PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		C 11/30/2018
	ROVIDER OR SUPPLIER	REHABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE  11 HARRILSON STREET  CHERRYVILLE, NC 28021	11700/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 000	INITIAL COMMENTS	8	F 000		
		was conducted from 11/28/18 nmediate Jeopardy was			
		600 at a scope and severity J 607 at a scope and severity J			
	Tags F600 and F607 Quality of Care.	constituted Substandard			
		began on 10/28/18 and was 8. A partial extended survey			
F 600 SS=J	Free from Abuse and CFR(s): 483.12(a)(1	_	F 600		12/21/18
	Exploitation The resident has the neglect, misappropri and exploitation as cincludes but is not lir corporal punishment	e right to be free from abuse, ation of resident property, defined in this subpart. This mited to freedom from it, involuntary seclusion and nical restraint not required to nedical symptoms.			
	§483.12(a) The facil	ity must-			
	physical abuse, corp involuntary seclusion				
	Based on observation interviews and staff	ons, record review, resident and Nurse Practitioner (NP)		F600 Free from Abuse and Neglect CFR(s):483.12(a)(1)	
		ermined that the facility failed s right to be free of sexual		483.12 Freedom from Abuse, Neglect,	
ABORATORY	I DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> E	TITLE	(X6) DATE

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

(X6) DATE

12/18/2018 **Electronically Signed** 

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345255	B. WING				C / <b>30/2018</b>	
NAME OF PE	ROVIDER OR SUPPLIER	1.020	<del></del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	30/2016	
TO UNIC OF TH	TO VIDERY OR OUT I EIER				11 HARRILSON STREET			
CAROLINA	A CARE HEALTH AND	REHABILITATION			CHERRYVILLE, NC 28021			
(VA) ID	STIMMADA	STATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Х	(EACH CORRECTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From pa	ge 1	F 6	600				
	abuse for 2 of 3 (Re	esidents #2 and #3) residents			and Exploitation			
	reviewed for abuse. Resident #2, a cognitively				Disclaimer Clause:			
	impaired resident, was observed having oral sex				Preparation and or execution of this pl	an		
	with Resident #1. R	lesident #3, a cognitively			does not constitute admission or			
	impaired resident, v	vas observed to have her			agreement by the Provider of the truth	of		
		Resident #1. Residents #2			facts alleged or conclusion set forth or	the		
		sed at the facility and found to			statement of deficiencies. The plan is			
	have no physical in	juries.			prepared and executed solely because			
		10/00/10			is required by the provisions of State a	.nd		
	·	y began on 10/28/18 when			Federal law.			
		Resident #2 in her wheel chair			On October 28, 2018, nurse removed resident #1 from resident #2 s room.			
		e residents were observed by x. Immediate Jeopardy began			Nurse completed head to toe assessm	ont		
	_	sident #3 when Resident #1			to ensure no physical harm. Resident			
		eel chair to his room and he			was monitored by staff to be free from			
		aff to squeeze her breast.			contact from resident # 1. Family for			
	-	y was removed on 11/30/18			Resident # 2 notified of incident. Police	3		
	·	plemented a credible			called and notified of incident. Family	ook		
		liate Jeopardy removal. The			resident #1 home for the night.			
