e Elder sing ff entation de ent enessed / traint ehaviors	04/21/16	
	supervisor who said thave time for that so situation for staff and	ve and Nurse #1 called the to call security but we did not in an effort to provide a safe resident, Nurse #1 took a ome tape and secured			 On April 22, 2016, these same top added to the list of annual competer required for any staff providing car treatment, or services to residents Skilled Nursing Facility. 	encies e,	04/22/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.000 1.000 1.000 1.000	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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IREDELL MEMORIAL HOSPITALINC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFI (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROPIRED HATCH)			ID PREFIX		27/19/0	TION (X5) ULD BE COMPLETION	
X TAG {F 226}	Continued From page	e 49 st to the side rail. The	(F 22	11. Education was prov	ENCY)	04/24/16	
	document revealed R his arm but was not a them. The document repositioned him, the pillowcase, all taking document indicated N always in the room di accepted full respons An attempt was made 04/19/16 at 2:00 PM I answer and no option During a phone interv with the night shift Nu she had not instructe #1's arm to the bed re rounds during the shi to call her when a res	esident #1 could still move able to swing his armat indicated we cleaned and n Nurse #1 released the less than 5 minutes. The lurse #1 stated she was uring this incident and ibility for her judgment. e to contact Nurse #1 on by phone but there was no		staff and ancillary s treatment, or servic Skilled Nursing Fac based learning mod 2016 on the followir Resident's Elder Just Proper No Suspected Applicatio Restraint- Managing Abuse Pro Chain of C Caregiver After April 24, 2016 allowed to work on Facility until this ed completed	taff that provide care, es to residents of the ility via a computer-lule from April 22 – 24, ng topics: a Rights ice Act of Abuse or Restraint of Challenging Behaviors chibition policy Command Fatigue 5, no staff will be the Skilled Nursing ucation has been		
	#1 should have callettied Resident #1's arrhim in the face and N should have reported The initial 24 hour reported The initial 24 hour reporth Carolina Health facsimile (fax) was daren the allegation dereported to the DON Nurse #1 had briefly right hand to the bed tape to protect herse peri care due to compare the source of the 5 works.	d her and should nothave in to the bed rail or sprayed urse #1, NA #1 and NA #2 the incidents immediately. Doort that was sent to the incare Personnel Registry by ated 03/24/16 at 6:05 PM. It was completed by the DON scription revealed it was on 03/24/16 at 11:00 AM that restrained Resident #1's rail with a pillow case and if and Resident #1 during		education from Aprilactions to be taken event where reside jeopardy ("5 Rights These actions incluenvironment for the about the event, doenlisting help from ensuring staff safet no staff will be allow Skilled Nursing Facthas been complete 13. Education was proving Facility clining staff and ancillary s	ility staff were provided il 22 -24, 2016 on in response to a safety at or staff safety are in of Duty To Report"). de providing a safe resident, speaking up cumenting the event, co-workers, and y. After April 24, 2016, wed to work on the ility until this education d.	04/24/16	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		ONSTRUCTION	COMPLETED	
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TO STAND AND AND AND AND AND AND AND AND AND	ROVIDER OR SUPPLIER	ис		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677			
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{F 226}	The report revealed if and the allegation des restrained Resident # side rail in order to accare. The description #1's hand was restrait with tape wrapped ar Resident #1 from hittidescription indicated found Resident #1 re immediately approach removing tape to reledescription also indicated found removing tape to reledescription also indicated found removing tape to reledescription further incompart with the sentence on his face description further incompart when she entered the spray bottle of cleans admitted she had sprowhen he did not coop. A review of a facility of titled Allegation of Recompleted by the Adrevealed a brief summer the document indicates assisted Nurse #1 who care to Resident #1. #1 assisted with proving room for a short period and when she finished Resident #1's room winside the room. The when she entered the #1's right hand was than the was taped and North Resident #1.	ated 03/30/16 at 1:00 PM. It was completed by the DON scription revealed Nurse #1 It's right hand to the bottom Idminister medication and further revealed Resident ined with a towel/pillowcase ound the restraint to avoid ing Nurse #1. The NA #1 entered the room, strained by Nurse #1 and hed Resident #1 and began hase restraint. The ated NA #1 noticed Resident olesauce and some form of he and she cleaned it up. The dicated NA #1 later stated he room that Nurse #1 hada hing lotion in her hand and hayed it in Resident #1's face herate. Idocument dated 03/30/16 history of interviews of staff. her they provided morning The document revealed NA hiding peri care then left the hid of time to do other duties hid she noticed the door of has closed so she went hid documents further revealed her oom she noticed Resident hid to the bed with a towel hurse #1 was present in the	{F 22		Skilled Nursing Facility via a computation based learning module from April 2 2016 that if abuse to a resident occenforcement must be notified within hours if there is serious bodily injur within 24 hours if there is no serious injury. In accordance with the Elde Justice Act, staff may notify law enforcement directly if abuse occurs at a computer-based learning module of importance of reporting challenging aberrant behavior promptly to licentursing staff. Education will be corby April 24, 2016. No staff will be a to work beginning April 25, 2016 unthey have completed this education. 15. All licensed nursing staff will be proceeded to the process of the proc	ez – 24, curs, law n 2 y or es bodily er s. iical a on the g or sed ellowed hless n. evided ellowed hless n. evided er taff will 25, this	04/24/16 04/24/16
