CENTERS FOR MEDICARE & MEDICAD SERVICES OME NO. 0984.031 AND PLAND & CORRECTION INFORMATION CONSTRUCTION MODEL SUPPLY AND DE CORRECTION INFORMATION CONSTRUCTION MODEL SUPPLY AND DE CORRECTION INFORMATION CONSTRUCTION MODEL SUPPLY ALMANCE MEALTH CARE CONTER INFORMATION CONSTRUCTION MODEL SUPPLY ALMANCE MEALTH CARE CONTER INFORMATION CONSTRUCTION MODEL SUPPLY (A) 100 SUMMARY STRUCTION OF DEPOLYCING SUPPLY PROVIDERS LANG CONSECTION C (A) 100 SUMMARY STRUCTION OF DEPOLYCING SUPPLY PROVIDERS LANG CONSECTION CONSTRUCTION OF DEPOLYCING THE SUPPLY SUPPLY (A) 100 SUPPLY SUPPLY PROVIDERS LANG CONSECTION CONSTRUCTION OF DEPOLYCING THE SUPPLY (C) 100 SUPPLY SUPPLY PROVIDER SUPPLY SUPPLY PROVIDER SUPPLY CONSTRUCTION OF DEPOLYCING THE SUPPLY (C) 100 SUPPLY SUPPLY SUPPLY SUPPLY SUPPLY (C) 100 SUPPLY SUPPLY SUPPLY SUPPLY SUPPLY (C) 100 SUPPLY SUPPLY SUPPLY SUPPLY SUPPLY SUPPLY <th></th> <th></th> <th>ID HUMAN SERVICES</th> <th></th> <th></th> <th></th> <th></th> <th>M APPROVED</th>			ID HUMAN SERVICES					M APPROVED	
AND FLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING COUNTERED 345420 a WING STREET ADDRESS. (ITY, STRE, 2)P CODE 0006/2018 INMUE OF PROVIDER OR SUIPLUER STREET ADDRESS. (ITY, STRE, 2)P CODE 0006/2018 IMAGE MEALTH CARE CENTER SUIMARY SUIMANT OF DENCINCENS PROVIDER IN OF CORRECTION 0006/2018 IPROFING SUIMARY SUIMANT OF DENCINCES PROVIDER IN OF CORRECTION 0006/2018 IPROFING SUIMARY SUIMANT OF DENCINCES PROVIDER IN OF CORRECTION 0006/2018 IPROFING SUIMARY SUIMANT OF DENCINCES PROVIDER IN OF CORRECTION 0006/2018 IPROFING SUIMARY SUIMANT ON INFORMATION IPROFING ACCORRECTION THE APPROPRIATE 0006/2018 IPROFING SUIMARY SUNTER SUIMARY SUIMARY	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>	
346420 PLWING 99/06/2018 NAME OF PROVIDER OR SUPPLIER ALAMANCE HEALTH CARE CENTER STREET ADDRESS. CITY STREE, 2PLODE MALMANCE HEALTH CARE CENTER SUMMARY STREETING TO DEFINICION OF DEFINICION OF DEFINICION, NC 27217 OF PROVIDER OR SUPPLIER SUMMARY STREETING TO DEFINICION SUMMARY STREETING TO CORRECTION INCOMENT: REPORTING OF Alleged Violations Summary Street Mark Street Mar				` ´			COMF	PLETED	
ALAMANCE HEALTH CARE CENTER 1937 HILTON STREET BURLINGTOR, NO. 27217 CMU ID PREFIX TAG SUMMARY STATEMENT OF DEFIDIENCES (LACH DEFIDIENCY MUST BELIXED TO THE PROCEEDED BY FULL TAG D (EACH CORRECTIVA CONCENTS NUMBER) (EACH CORRECTIVA CONCENTS NUMBER) (EACH CORRECTIVACION SINCLID BE CROSS-METRACION SINCLID BE CROSS-METRACION SINCLID BE CROSS-METRACION SINCLID BE CROSS-METRACION SINCLID BE SSED PEOTING of Alleged Violations SSED 9/29/18 F 609 Reporting of Alleged Violations created s483.12(c) (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is mode, if the events that cause the allegation is note in the events that cause the allegation is note in the state allow including to the State Survey Agency, within 5 working days of the incident, and if the allegat violation is verified appropriate corrective action must be laken. This REQUIREMENT is not met as evidenced by. Baseed on record review and staff inter			345420	B. WING			_		
ALAMACE HEALTH CARE CENTER BURLINGTON, NC 27217 (Y4)10 PHETRX TAC ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST & EMERCIDE YEAL) (EACH DEFICIENCE AND THE AND ADD ADD YEAL) (EACH DEFICIENCE AND THE AND ADD YEAL ADD YEAL) (EACH DEFICIENCE AND THE AND ADD YEAL ADD YEAL) (EACH DEFICIENCE AND THE ADD YEAL ADD YEAL ADD YEAL ADD YEAL ADD YEAL) (EACH DEFICIENCE AND THE ADD YEAL ADD YEAL ADD YEAL ADD YEAL ADD	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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PREFIX TAC IEACH CORRECINCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG IEACH CORRECINCE ACTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONSTRUCT CONSTRUCT CONSTRUCTION DEFICIENCY) F 600 SS-D Reporting of Alleged Violations CFR(s): 483.12(c)(1) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must. F 609 F 609 9/29/18 9/29/18 § 443.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injurices of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse or result in serious bodily injury, or not later than 2 hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 2 hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 2 hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 2 hours if the events that cause the allegation bease or result in serious bodily injury, or not later than 2 hours if the events that cause the allegation involve abuse and do not result in serious bodily injury, to the administrator of the facilities) in accordance with State law through established procedures. The statements included are not an admission and do not constitute agreement with the alleged dictioneries herein. This REQUIREMENT is not met as evidenced by. The statements included are not an admission and do not constitute agreement with the alleged dictioneries herein. The plan of corecorion is completed in the compliance of state and fe	, (D) (11) (11)				E	BURLINGTON, NC 27217			
SS=D CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misapropriation of resident property, are reported immediately, but not later than 2 hours after the allegation in ovive abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility failed to notify the administrator and the state agency within 5 working days of the incident, and if the alleged violation is or allegation of staff-to-resident sexual abuse for one of one resident reviewed for abuse (Resident #2). The findings included: The findings included:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
neglect, exploitation, or mistreatment, the facility must: \$483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation is made, if the events that cause the allegation on on tinvolve abuse and do not result in serious bodily injury, or the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law, including to the State survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to notify the administrator and the state agency within two brurs of an allegation of staff-to-resident sexual abuse for one of one resident reviewed for abuse (Resident #2).		CFR(s): 483.12(c)(1)	(4)	F	609			9/29/18	
involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to notify the administrator and the state agency within two hours of an allegation of staff-to-resident sexual abuse for one of one resident reviewed for abuse (Resident #2). The findings included: The indings included:		neglect, exploitation,							
§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to notify the administrator and the state agency within two hours of an allegation of staff-to-resident sexual abuse for one of one resident reviewed for abuse (Resident #2).The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state		 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to notify the administrator and the state agency within two hours of an allegation of staff-to-resident sexual abuse for one of one resident reviewed for abuse (Resident #2). 							
						admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state as federal regulations as outlined. To rem	nd Iain		
						TITLE		(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