	facility will remain o	ut of compliance at a lower			On October 29, 2018 Administrator			
	•	level of D (no actual harm with			started resident on one to one supervi			
	•	nal harm that is not Immediate			for 24 hours, after family returned residual	dent		
	• • •	e monitoring of systems are			to facility. After 24 hours, facility then			
	•	complete employee in-service			started 15-minute checks ongoing on			
	training.				resident # 1 s location. Social			
	The findings include	ed:			worker/designee in serviced all facility action plan to monitor resident #1	OH		
	The infalligs include	<del>5</del> u.			regarding being around female resider	nte		
	1 Resident #1 was	admitted to the facility on			Administrator issued 30-day discharge			
		osis including unspecified			notice to resident # 1 for being a dang			
		ehavioral disturbance, bipolar			to himself and others as well as reside			
		ajor depressive disorder.			level of care no longer requires Skilled		] ]	
					Nursing Care. Social Worker began			
	Review of Resident	:#1's quarterly Minimum Data			seeking ALF placement for resident #			
	· · ·	nent dated 09/12/18 revealed			On October 30, 2018 Female resident	s on		
		he brief interview of mental			hall where Resident # 2 resided were			
	, ,	ating that he had no cognition			interviewed by Social Worker or design	пее		
		appropriate behaviors were			for any signs of abuse. None were		] ]	
	noted during the as	sessment period. He required			reported.			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 501251			Ι,	c
		345255	B. WING			1	/30/2018
NAME OF P	ROVIDER OR SUPPLIER	0.0200		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	30/2010
TVAINE OF T	TOVIDER OR OUT FILE				11 HARRILSON STREET		
CAROLIN	A CARE HEALTH AND R	EHABILITATION					
				C	HERRYVILLE, NC 28021		ı
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 2	F	600			
		walking in corridor. The			On November 5, 2018 Social Worker/		
		assessed as having no			designee in serviced staff on facility ab	use	
	limitations with range	<u> </u>			policy regarding sexual abuse and		
					resident □s right to be free from abuse.		
	Review of Resident #	t1's care plan revealed the			On November 8, 2018 Discharge appe		
		vhich was initiated on			was held at 1:00pm. On December 1,		
		viewed by staff on 9/06/18:			2018, appeal decision received by facil	ity.	
	"Mr. (Resident #1's la	ast name) was previously					
	reported by staff and						
	of inappropriate toucl	hing of female residents. He			On November 28, 2018, nurse remove	d	
	has signed a behavio	oral contract that he will not			resident #3 from resident # 1's room.		
	engage in such behavior or risk discharge." The				Nurse completed head to toe assessm		
	_	t #1 will not exhibit socially			to ensure no physical harm. Resident 3	3	
		ve behavior. Care plan			was monitored by staff to be free from		
		; "Assess whether the			contact from resident # 1. Family for		
	_	the resident and/or others.			Resident # 3 notified of incident on		
		y", "If Mr. (Resident #1)			November 28, 2018. Police called and		
		cially inappropriate redirect			notified of incident on November 28,	4.4	
	him immediately and behavior will not be to				2018. Administrator amended plan to supervision for resident # 1 until ALF	1.1	
		ity name)." and "Observe			placement is secured. Administrator		
		appropriate/disruptive			initiated immediate discharge of reside	nt	
	behaviors when arou				#1 to family. Social Worker to seek placement in ALF.		
	Further review of Res	sident #1's care plan			Social Worker/ designee in serviced a	11	
		g "Problem" which was			staff on November 28-30, 2018 on facilities		
	,	and was most recently			abuse policy regarding sexual abuse a	-	
		9/06/18: "Mr. (Resident #1's			resident right to be free from any abuse		
	-	nale resident who had			all times. On December 5, 2018 Rehab		
	significant physical lir	mitation outside of facility			Director in serviced all rehab staff		
	when he had been to	ld that until this issues was			regarding resident # 1 being around or		
		TRATION he was not to take			pushing female residents in wheelchair		
		f facility." The goal was for			On November 29, 2018 Social worker/		
		arm others secondary to			appointed designee's and interviewed		
		or. A care plan approach			interviewable female residents through	out	
		o an adjustment to his			facility.		
	·	contract and all parties will			On November 30, 2018, all		
	sign."				non-interviewable residents were		
					assessed head to toe by Director of		1

Facility ID: 923063

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
						С	
		345255	B. WING _			11/	/30/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
				11	11 HARRILSON STREET		
CAROLIN	A CARE HEALTH AN	D REHABILITATION			HERRYVILLE, NC 28021		
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	'	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 600	Continued From p	age 3	F	600			
		nt #1's behavioral contact that sident #1, his Power of Attorney			Nursing or designee.		