	room. The document immediately began to	indicated NA #1 remove the tape and towel			100% of working Skilled Nursing F	acility	04/22/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5.00 Str. 00 S		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{F 226}	to free his hand and Fon his face and a subdripping down from his The document reveal trying to give Resider was not listening. The on 03/24/16 the DON reported the incident 03/01/16. The document further hand to his bed and tape to protect he providing peri care due the document further hurse #1 and NA #2 Resident #1 up out of and over to a chair. The document further hurse #1 and spitting continuous transferred to his characteristic observed Nurse #1 and the face with clean at her. The document wash cloth and wiped the lotion off. The document off. The document of the lotion off.	Resident #1 had applesauce stance on his face that was is face onto the front of him. ed Nurse #1 stated she was at #1 his medications buthe edocument further revealed met with NA #1 and she that had occurred on ment indicated NA #1 efly restrained Resident #1's rail with a pillowcase/towel erself and resident while to combative behavior. In indicated on 03/04/16 were attempting to get is bed with a sit to stand lift is he document revealed agitated and began hitting usly and after he was ir NA #2 turned and is she sprayed Resident #1 sing lotion due to his spitting it indicated NA #2 got a wet it indicated NA #2 got a wet it indicated NA #1 and she that had occurred on ment revealed NA #1 efly restrained Resident #1's rail with a pillowcase/towel erself and resident while use to combative behavior.	{F 2	226}	clinical and non-clinical staff will receducation on managing challenging behaviors, resident rights, and residabuse. 3. The Facility Administrator will monit weekly to ensure that seven "Daily Reminders" were posted by the DO the staff. Monitoring will continue for months and results will be reported Quality Coordinating Council and the Skilled Nursing Facility Quality Assocommittee. 4. 100% of working Skilled Nursing Facilinical and non-clinical staff will rectaining on resident rights and the Notarolina Elder Abuse Act. 5. 100% of employees hired to the Sk Nursing Facility after 04/21/16 will reducation during orientation on resifree environment, proper notification witnessed/suspected abuse or restapplication, managing challenging behaviors, Abuse Prohibition policy Justice Act, caregiver fatigue, and command. Orientation records for of new hires to the Skilled Nursing will be audited by the Facility Adminfor 3 months to ensure all employer received training on these items. A results will be reported to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Commited. 6. 100% of working Skilled Nursing Facilinical and non-clinical and ancillar will complete the 2016 competency	dent tor ON for or 3 to the ne urance acility ceive North cilled receive traint- n of raint /, Elder chain of 100% Facility nistrator es udit ty ed ttee. acility ry staff	Ongoing 04/27/16 Ongoing 04/24/16
	Nurse #1 sprayed Recleansing lotion.	urred on 03/04/16 when esident #1 in the face with uments revealed a report of			proper notification of witnessed/sus abuse or restraint application, care fatigue, and chain of command.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 226}	A review of facility invocompleted by the Adr Summary of Investigate determined Nurse #1 consistent story. The was inconsistent on the hand that was restrain room, when the restrate a Nurse Supervisor was fact she restrained Repillowcase and tape to also revealed NA #1 and remembered Nurse fact she restrained Repillowcase and tape to also revealed NA #1 and remembered Nurse deansing lotion in her Resident #1's room of told NA #1 she had state because he did indicated therefore, it intentionally restrained intentionally sprayed 03/01/16 and intention or around the face on punishment for hitting and/or not following hemedication administrations and interview of the Director of Nursin Nurse #1 and NA #1 and Resident #1 on the nithrough 03/01/16. She witnessed Resident # early in the morning by	submitted to the North sing on 03/31/16. restigation dated 03/30/16 ministrator titled Final ation revealed it was was unable to provide a report indicated Nurse#1 me date of the incident, the med, the NA present in the mint was actually applied or if was notified. The report e #1 was consistent with the resident #1's hand with a provided further clarification are #1 had spray bottle of the hand when NA #1 entered in 03/01/16 and Nurse #1 prayed Resident #1 in the mot listen. The report was concluded Nurse #1 d Resident #1 and him in or around the face on mally sprayed Resident #1 in 03/04/16 to serve as so, kicking or spitting at her er direction during ation. In 04/19/16 at 11:08 AM with g (DON) she confirmed were assigned to care for ght shift from 02/29/16 er also confirmed NA #1 had entered the end of the shift on it immediately report the	{F 220	9.	100% of working Skilled Nursing Ficlinical and non-clinical and ancilla will complete education on Resider Rights, Elder Justice Act, proper notification of witnessed/suspected or restraint application, restraint-freenvironment, managing challenging behaviors, Abuse Prohibition policy caregiver fatigue, and chain of commod 100% of working clinical and non-citied Skilled Nursing Facility staff will conceducation on actions to be taken in response to a safety event where row staff safety are in jeopardy ("5 R Duty to Report"). 100% of working Skilled Nursing Facility and ancilla will complete education on abuse requirements according to the Elder Justice Act. 100% of working unlicensed and noursing Skilled Nursing Facility clinical staff will complete education on the importance of reporting challenging aberrant behavior promptly to licentursing staff. 100% of working licensed nursing a complete education on the importance of reporting challenging or aberrant behavior promptly to licentursing challenging or aberrant behavior aberrant behavior of Commandate of Com	ry staff nt's I abuse ee g /, nmand. clinical mplete n esident cights of acility ry staff reporting er on- nical e g or ased staff will ance of ehavior	04/24/16 04/24/16 04/24/16