09/20/2018

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
				C		
		345420	B. WING		09/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANCE HEALTH CARE CENTER						
(X4) ID PREFIX			ID PREFIX	BURLINGTON, NC 27217 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL		
TAG			TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	DATE	
F 609	Continued From page	e 1	F 609	9		
				regulations the center has taken or		
	Resident #2 was adn			take the actions set forth in the foll	-	
		led diabetes mellitus type 2,		plan of correction. The following p		
	history of pulmonary			correction constitutes the center		
	schizoaffective disord			allegation of compliance. All allege		
	quarterly Minimum D 07/13/18 revealed that			deficiencies cited have been or wil	be	
		a the resident was		completed by the dates indicated.		
		es of daily living except for		F609		
		o hallucinations or delusions		1 000		
		Iring the seven-day lookback		The plan of correcting the specific		
	period.			deficiency. The plan should addres	s the	
	penear			processes that led to the deficience		
	Resident #2 ' s care	plan dated 05/03/18 included		The facility Licensed Nurse failed t		
		06/18 for "adverse behavioral		the administrator and the state age	-	
		mood instability, depressive		within two hours of an allegation of	-	
	episodes and inability			resident sexual abuse by Resident		
	Resident #2 made ar	n allegation of staff-to-		The hospital Emergency room disc	harge	
	resident sexual abus	e on 07/26/18 during the		summary revealed that Resident #	2 was	
	facility 's annual rece	ertification survey. The facility		screened for domestic violence du	ring the	
		ed incident and the claim		ED admission procedure. Residen		
	was unsubstantiated.			reported that a fat girl had sex with		
				the skilled nursing facility, and stat	ed they	
		ote dated 08/31/18 indicated the facility on 08/31/18 for an		sexually abuse me.		
		und care center. While there,		The procedure for implementing th		
	-	est pain and was sent to the		acceptable plan of correction for th	e	
		ent (ED) of a local hospital.		specific deficiency cited.		
	He returned to the fac	cility later that day.		Licensed Nurses will be educated		
		/10 beenitel discharge		licensed nurse will immediately rep		
		/18 hospital discharge		allegations involving abuse, neglec		
	summary revealed th	ic violence during the ED		exploitation, mistreatment, includin injuries of unknown source and	9	
		. He reported to the ED		misappropriation of patient propert	vora	
	-	had sex with him at the		crime against a patient to Administ	-	
		. When asked if he felt safe		DON, and report to state agency, A		
		y, he replied "no, they		protective services, and Police with		
	-	Resident #2 was assessed		hours if involves abuse, or results		
		, time, place and situation.		serious bodily injury in person or v		