				Administrator or designee began			
	and facility staff members on 10/26/16 specified the following; "I (Resident #1's name) understand				randomly interviewing 4 residents 5 tir	mes	
		pehavioral agreement signed			per week for any potential abuse and	1103	
		n effect as long as I am a			reporting to include if resident has eve	r	
		at agreement was that I			experienced abuse at facility for 1 mor		
		I touched any female in an			then 3 days per week for 1 month then		
	inappropriate manner that I would be discharged				time per week for 1 month and 2 times		
	from Carolina Car	e Center. Today I understand			per month for 3 months. Administrator		
	that I am signing a	an addendum to that			updated QAPI Committee to change or	f	
	•	e that I will not take any female			1:1 and reviewed findings for any furth	er	
		f facility. I understand that I am			corrections.		
		ith other residents in public					
		acility with their consent. I			Administrator conducted in service for		
		can attend supervised out of			department managers on importance of		
		other residents. I understand			reporting and completing 24/5-day rep		
		touching of females and taking			timely 12-14-18. All Licensed Nursing		
		f facility without administration ult in discharge from Carolina			staff will be in-serviced on reporting ab within 2 hours 12-21-18.	use	
	Care Center."	uit iii discharge irom Carolina			WILIIII 2 HOUIS 12-21-10.		
	Care Cerner.				Administrator or designee will monitor	4	
	a Review of Resi	dent #1's progress notes			staff members 5 days a week for one	7	
		g note dated 10/28/18 at 5:33			month, then 4 staff members 3 days a		
	1	rse #1 which stated, "CNA			week for 1 month, then 4 staff member		
		assistant) reported resident			time a week for one month, then 4 state		
	'	female residents breasts			members 2 times a month for 3 month		
	_	then whispered in her ear and			Administrator or designee will review		
	'	om. Nurse went to room and			Allegation log sheet daily for 3 weeks a	and	
	female resident wa	as sitting up in wheelchair in			weekly thereafter for 3 months. Copies		
	front of bathroom	with head moving back and			reportable allegations will be given to		
	forth and resident	was standing in front of her			Regional Manager or designee to revie	€W	
		en, penis out and residents			for timeliness.		
	l •	nouth. When I asked them what					
		he states, 'I'm just doing what			Reports will be reviewed in monthly Q/		
		.' He didn't say anything but			meeting monthly for 6 months. IDT tea	.m	
	·	dent to leave room at this time.			will make any necessary changes to		
		the was not allowed to go back			monitoring as needed during monthly		
	down to her room	and that he had violated his			QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	` '	(X3) DATE SURVEY COMPLETED		
		345255	B. WING _			C 11/30/2018	
	ROVIDER OR SUPPLIER	REHABILITATION	,	STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021	DDE	11769/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	·	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From page	esident walked out of room at	F	600			
	she was admitted to Resident #2 diagnos without behavioral d disorder, anxiety dis arousal disorder.  Review of Resident 10/18/18 revealed sl Interview for Mental indicated moderately required supervision locomotion on the un assistance with one	#2's medical record revealed the facility on 06/05/17. Bes which included; demential isturbance, major depressive order and female sexual  #2's quarterly MDS dated the had a BIMS (Brief Status) score of 8 (which or impaired cognition), with set up help only with hit, required extensive person physical assistance seed a wheelchair as a mobility					
	following "Problem" "Decision making: (F difficulty making her decisions, long and noted." The goal spename) will suffer no loss." Approaches in and redirect as mucl further decline in cognitive at 5:18 PM which spename (certified nursing as resident feeling on rewhispered in her ear Nurse went to room	#2's care plan revealed the was initiated on 10/16/18: Resident #2's first name) has own safe/appropriate short term memory deficit is ecified, "(Resident #2's first loss of dignity due to memory icluded; "Assist to reminisce in as possible to decrease gnition."  #2's progress notes revealed en by Nurse #1, on 10/28/18 ecified the following; "CNA sistant) reported another esidents breasts and then and took her to her room.  and resident was sitting up in f bathroom with head moving					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTI	ON	(X3) DATE COMP	SURVEY PLETED
		345255	B. WING				C 30/2018