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	COMPLETED		
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{F 226}	her on 03/24/16 where come in and meet with meeting NA #1 show document and stated. The DON stated she not reported the incidence observed Nurse #1 in the bed rail and NA areported the incident personal reasons an what she was going explained on 03/04/1 spraying a cleansing but did not report the stated she met with 1 her why she had not NA #2 stated at the the something that show verified Resident #1 facility. She further who longer employed by During an interview of Administrator explaint to meet with her on the she had finished work explained she came and she was crying Resident #1 had been at her. She stated she numerous times if an and Nurse #1 told her happened. The Administrator was expericompletely unaware abuse had occurred	dated 02/29/16 was given to a she had called NA #1 to th her and at the end of the red her the handwritten of she needed to discuss it. The asked NA #1 why she had dent immediately after she had tied Resident #1's arm to red to anyone because of the date of the had been processing to do about it. The DON 16 NA #2 observed Nurse #1 to lotion in Resident #1's face of incident immediately. She NA #2 on 03/25/16 and asked reported it immediately and time she didn't think it was led be reported. The DON was still present in the rerified Nurse #1 was no the facility. The on 04/19/16 at 3:00 PM the ned Nurse #1 had requested the morning of 03/04/16 after reking the night shift. She in and met with Nurse #1 and upset and told her on hitting, kicking and spitting the asked Nurse #1 hything else had happened	{F 2	26}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 No. 10	IPLECONSTRUCTION NG		COMPLETED R-C		
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	ROVIDER ORSUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CO 557 BROOKDALEDRIVE STATESVILLE, NC 28677				
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{F 226}	regarding abuse and facility during orienta annually and more of stated during the tra abuse and neglect with stated it was her exploy the facility policien neglect and Nurse # immediately reporte an investigation could immediately. The Dound NA #2 should have been done. The have any evidence Resident #1 after the was no documentate record that he was a arm was tied to the assessed for any irreyes when the body face on 03/01/16 or would have expected assessed Resident incidents and should assessments in the explained she was a incidents that had on 03/04/16 and assess as part of her invest physical signs of injury or irritation to his eye. During a follow up in PM the Administrate expectation that all sof the abuse and new transport in the process of the subuse and new transport in the state of the abuse and new transport in	facility staff received training dineglect when hired at the ation and it was repeated often as needed. She further ining the facility policies for were reviewed with staff. She bectation for all staff to abide as to prevent abuse and and NA #1 should have do the incident on 03/01/16 so lid have been started DN further stated Nurse#1 ave reported the incident on ly and an investigation would be DON explained she did not hurse #1 had assessed incidents because there from in Resident #1's medical assessed for injuries after his bed rail on 03/01/16 or was itation on his face or inhis are lotion was sprayed in his 03/04/16. She stated she did for Nurse #1 to have #1 immediately after the did have documented her nurse's notes. The DON notified on 03/24/16 of the courred on 03/01/16 and sed Resident #1 on 03/25/16 igation and did not see any cury to Resident #1's right arm less.	{F 2	26}				

	DENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345306	B. WING		R-C 05/03/2016
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 557 BROOKDALEDRIVE STATESVILLE, NC 28677		00/00/2010
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{F 226}	Resident #1's arm wa and when Resident # with the cleansing bo been investigatedimn The facility Administra Administrator and hos notified of immediate	orted immediately when as restrained to the bed rail as was sprayed in the face dy lotion so it could have nediately.	{F 226	}	
{F 279} SS=D	to develop, review and comprehensive plan of the facility must develop plan for each resident objectives and timetal medical, nursing, and	CAREPLANS e results of the assessment d revise the resident's	{F 279	CORRECTIVE ACTION FOR AFFECT RESIDENT 1. On April 20, 2016, review of Reside care plan revealed that the Resider psychotropic medications were reflerent on the care plan on February 29, 20 an intervention to observe for side of the medications. On March 11, 2 an intervention was added to monit Resident #1's behavior for effective medication and to notify the resider physician for escalations or change behavior.	ent #1's 04/20/16 nt's ected 016 with effects 2016, or eness of nt's