Facility ID: 932930

If continuation sheet Page 2 of 8

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/09/20 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345420	B. WING		C 09/06/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP CODE	•
ALAMANO	CE HEALTH CARE CENT	ER		1987 HILTON STREET BURLINGTON, NC 27217	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIO
F 609	Continued From page	e 2	F 60	9	
	The ED nurse noted	that she placed a social work he local Police Department.		telephone by the Director of Nur Assistant Director of Nursing or Development Nurse.	Staff
	that a second nurse a family member (with			Any Licensed Nurse that has no educated will not be allowed to v receive education in person or v	work until ia
	resident was being for there was currently a	hily member stated that the blowed by a psychiatrist and n open Adult Protective		telephone by Director of Nursing Assistant Director of Nursing or Development Nurse	Staff
	resident to return to t	found "as he is in close		All new Licensed Nurses, includ Agency staff before their first as will be educated in orientation in by Staff Development Nurse or I	signment, person
	Nurse #1 documente	d in a progress note that		Nursing or Assistant Director of on A licensed nurse will immedia	Nursing ately
		I to the facility 08/31/18 at tated to "see discharge notes tion."		report all allegations involving at neglect, exploitation, mistreatme including injuries of unknown so misappropriation of patient prop	ent, urce and
		/04/18 at 2:15 p.m., the stated that she was not		crime against a patient to Admin DON, and report to state agency	istrator or
	-	egations of sexual abuse by s last five weeks at the		protective services, and Police v hours if involves abuse, or result serious bodily injury.	ts in
		/04/18 at 3:00 p.m., Resident nembers at the facility did not and respect.		The monitoring procedure to ensitive plan of correction is effective specific deficiency cited remains and/or in compliance with the representation of the second s	e and that s corrected
	#1 stated that she real the hospital on the tra	/05/18 at 4:09 p.m., Nurse ceived a verbal report from ansfer of Resident #2 but his		Director of Nursing or Assistant nursing will audit all Emergency discharge summaries for allegat	room ion of
	She did, however, lea 08/31/18 when she re	abuse was not mentioned. arn of it later that evening on ead the full discharge notes		sexual abuse, 3 X weekly X 4 w weekly X 4 weeks, and Bi-weekl Director of Nursing or Assistant	ly X 2. Director of
	admission note. Whe not phone the ED nu	eferred to them in her en asked, she stated she did rse for clarification. She did of sexual abuse to the		nursing will audit all allegations of abuse, regardless of where repo determine if incidents were repo two hours 3X weekly X 4 weeks	orted, to rted within

Facility ID: 932930

If continuation sheet Page 3 of 8

		MEDICAID SERVICES				D. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING	·		С		
		345420	B. WING			06/2018		
	ROVIDER OR SUPPLIER	010120		STREET ADDRESS, CITY, STATE, ZIP COD		/06/2018		
				1987 HILTON STREET	· L			
ALAMANCE HEALTH CARE CENTER				BURLINGTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 609	Continued From page 3 oncoming third shift nurse but couldn ' t remember if she told the second shift nursing supervisor. She stated that the third shift nurse told her that this was not the first time that		F 60	9 4 weeks, and Bi-weekly X 2. Results of these audits will be Quarterly Quality Assurance for further problem resolution	Veeting X1			
	Resident #2 had mad Nurse #1 indicated h requirement to report neglect. She acknow	de a claim of sexual abuse.		The Director of Nursing is res implementing the acceptable correction by 09/29/2018	ponsible for			
	In an interview on 09/05/18 at 3:55 p.m., Nurse #2 confirmed that she was the second shift nursing supervisor on Friday evening 08/31/18 when Resident #2 returned from the hospital. She stated that she did not work that weekend or on Monday. She was not aware of the allegation of sexual abuse until Tuesday 09/04/18.							
	Director of Nursing (I learn of the allegation hospital social worke speaking to her on the matters. She stated the familiar with the Resi room transfer to her Nurse #1 should hav incident to the nursin sharing it on the shift	hat Nurse #1 was not dent #2 as he recently had a hall. She acknowledged that e reported the alleged g supervisor in addition to report. The DON became illegation on 09/04/18 on						
	Administrator shared allegations of abuse as soon as staff men indicated that he faxe	be reported to management bers become aware. He ed an Initial Report of the he state agency on 09/05/18						