	ROVIDER OR SUPPLIER  A CARE HEALTH AND F			STREET ADDRE		1 117	30/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	front of her with his z residents penis was them what they were doing what all other a resident to leave roo wanted to do it and the was telling him to consider the stelling him to consider	ne other resident standing in cipper open, penis out and in her mouth. When I asked a doing she states, 'I'm just adults do.' Asked other m at that time. She states, 'I hen grabbed his arm and me back to her bed later.' It he was not allowed to go om. Removed other resident p in her room NAD (no The note also specified was made aware.  's "Investigation Report" or of Nurses (DON) revealed and oriented in all spheres the no short term or long term the investigation specified is interviewed by the police on nitted to being in female thaving inappropriate contact westigation report specified able to remember the incident the police.  Ininterview with Resident #1 PM revealed he was able to ntly and was able to verbally uring the interview with do he remembered he had to denied inappropriately alle residents since this	F	500			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	l\ /	E SURVEY IPLETED
		345255	B. WING			C
	ROVIDER OR SUPPLIER  A CARE HEALTH AND			STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET  CHERRYVILLE, NC 28021	11	1/30/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	and was pleasantly recall what day it was that day. Resident # incidents of inapproperation in the properation of the properati	ge 6 as seated in her wheel chair confused. Resident #2 did not as or what she ate for lunch 2 also did not recall any priate behaviors being asidents or staff members  cility's Social Worker (SW) on M revealed Resident #1 was and could consent to engage in Resident #2 was cognitively able to consent to sexual  gation-employee statement (NA) #1 dated and signed #1 saw Resident #1 bending did touching Resident #2's ay and started rolling to her thair and immediately reported  11/30/18 at 12:05 PM with NA (28/18 she observed Resident #2 in her wheelchair in the ed that she was seeing the aid, so she could not see if arching Resident #2's breasts, aped over her shoulder. She erbally tell Resident #1 to stop in her wheel chair because ead of her, but she followed in together in Resident #2's she could hear the residents in doorway and it sounded goral sex. NA #1 stated she vay and she could not directly doing because they were	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345255	B. WING _			C 11/30/2018	
	ROVIDER OR SUPPLIER  A CARE HEALTH AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	could hear it sound oral sex. NA #1 state what she heard and say anything to the them, but immediat Manager (Nurse #1 Manager (Nurse #1 request to check or #2. NA #1 stated s should have immed Resident #1 and Re residents and then Unit Manager.  During an interview Nurse #1 (Unit Manager.  During an interview Nurse #1 (Unit Manager.  During an interview Nurse #1 (Unit Manager.  #1 touching Reside and they were now #1 stated she went room's opened doo Resident #2's room and Resident #2's room and Resident #2 en stated she observer Resident #2's mout the residents what is stopped. Nurse #1 go to his room and to the Director of Nurse #1 called her Resident #1 and R	on the room, but from what she ed like they were engaged in teed she was so shocked from a could see that she did not residents or attempt to stop ely went to report it to the Unit.  On the like they were engaged in teed she was so shocked from a could see that she did not residents or attempt to stop ely went to report it to the Unit.  On the like they engaged to her a Resident #1 and Resident he was now aware that she intelligent interrupted and stopped esident #2, separated the reported their activity to the serior of the reported their activity to the serior of the room, shocked her to go to because she saw Resident int #2's breasts in the hallway in Resident #2's room. Nurse to the room, knocked on the rand when she entered she observed Resident #1's gaged in oral sex. Nurse #1 d Resident #1's penis in the Nurse #1 stated she asked they were doing and they stated she told Resident #1 to she immediately reported this	F	600			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET  CHERRYVILLE, NC 28021	11/30/2016
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 600	he was aware of hi placed Resident #1 observation for 24 in an effort to prote residents. The DOI an abuse investiga department was not linterview with the Drevealed staff are to form they are to ke abuser to leave and The DON stated Not stopped Resident #10/28/18 when the room together and engaged in sexual Review of the police report of a sexual and 10/28/18 at 6:21 Pl "Suspect engaged listed Resident #2 and Informed of Reside observed engaged room on 10/28/18 at 6:d1 Pl informed of Reside observed engaged room on 10/28/18 at 6:d1 Pl informed of Reside observed engaged room on 10/28/18 and an of investigate. The ad #1's family was not for the night. Upon 10/29/18 the reside	aing of a female resident and a sactions. So, the facility on 1 on 1 direct staff hours to monitor his behaviors of Resident #2 and other is specified the facility started tion and the local police of tified about the incident.  DON on 11/29/18 at 4:30 PM rained if they see abuse in any ep the resident safe, ask the id not leave the resident alone. A #1 should have immediately and Resident #2 on residents were alone in a NA #1 thought they were activity.  The incident/investigation report responded in reference to a assault at the facility on in a sex act with victim" and	F 60		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 t. BOILB	_		(	C