	to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's			2. It was determined that Resident #1 plan should be updated to address aggressive behavior and sexual be disinhibitions. The care plan was ton April 20, 2016, to include interversion staff to utilize to protect Reside and staff from Resident #1's sexual behavior, inappropriate touching, a verbal and physical aggression. CORRECTIVE ACTION FOR OTHER RESIDENTS	s his ehavior updated entions nt #1
	by:	is not met as evidenced iews and staff interviews the		Additionally, on April 20, 2016, all recare plans were reviewed by the M Nurse to ensure that there were no	DS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII		COMPLETED			
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{F 279}	with inappropriate an during nursing care. care plan intervention tied to the bed rail wit plastic medical tape a face with a cleansing for 1 of 1 resident sat #1). Immediate Jeopardy Nurse #1 tied Reside rail with a towel and to tape to secure it and she had sprayed Reside cleansing body lotion behavior during nursion. The immediate jeopa The facility provided to Centers for Medicare acceptable allegation 04/29/16. A revisit survey was determine the status Jeopardy. The facility for review of the folloreside in the prohibition and use of the company of the company of the follorestraints and physic of Documentation of developed to be individual.	op a care plan with staff for handling a resident d combative behaviors. As a result of the lack of as the resident's arm was he a towel and secured with a land he was sprayed in the body lotion on 2 occasions ampled for abuse (Resident began on 03/01/16 when the state of the bed laped it with a plastic medical lowers with a land he was sprayed in the bed laped it with a plastic medical lowers with a land to his combative and the land of combative land land land land land land land land	{F 2	79}	residents within the facility at risk of challenging behaviors not being addressed in their care plan. Then no other residents with challenging behaviors in the Skilled Nursing Fathe time of this review; therefore, it determined that there were no other residents at risk. SYSTEMIC CHANGES 1. The Skilled Nursing Facility's procedeveloping resident-specific care pwas evaluated on April 20, 2016. review of all resident care plans rethat each care plan included resides specific problems, interventions, a measurable goals with a specific timeframe for measurement. Care for all residents are reviewed and on an ongoing basis with a formal weekly during Interdisciplinary Team Meeting. 2. As a result of the review of Reside care plan, the Skilled Nursing Factor process for managing challenging behaviors, specifically incorporatic challenging behaviors into the Residencian staff in addressing challed behavior, any such behave a staff in addressing challed behavior disinhibitions) wincorporated into the residencial staff will be provided in the following revisions and appropriate notified if such behavior or exacerbates. • All unlicensed and non-miclinical staff will be provided.	e were acility at a was er ess for blans A vealed ent- nd e plans updated review am ent #1's acident's process ace for acident's expension (for ual ill be dent's e	04/20/16
	abuse made since 04	1/20/16.			education via a computer	-based	

		IDENTIFICATION NUMBER		(2)MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE BROOKDALEDRIVE			
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{F 279}	Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 279 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm thatis not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action. The findings included: Resident #1 was admitted to the facility on 09/24/15 with diagnoses which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia.		{F 27	79}				
	(MDS) dated 10/01/15 severely impaired in obehaviors. The MDS #1 required extensive bathing and hygiene staff for bed mobility extremity impairment Care Area Assessment trigger. A review of a quarter indicated Resident #1 cognition and exhibite further indicated Residependent on staff for	ssion Minimum Data Set 5 indicated Resident #1 was cognition and exhibited no further indicated Resident e assistance for transfers, but was totally dependent on and toileting and had upper on one side. A review of the ints revealed behaviors did y MDS dated 12/29/15 I was severely impaired in ed no behaviors. The MDS dent #1 was totally r activities of daily living and impairment on one side.		2	the Director of Nursing for six mon- ensure that any challenging behav changes in the resident's condition reflected in the Resident's care pla reported to appropriate parties. Au results will be reported to the Quali Coordinating Council and the Skille Nursing Facility Quality Assurance Committee.	ths to iors or are an and udit ity ed on- ical e	Ongoing 04/24/16	

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F 279} Continued From page 58 A review of a care plan dated psychotropic's revealed Resider receiving Prozac and Rispered disinhibitions. The goal indicate behavior will be managed by dose of medications. The intellisted to observe for side effect as anxiety, somnolence (drow or headaches and observe for Risperdal such as nausea, contain any interventions on wifthe resident exhibited inapprombative behaviors. A review of a care plan with a 02/17/16 tiled psychotropic's was discontinued and Reside Zyprexa and to continue goal behavior will be managed by dose of medications. The intellisted to observe for side effect dry mouth, sedation and som resident's care plan did not continue the continue of a care plan with a 02/22/16 titled psychotropic's and Zyprexa were discontinued. A review of a care plan with a 02/29/16 titled psychotropic's and Zyprexa were discontinued. A review of a care plan with a 02/29/16 titled psychotropic's 25 milligrams was started for disorder and the goal indicate behavior will be managed by dose of medications. The intellisted to observe for side effect of the process of the discontinued of the goal indicate behavior will be managed by dose of medications. The intellisted to observe for side effect.	