Facility ID: 932930

If continuation sheet Page 4 of 8

		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345420	B. WING		C 09/06/2018		
	ROVIDER OR SUPPLIER	ER		19	IREET ADDRESS, CITY, STATE, ZIP CODE 187 HILTON STREET URLINGTON, NC 27217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657 SS=D	CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the r An explanation must I medical record if the p and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by the (iii)Reviewed and revi team after each asses comprehensive and q assessments. This REQUIREMENT by: Based on record revi facility failed to develop plan to address the en	i)-(iii) ensive Care Plans prehensive care plan must i' days after completion of sessment. erdisciplinary team, that ited to rsician. e with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary asment, including both the uarterly review i is not met as evidenced ew and staff interviews the op an individualized care motional and psychosocial resident reviewed for an	F	657	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cit. The facility Failed to develop an individualized care plan to address the emotional and psychosocial needs for Resident # 2 for an allegation of staff to	ed.	9/29/18

Event ID: YWEU11

Facility ID: 932930

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CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			OMB N	M APPROVE 0. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345420		B. WING		09	C 0/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			1987 HILTON STREET				
ALAMANCE HEALTH CARE CENTER				BURLINGTON, NC 27217			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 657	Continued From page	e 5	F 65	7			
	REGULATORY OR LSC IDENTIFYING INFORMATION)			 Psychologist # 1 recommended Resident # 2 that staff enter resiling room with a witness due to recell unfounded claims made by Resiling of sexual abuse, and this recommendation was not put or until 9/5/2018. The procedure for implementing acceptable plan of correction for specific deficiency cited. Director of Nursing and Assistant of Nursing will be educated on the development of an individualize plan to address the emotional and psychosocial needs for any resilial allegation of sexual abuse. The monitoring procedure to end the plan of correction is effective specific deficiency cited remains and/or in compliance with the re- requirements. Director of Nursing will audit all allegations of sexual abuse for the development of an individualize address the emotional and psych needs weekly X 4 weeks, Bi-we and monthly X 1. Results of these audits will be re- quarterly Quality Assurance Me for further problem resolution if The Director of Nursing is respon- implementing the acceptable pla- correction by 09/29/2018 	sident □s ent sident # 2 n care plan g the r the nt Director timely d care and ident sure that e and that s corrected egulatory resident timely d care to chosocial eekly X 2, eviewed at eeting X 1 needed. onsible for		

If continuation sheet Page 6 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345420	B. WING			C 09/06/2018		
NAME OF PI	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMANCE HEALTH CARE CENTER					1987 HILTON STREET BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	9 6	F	657	7			
	sexual abuse were co Nursing (DON). In he DON indicated that th members not to spea alleged incident "so th mind."	ation of the first allegation of ompleted by the Director of r undated statement, the e psychiatrist advised staff k to Resident #2 about the nat it will go away from his						
	Resident #2. The resi	riate sexual behavior by dent "had his hand in his ide to come closer stating to						
	08/06/18. Psychologis has a history of sever "impaired reality testin Other Providers," she enter [resident ' s roo	n by Psychologist #1 on st #1 noted that Resident #2 re mental illness with ng." In the section "Notes to "recommended that staff m] with a witness due to ims made by pt. of sexual						
	08/31/18 revealed that allegation of sexual a	discharge summary of at Resident #2 made another buse by facility staff on al Report was filed with the 5/18.						
	Assistant Director of I she was aware of the Psychologist #1 that s room with a witness of sexual abuse. She sta discussed in an Intero	05/18 at 11:45 a.m., the Nursing (ADON) stated that recommendations by staff entered the resident ' s lue to unfounded claims of ated that the issue was disciplinary Team (IDT) f were now following this						

If continuation sheet Page 7 of 8

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 10/09/2018 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345420	B. WING				C 06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	CE HEALTH CARE CENT	FD		1987 HILTON STREET			
ALAMAN	E REALTH CARE CENT	ER		BURLINGTON, NC 272	17		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	27	F 65	57			
	In an interview on 09/	05/18 at 12:14 p.m., the					
		arrative notes written by the					
		ing residents were emailed					
		printed them and provided					
	them to Medical Reco	ctronic health record. The					
	DON was aware of the						
	recommendation not t	to enter the room of					
		d she had informed staff					
	discussed in an IDT n	f this guidance. It was also					
	resident 's allegation,						
		cumented in the medical					
		at staff members were					
		ident #2 's inappropriate					
		abuse allegation and were airs. The DON stated that					
		t see the need to update the					
	care plan because sta	aff were already					
	implementing the reco						
		are plan revisions to address					
	-	l impaired reality testing consistent behavioral					
	approach for the resid						
	In an interview on 09/	05/18 at 5:30 p.m., the					
	Administrator acknow	•					
	formulate a care plan	for Resident #2 with					
	strategies that may he						
	allegations of sexual a impaired reality testing						
		y.					

If continuation sheet Page 8 of 8