		345255	B. WING			11/	30/2018
	ROVIDER OR SUPPLIER  A CARE HEALTH AND	REHABILITATION	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 11 HARRILSON STREET CHERRYVILLE, NC 28021	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	During another inter 11/29/18 at 4:05 PM 10/28/18 NA #1 sho and Resident #2 wh together in Resident they were having in of going to report where doing to Nurse Resident #1 should resident's in their whoserved doing this stated Resident #1's been shared with domorning stand up or by department man stated her expectati managers to share Resident #1's inapp female residents and their wheel chairs, which wheel chairs, which wheel chairs, which administrators remain on 1 on 1 didischarged from the facility.  b. Review of Resider revealed a social set 12:15 PM which spen notified of incident wheel chairs was grounds for that he needed to be states she is at work.	d on 15 minute staff checks to	F	600			

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		345255	B. WING _			C 11/30/2018
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021	DDE	11730/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	called, and this was discharge. Resident (responsible party) verported and that the Review of Resident she was admitted or diagnoses which incidisorder, anxiety discrete Review of Resident 10/05/18 revealed states.	e to the state, the police were grounds for immediate states understanding. RP was also notified that it was e police were called."  #3's medical record revealed in 5/31/16. Resident #3 had luded; major depressive order and difficulty walking.  #3's Annual MDS dated the had a BIMS (Brief	F	600		
	indicated severely in of walking in room a utilized a wheel chair required supervision assistance with loco.  Review of Resident a social services not which specified. "Reincident with male rewas notified that we police were called. Fer police when they can was notified of incide it was reported to stawith resident. RP apthis time."	Status) score of 7 (which inpaired cognition), the activity and corridor did not occur, she is as a mobility device and with one person physical motion on and off the unit.  #3's progress notes revealed the dated 11/28/18 at 2:17 PM is sident interviewed regarding resident this morning. Resident reported to state and the Resident agreed to speak with me. RP (responsible party) tent and also made aware that after and police came to speak preciative of notification at the report and allegation report.				
	revealed on 11/28/1 (Resident #1) pushe #3) in his room and behind them and (Refemale resident sitting	y's initial allegation report 8 at 9:45 AM a male resident d female resident (Resident Licensed Nurse went directly esident #1) was bending over ng in wheel chair fondling her diately removed female				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345255	B. WING			C 11/30/2018
	ROVIDER OR SUPPLIER  A CARE HEALTH AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET  CHERRYVILLE, NC 28021		11/30/2010
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	interview the Social Resident #3 on 11/3 following; "Resident room, male resident wanted to show her resident pushes he room. At this time, the male resident as he gave him perm forehead. Male resiforehead, and nurs of the room. At this BINGO but does not there."  Observations of Read AM revealed she wand was pleasantly Resident #3 at this recall any incidents acted or touched here."	cy's investigation revealed an Worker conducted with 28/18 which revealed the t states the she was in her t came to her room and a picture in his room. Male in her wheelchair to his (Resident #3's name) states sked if he could kiss her, and ission to kiss her on the dent kissed her on the e came in and pushed her out time, she remembers going to out recall who pushed her sident #3 on 11/29/18 at 10:24 as seated in her wheel chair confused. Interview with time revealed she did not where a male resident had er inappropriately.	F 60	· · ·		