dent #1 was all for behavior ted resident's lowest possible reventions were cts of Prozacsuch vsiness), dizziness r side effects of enstipation, sedation care plan did not what staff should do ropriate or revised date of indicated Risperdal int #1 was started on that resident's lowest possible erventions were cts of Zyprexa such nolence. The entain any ould do if the ate or combative revised date of indicated Prozac ed. revised date of indicated Seroquel schizoaffective d that resident's lowest possible erventions were ed that resident's lowest possible erventions were	{F 27	79}	3. 100% of working licensed nursing secomplete education on the important reporting challenging or aberrant be according to the Chain of Comman The command of the chain of	nce of ehavior	04/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	COMPLETED		
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{F 279}	contain any interventiif the resident exhibite combative behaviors. A review of a facility of titled Allegation of Rethe Administrator reviews of staff. The 03/01/16 NA #1 assist provided morning car assisted with providing room for a short period When she finished shade the room. When she finished shade with a towel and was present in the robegan to remove the hand but Nurse #1 as The document further applesauce on his face that was dripping Nurse #1 stated she with a pillowcase/towerstrained Resident # with a pillowcase/towerstrained Resident was dripping Nurse #1 and NA #2 Resident #1 up out of and over to a chair. It agitated and began he continuously and after	dent's care plan did not ons on what staff should do ed inappropriate or document dated 03/30/16 sident Abuse/Restraint by ealed a brief summary of e document indicated on ted Nurse #1 when they e to Resident #1. NA #1 g peri care then left the d of time to do other duties. He noticed the door of was closed so she went in she entered the room she eright hand was tied to the was taped and Nurse #1 om. NA #1 immediately tape and towel to free his ked what she was doing. Trevealed Resident #1 had be and a substance on his g down the front of him. Was trying to give Resident with he was not listening and the striph thand to his bed rail the land tape to protect herself ombative behavior. On the with NA #1 and she that had occurred on tent indicated on 03/04/16 were attempting to get bed with a sit to stand lift Resident #1 became	{F 2	79}				

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED
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{F 279}	got a wet wash cloth face to get the lotion met with NA #2 and shad occurred on 03/0 sprayed Resident #1 lotion. An attempt was mad 04/19/16 at 2:00 PM answer and no option During an interview of the MDS nurse, who care plan for psychologore plans. She explicate plans. She explicate plans to cover in because otherwise a numerous care plans when psychotropic medications were efficiently and her goat to monitor the reside medications were effithink about implementating staff to deal with the modern than the case of the stated Resident behaviors on the admand as a result no cated eveloped at that timed eveloped the care in the case of the stated resident that timed eveloped the care in	and wiped Resident#1's off. On 03/25/16 the DON she reported the incident that 04/16 when Nurse #1 in the face with cleansing the to contact Nurse #1 on by phone but there was no in to leave a message. On 04/20/16 at 4:17 PM with developed Resident #1's tropic medications on ed herself as being new to in the learning process of ained she tried to combine individual areas for residents a resident might have is. The MDS nurse explained medications were added for olan for the use of tions was developed on all with the interventions was int to determine if the fective. She stated she didn't inting interventions for with the behaviors and was ow a staff member would andle Resident #1's are plan she had developed. #1 was not coded with mission MDS dated 10/01/15 are plan for behaviors was not. She explained she	{F 2'	79}	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	.10 %		NSTRUCTION	COMPLETED
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800000000000000000000000000000000000000	ROVIDER OR SUPPLIER	ıc		557 E	EET ADDRESS, CITY, STATE, ZIP CODE BROOKDALEDRIVE .TESVILLE, NC 28677	
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{F 490} SS=D	DON explained the M plans and Resident # plan for behaviors with use when he exhibite interventions should be step away or reach or supervisors when a red or redirect residents when the sometimes different is to behaviors or change sometimes different is to administrator and hos notified of immediate 5:11 PM. 483.75 EFFECTIVE ADMINISTRATION/READMINIST	ehaviors. n 04/20/16 at 2:58 PMthe IDS nurse created care 1 should have had a care h interventions for staffto d behaviors. She stated have included for staff to ut for help from coworkers or esident exhibited behaviors when they exhibited staff members because taff would calm the resident. ator, DON, hospital spital Vice President were jeopardy on 04/20/16 at ESIDENT WELL-BEING hinistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced iews and review of facility dministrative staff failed to culture that all residents om extreme resident nd that staff would	{F 4	90} (CORRECTIVE ACTION FOR AFFECT RESIDENT 1. The DON immediately notified the Facility Administrator when NA #1 reported the restraint application a suspected abuse of Resident #1. 2. NA #1 was interviewed by the Fac Administrator and the hospital Administrator-on-Call and Patient Officer were notified of NA #1's allegations. 3. The Facility Administrator instruct Director of Nursing to assess the resident for injury on March 24, 20 The resident wasn't assessed on 24, 2016, as the Director of Nursing knew that she had been in Reside room and assisted in his care on 1, 2015 and March 4, 2015. On be	o3/24/16 1 and cility 03/24/16 Safety ted the 03/24/16 O16. March ng ent #1's March