	showed interest in shis room, so he were and pushed her to large 'nothing else happename) walked in arname) in exasperat (DON's first name) (Resident #1's last When asked, Mr. (First name)	t states that female resident seeing the Christmas tree in int to get her out of her room nis room and states that seed'. Nurse (Nurse #2's first ad said (Resident #3's first sed tone, and nurse went to (DON) office and Mr. name) went to BINGO alone. Resident #1's last name) ot touch female resident in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED  C 11/30/2018	
		345255	B. WING				
	ROVIDER OR SUPPLIER  A CARE HEALTH AND			STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021	•	1/30/2016	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	on 11/28/18 at 3:55 ambulate independe answer questions. In Resident #1 he stati inappropriate containmenth or so ago, but touching of any femincident which occu #1 did admit to push wheel chair from he morning of 11/28/18 touch the female resident On 11/30/18 at 2:40 conducted with the who interviewed Re as part of the facility stated Resident #1 could consent to en Resident #3 was counable to consent to stated that when sh denied touching Re 11/28/18, but admitt her wheel chair into SW stated the facility inding placement for living facility.  Review of the facility written statement from "Informed by therap name) pushing a few Went immediately to	n interview with Resident #1 PM revealed he was able to ently and was able to verbally During the interview with ed he remembered he had et with a female resident a at denied inappropriately ale residents since this erred a month ago. Resident hing a female resident in her er room to his room during the en, but stated that he did not sident inappropriately while	F 6				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		<b>345255</b> B. V				C 11/30/2018		
	ROVIDER OR SUPPLIER	REHABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP  111 HARRILSON STREET  CHERRYVILLE, NC 28021	CODE	11/00/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 600	her. Walked in and breast. Asked (Res He jerked his hand back away from wo ready to go to Bingreached over picke nurse and stated 'h both residents they and immediately afresident from room Nursing)."  Interview with Nurs revealed on 11/28/her that Resident # his room. Nurse #2 responded and wheroom Resident #1 v Resident #3's whee a blanket that was stated she then obshand to squeeze R. Nurse #3 stated she what he was doing away from Resident getting ready for bir #1 then picked up a Nurse #2 stated she they should not be	lent's wheel-chair leaning over noted hand fondling her right ident #1) what he was doing. away quickly and stepped man. Stated 'we were getting o.' (Resident #1's name) d banana up and gave to this ere this is for you.' Instructed were not to be in the room terward removed female. Reported to DON (Director of e #2 on 11/29/18 at 11:30 AM 18 Therapy staff #1 reported to 1 had rolled Resident #3 into stated she immediately en she entered Resident #1's vas standing to the side of el chair and was straightening on Resident #3's lap. Nurse #2 served Resident #1 use his left esident #3's right breast twice. The therapy staff they were not he said they were not he said they were not he said they were not not stated Resident #1 and he immediately stepped the said they were not he said they were not huse #2 stated Resident had banana and gave it to her. The informed the residents that in the room together and she #3 from Resident #1's room	F	600				
	written statement fr specified, on 11/28/ passing by room #2 Resident #3 and Re	cy's investigation revealed a om Therapy staff #1 which /18 at 9:15 am she was 215 which was occupied by esident #5 and Resident #1 the room with both residents						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I \ '		(X3) DATE SURVEY COMPLETED		
		345255	B. WING		C 11/30/2018		
	ROVIDER OR SUPPLIER  A CARE HEALTH AND F			STREET ADDRESS, CITY, STATE, ZIP COD 111 HARRILSON STREET CHERRYVILLE, NC 28021	•	11/30/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	#1 reported to nursing of situation and later asked Resident #1 if resident to BINGO. If the staff member reresident #1 pushed toward the 100 hall. "When I checked to a (Resident #1's name direction toward BIN resident (Resident #3's name reported to staff with (Resident #3's name reported to staff with (Resident #3's name #1's name) room."  Interview with Therating 11:55 AM revealed so act inappropriately, and the resident to be if female resident to be if female resident to be if female resident to the if female resident #1 had a haresident inappropriately incident of inappropriately (Resident #1 stated she also with should not be pushing wheelchairs.  