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{F 490}	to immediately notify responsible party who combative during nurrestrained the resider to protect a resident's restraint, failed to immincidents of physical areport placed other re The facility also failed procedure when staff administrative staff of physical abuse and fawith interventions to gresident with inappropersident who experies abuse without immediately protection and implementative staff of the physical abuse and fawith interventions to gresident with inappropersident with inappropersident who experies abuse without immediately protection and implementations.	the physician and en a resident became sing care and a nurse nt's arm to the bed rail, failed s right to be free ofphysical mediately report witnessed abuse and the failure to esidents at risk for abuse. I to operationalize policy and failed to immediately notify f 2 witnessed incidents of ailed to develop a care plan guide staff for handling a priate and combative sing care for a combative nced 2 episodes of physical liate facility intervention, mentation of abuse policies of 1 sampled residents	{F 48	4. 5.	these dates, the Director of Nurs not identify any injury to Resider eyes, wrists, or arms. The DON presence in Resident #1's room of these dates was documented nursing notes in the electronic mrecord. Throughout the month of the DON frequently participated Resident #1's care with no injurified identified. Nurse #1 was interviewed and at to application of restraint, The Donotified the Director of Human Rand Assistant VP of Quality and Outcomes of Nurse #1's statemed DON also updated the Administical and Patient Safety Officer of #1's interview. Nurse #1 was suspended on Ma 2016 at 4:45 p.m. pending investof the alleged abuse.	nt #1's 's on both in the nedical f March, in es dmitted ON desources Clinical ents. The rator-on- Nurse arch 24, stigation	03/24/16
	#1 witnessed Nurse # right arm to the bed ritaped with a plastic m	began on 03/01/16 when NA #1 had tied Resident#1's ail with a towel that was nedical tape and Nurse#1 had sprayed Resident #1 in		6.	The Vice President of Professio Services and Facility Planning w notified by the Facility Administr the allegations and actions take March 24, 2016.	as ator of	03/24/16
	the face with a cleans combative behavior a	sing body lotion due to his		7.	On 3/24/16, the Vice President of Professional Services and Facili Planning notified the President/0 Executive Officer of the allegation actions taken.	ity Chief	03/24/16
	The facility provided t	s present and ongoing. the State Agency and the and Medicaid with an of compliance (AOC) on		8. 9.	Suspension of Nurse #1 continupending full investigation with te of the nurse's employment on N 2016 for restraint application an abuse. Resident #1's care plan was rev	rmination larch 30, d alleged	03/30/16
	A revisit survey was	conducted on 05/03/16 to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{F 490}	Jeopardy. The facility for review of the followard of the followard of the followard of the facility for review of the facility for the facili	of the ongoing Immediate y provided documentation wing: f in-servicing on abuse f restraints. of audits for abuse, use of ian notification. of care plans revised and	{F 49	C	the MDS nurse, and it was determent that the care plan should be updated address his aggressive behavior sexual behavior disinhibitions. CORRECTIVE ACTION FOR OTHER RESIDENTS 1. Review of resident weekly skin assessments on March 2, 2016,	ated to and	03/23/16
	areas - There had been abuse made since 04 Observations of nurs cognitively intact resistaff present in the fa all documentation to interviews with the fa	no additional allegations of 4/20/16. ing care, interviews with idents and interviews with acility on 05/03/16, review of support the AOC and acility's Administrator and rovided sufficient evidence to			2016. March 16, 2016, and March 2016 by the DON revealed no documentation or reports of any or wounds potentially secondary abuse. 2. The Director of Nursing was couron March 25, 2016 on the need immediate assessment of a residute event of alleged abuse.	h 23, injuries to nseled	03/25/16
	support corrective ac the immediate jeopal scope and severity o with potential for more	ction by the facility to remove ordy at F- 490 at a lower f (D) isolated, no actual harm re than minimal harm thatis			 NA #1 and NA #2 were suspend March 25, 2016 for failure to imm notify management staff of the re application and /or suspected ab 	nediately estraint	03/25/16
		es of monitoring the e corrective action.			4. On March 29, 2016, interviews veconducted by the DON with all a oriented long-term residents who residents of the facility during the alleged events. All residents verbalized that they had no comabout the care they had received.	lert and o were e time of plaints	03/29/16
	failed to immediately responsible party wh combative during nu restrained the reside towel and secured it	notify the physician and ten a resident became rsing care and a nurse ent's arm to the bed rail with a with a plastic tape and in the face with a cleansing			5. Interviews were conducted with Skilled Nursing Facility clinical simembers by the DON and the F Administrator from March 24, 20 March 29, 2016 to inquire wheth other instances of suspicious injabuse had been witnessed or obwith any other residents. No conwere identified.	taff acility 16 – er any ury or oserved	03/29/16

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{F 490}	staff and physician int and record reviews the resident's right to be the when staff restrained symptoms. As a result resident's arm to the	Based on observations, terviews, police interview e facility failed to protect a free of physical restraint a resident without medical It a nurse restrained the bed rail with a towel and	{F 49	0} 6.	The DON or Facility Administrato interviewed 3 physicians, who ha majority of the residents on the S Nursing Facility, including the SN Medical Director, to inquire wheth had any concerns about the care rendered for any of their resident concerns were identified.	ve the killed F ner they	03/29/16
		h a plastic medical tape abative during care for 1 of 1 abuse (Resident#1).		7.	Education on the facility's Abuse Prohibition Policy was provided to and NA #2 before their return to v		04/02/16
		Based on observations, terviews, police interview		SYS	STEMIC CHANGES		
	and record reviews the resident's right to be to when a resident becanursing care and a nursing care and a nursing to the bed rail with a plastic tape and face on 2 occasions were resident.	e facility failed to protect a free from physical abuse		1.	To mitigate this type of event fror reoccurring, on March 24, 2016, 25, 2016, and March 26, 2016, a Nursing Facility clinical and non-staff was provided education by t prior to the start of shift on facility related to resident abuse, mainta restraint-free environment, and p notification of appropriate parties change in resident behavior or pl condition.	March II Skilled clinical he DON policies ining a rompt for any	03/26/16
	and record reviews the immediately report with physical abuse and the other residents at risk failed to immediately became combative dururse restrained the residents.	Based on staffinterviews the facility staff failed to the facility staff failed to the failure to report placed to for abuse. The facility staff treport when a resident turing nursing care and a tresident's arm to the bedrail tred it with a plastic tape and		2.	On 3/29/16 and 3/31/16, education again provided to all Skilled Nurse Facility staff regarding immediate notification of management staff suspected or witnessed abuse or neglect, including content regard managing challenging behaviors, resident rights, and resident abuse	ing of any ing	04/22/16
	sprayed the resident body lotion on 2 occa sampled for abuse (R Cross refer to F 226 -	in the face with a cleansing sions for 1 of 1 resident		3.	During the Root Cause Analysis, "Chain of Command" policy was reviewed by the Director of Nursi Facility Administrator and determ be appropriate. The Chain of Copolicy specifies that staff may be their immediate suppopular when	ng and ined to mmand	03/30/16
		and procedure when staff			their immediate supervisor when		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	280000800000000000000000000000000000000		STRUCTION	COMPI	LETED
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{F 490}	2 witnessed incidents resident became com and a nurse restraine bed rail with a towel at tape and sprayed the cleansing body lotion staff also failed to assinjury after both of the for 1 of 1 resident sai #1). Cross refer to F 279 and staff interviews the care plan with intervent handling a resident we combative behaviors result of the lack of cresident's arm was the and secured with a pwas sprayed in the fat	notify administrative staff of s of physical abuse when a abative during nursing care and the resident's arm to the and secured it with a plastic resident in the face with a on 2 occasions. The facility sees the resident for physical ese instances of staff abuse empled for abuse (Resident - Based on record reviews the facility failed to develop a certions to guide staff for with inappropriate and during nursing care. As a are plan interventions the end to the bed rail with a towel lastic medical tape and he are with a cleansing body is for 1 of 1 residentsampled	{F 4		reporting an event if their supervunresponsive or unavailable. Be the Chain of Command was not at the time of the March 1, 2016 March 4, 2016 events, it was de that additional staff education windicated. 4. The root cause analysis was coron April 1, 2016. This investigat revealed that Nurse #1 felt frustrat her "wit's end" with resident's combativeness. It was noted the "1 closed Resident #1's door durestraint application on March 1, and instructed NA #1 to close the when she re-entered Resident #1 twas concluded that Nurse #1 violated the facility's Restraint-policy. NA #1 recognized that the restraint application should have immediately reported, but opted withhold the report due to persor reasons. NA #2 did not recogni spraying Resident #1 in the face cleansing lotion was a form of a even if it was immediately addred did not result in harm; therefore, not report the event as abuse. determined that additional educ needed to be provided to Skilled Facility staff on the definition of and examples of abusive behaviors, and methods of deal frustration or burn-out. 5. On 4/09/16, the Director of Nursimplemented "Daily Reminders" clinical staff. These reminders a clinical staff.	ecause enacted and termined as mpleted tion rated and nat Nurse uring the , 2016 ne door f1's room. willfully free ne been to mal ze that e with buse essed and , she did It was ation d Nursing abuse rior, rting any ed or allenging ing with	

{F 490}	{F 490}	printed document on a topic related to resident care selected by the Director of Nursing. Topics include challenging behaviors, care of the resident with dementia, resident rights, and other pertinent topics. The reminders are posted for all staff members to review daily seven days/ week.	