An interview with the 11/29/18 at 2:10 PM alert and oriented and The NP stated follow where Resident #1 as	tement specified therapy staffing on the hall to make aware returned to the room and the was there to take Resident #1 stated "yes" and mained in the room until Resident #3 out of room The statement specified; see if that the resident e) was headed in the right GO, resident was not, 1 name) pushed resident e) into his room. I then staff removing resident e) from residents (Resident e) from residents (Resident e) from residents (Resident e) to the nursing #1 stated she was unaware resistory of touching female ately and that he was being minutes by staff for an residents in the resident #1 and the did not see Resident #1 are the behaviors with a female 2) on 10/28/18. Therapy staffing other residents in their e. Nurse Practitioner (NP) on revealed Resident #1 was and was aware of his actions. Ving the 10/30/18 incident and Resident #2 were ppropriate contact Resident	F 6				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345255	B. WING _			C 11/30/2018	
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021	•	11/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 600	initial 24 hour period minute checks by sta The NP stated she was to place Resident #1 monitoring and was decision. The NP state second occurrence of contact with another #3) on 11/28/18 he was monitoring which word discharged to an assensident #1 no long. Interview with the Di 11/28/18 at 4:35 PM not be allowed to pure wheelchairs. The DO previously exhibited female resident and The DON stated if significant pushing another resistant member should the resident and repulated back on 1:1 separate was observed by a resident #3 in her was observed by a resident #1 should #1 should resident #1 should resident #1 should resident #1 shoul	nour period and following the he was then placed on 15 aff to monitor his behaviors.	F	500			

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		` '	(X3) DATE SURVEY COMPLETED		
		345255	B. WING			C		
	ROVIDER OR SUPPLIER  A CARE HEALTH AND			STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021	DE	11/30/2018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 600	morning stand up m by department mans stated her expectati managers to share a Resident #1's inapp female residents an their wheel chairs, v department to prote The administrator st remain on 1 on 1 did discharged from the facility.  On 11/30/18 at 8:32 informed of the Imm provided an accepta Immediate Jeopardy PM. The facility's cri indicated:  Carolina Care Healt Allegation of Immediate For the purpose of t Health and Rehabili substantial complian forth, this plan of co credible allegation of removal.  On October 28, 201 2 to her room and re on resident # 1. Nu from resident # 2's r to toe assessment to Resident # 2 will be from contact from re Resident # 2 notified	ge 16 eetings which are attended agers. The administrator on was for the department any concerns, such as ropriate behaviors of touching d rolling other residents in with the employees in their ct the residents in the facility. The facility atted Resident #1 would rect staff monitoring until he is facility to an assisted living  AM the administrator was rediate Jeopardy. The facility able credible allegation of a removal on 11/30/18 at 8:40 redible allegation of Jeremoval on 11/30/18 at 8:40 redible allegation Carolina Care tation (CCHR) is not in the with the regulation set rection constitutes CCHR of Immediate Jeopardy  8 Resident # 1 took resident # resident # 2 performed oral sex rese # 1 removed resident #1 removed resident #1 removed resident #1 removed by staff to be free resident # 1. Family for dof incident on October 28, and notified of incident on	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345255	B. WING		C 11/30/2018	
	ROVIDER OR SUPPLIER  A CARE HEALTH AND	REHABILITATION	<b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET  CHERRYVILLE, NC 28021	1 11/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 600	October 28, 2019 in Resident # 2 will be On November 28, 2 with resident # 3 touremoved resident # 1 Nurse completed he ensure no physical monitored by staff to resident # 1. Family incident on Novembrotified of incident or regards to resident protected from abuse Facility identified off all female residents allegation. Social winterviewed all intenthroughout facility a non interviewable renursing staff to ensuall non interviewable renursing staff to ensuall non interviewable head to toe by Direct November 30, 2018 Family took resident avoid further incider on Ootober 29, 2018 resident on one to confacility then started resident # 1 wherea worker/designee in October 29, 2018 or resident # 1 in regardesidents. Social Workersidents. Social Workersidents. Social Workersidents.	regards to resident # 2. protected from abuse.  018 resident # 1 was seen uching her breast. Nurse #2 3 from resident #1's room. and to toe assessment to harm. Resident # 3 will be to be free from contact from for Resident # 3 notified of her 28, 2018. Police called and on October 28, 2019 in # 3. Resident # 3 will be see.  