		 On 4/12/16, the Regional Ombudsman provided education to clinical and non- clinical Skilled Nursing Facility staff regarding resident rights, including the right to be free from abuse and the North Carolina Elder Abuse Law. A second training session with the Regional Ombudsman is scheduled for 4/27/16. 	04/27/16
		7. The Skilled Nursing Facility's process for developing resident-specific care plans was evaluated on April 20, 2016. A review of all resident care plans revealed that each care plan included resident-specific problems, interventions, and measurable goals with a specific timeframe for measurement. Care plans for all residents are reviewed and updated on an ongoing basis with a formal review weekly during Interdisciplinary Team Meeting. The care planning process was revised to require that challenging behavior (for example aggression, sexual behavior disinhibitions) will be incorporated into the resident's care plan and appropriate parties notified if such behavior develops or exacerbates.	04/20/16
		 On April 21, 2016, the Abuse Prohibition Policy was revised to incorporate the timeframes for reporting suspected or witnessed abuse as specified in the Elder Justice Act. 	04/21/16

{F 490}	{F 490}	9. On April 21, 2016, the Skilled Nursing Facility staff annual competencies and the orientation checklist were expanded to include specific education on: • Elder Justice Act • Proper Notification of Witnessed / Suspected Abuse or Restraint • Managing Challenging Behaviors • Abuse Prohibition policy • Chain of Command • Caregiver Fatigue	04/21/16
		 On April 22, 2016, these same topics were added to the list of annual competencies required for any staff providing care, treatment, or services to residents of the Skilled Nursing Facility. 	04/22/16
		11. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the Skilled Nursing Facility via a computer- based learning module from April 22 – 24, 2016 that if harm to a resident occurs, law enforcement will be notified by the Facility Administrator or the DON. Alternatively, in accordance with the Elder Justice Act, staff may notify law enforcement directly if an event occurs. Law enforcement notification of abuse or neglect must occur within 2 hours if there is serious bodily injury to a resident or within 24 hours if there is no serious bodily injury to a resident. This education also included: Resident's Rights Elder Justice Act Proper Notification of Witnessed / Suspected Abuse or Restraint Application Restraint-free Environment	04/24/16

{F 490}	{F 490}	 Managing Challenging Behaviors Abuse Prohibition policy Chain of Command Caregiver Fatigue 	
		12. Additionally all clinical and non-clinical Skilled Nursing Facility staff were provided education from April 22 -24, 2016 on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty To Report"). These actions include providing a safe environment for the resident, speaking up about the event, documenting the event, enlisting help from co-workers, and ensuring staff safety. After April 24, 2016, no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed.	04/24/16
		13. To promote a culture of safety and open communication, the VP will make rounds on the Skilled Nursing Facility biweekly effective 4/28/16. The VP maintains an "open door" policy for all staff to be able to communicate concerns. During biweekly rounds, the VP will communicate his open door policy and office location to the Skilled Nursing Facility staff.	Ongoing
		MONITORING 1. 100% of working Skilled Nursing Facility clinical and non-clinical staff will complete education on facility policies related to a resident abuse and maintaining a restraint-free environment.	03/26/16

{F 490}	{F 490}	2.	100% of working Skilled Nursing Facility clinical and non-clinical staff will receive education on managing challenging behaviors, resident rights, and resident abuse.	04/22/16
		3.	The Facility Administrator will monitor weekly to ensure that seven "Daily Reminders" were posted by the DON for Monitoring will continue for 3 months and results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	Ongoing
		4.	100% of working Skilled Nursing Facility clinical and non-clinical staff will receive training on resident rights and the North Carolina Elder Abuse Law.	04/27/16
		5.	100% of 24-hour reports will be audited by the Director of Nursing for six months to ensure that any challenging behaviors are reflected in the Resident's care plan and appropriate parties were notified. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	Ongoing
		6.	100% of employees hired to the Skilled Nursing Facility after 04/21/16 will receive education during orientation on proper notification of witnessed/suspected abuse or restraint application, managing challenging behaviors, Abuse Prohibition policy, Elder Justice Act, caregiver fatigue, and chain of command. Orientation records for 100% of new hires to the Skilled Nursing Facility will be audited by the Facility Administrator for 3 months to ensure all employees received training on these items. Audit results will be reported	Ongoing

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{F 490}	{F 490}	7.	to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Committee. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete the 2016 competency on	04/24/16
			proper notification of witnessed/suspected abuse or restraint application, managing challenging behaviors, Abuse Prohibition policy, Elder Justice Act, caregiver fatigue, and chain of command.	
		8.	100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on Resident's Rights, Elder Justice Act, proper notification of witnessed/suspected abuse or restraint application, restraint-free environment, managing challenging behaviors, Abuse Prohibition policy, caregiver fatigue, and chain of command.	04/24/16