The residents to be at risk as due to the nature of the bricker/ appointed designee's viewable female residents so of November 29, 2019. All tesidents will be monitored by the they are free from abuse. The residents will be assessed eter of Nursing or designee by the they are free from abuse. The residents will be assessed to of Nursing or designee by the they are free from abuse. The residents will be assessed to of Nursing or designee by the they are free from abuse. The residents will be assessed to of Nursing or designee by the they are free from abuse. The residents will be assessed to of Nursing or designee by the they are free from abuse. The residents will be assessed to of Nursing or designee by the first product of the produc	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345255	B. WING _			C 11/30/2018	
	ROVIDER OR SUPPLIER	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 111 HARRILSON STREET CHERRYVILLE, NC 28021	•	11/33/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	resident # 1 on Oobeing a danger to resident level of conversion on Notatill pending. Social safe location for the 2018 Administrate supervision for resensure that a staff resident # 1 at all secured. Nursing ensure they are from serviced all rehalf being around or wheelchair. Administrator and contacts for any pote include if resident facility for 1 month month then 1 times per month for the serviced and contacts for place review action plant adjustments until is obtained. Administrator and contacts for place review action plant adjustments until is obtained. Administrator and contacts for place review action plant adjustments until is obtained. Administrator 30, 20° Facility will remove November 30° Facility will remove Novemb	ed 30 day discharge notice to be be 29, 2018 in regards to himself and others as well as are no longer requires Skilled mily appealed. Discharge notice ovember 8, 2018 with decision al Worker will attempt to find ansfer. Effective November 28, or amended plan to 1:1 sident # 1. Administrator will member is assigned to times until other placement is will monitor residents daily to be from abuse. Rehab Director ab staff in regards to resident # pushing female residents in histrator or designee will a 4 female residents 5 times per intial abuse and reporting to has ever experienced abuse at a then 3 days per week for 1 per week for 1 month and 2 or 3 months.  Bewed findings to QAPI rember 30, 2018 for any further I working will update QAPI committee of any ment. CCHR will continue to and make any necessary placement of accused resident histrator updated QAPI rege of 1:1 supervision on 18.	F	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345255	B. WING		C 11/30/2018	
	ROVIDER OR SUPPLIER  A CARE HEALTH AND R	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	11100/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 607 SS=J	revealed Resident #1 monitoring in place a or staff behaviors we Interviews with reside safe in the facility, intrevealed they had reresident abuse and vimmediately stop any observe, separate the protect the residents review of facility doct skin audits were come credible allegation will bruising or injuries ar interviews conducted felt safe at the facility mistreated.  Develop/Implement ACFR(s): 483.12(b)(1)  §483.12(b) The facility implement written poor separate and exploits misappropriation of resident safe and exploits and exploits misappropriation of resident safe and safe safe safe and safe safe safe and safe safe safe safe safe safe safe safe	at 9:05 PM. Observations I had 1 on 1 direct staff and no inappropriate resident re observed in the facility, ents revealed that they felt derviews with facility staff derived inservice training on were aware they should of form of resident abuse they re residents involved to and then report the abuse, umentation revealed resident apleted as specified on the high review of resident I by staff revealed residents of and had not been Abuse/Neglect Policies (-(3))  ty must develop and licies and procedures that: it and prevent abuse, tion of residents and resident property, ish policies and procedures	F 600			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		345255	2.55 B. WING			C 11/30/2018		
NAME OF PE	ROVIDER OR SUPPLIER	0.0200		STI	REET ADDRESS, CITY, STATE, ZIP CODE	<u>  11/-</u>	30/2018	
TVAINE OF T	COVIDER OR OUT FEILER							
CAROLINA	A CARE HEALTH AND R	EHABILITATION			1 HARRILSON STREET			
				CF	HERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 607	Continued From pag	e 20	F6	607				
F 607	facility's abuse policic resident to resident sampled residents re #2, a cognitively impained having oral sex with cognitively impaired have her breast sque Residents #2 and #3 and found to have no also failed to impleme abuse by not reporting resident sexual abuse two hours for 1 of 3 s for abuse (Resident standard	es to protect and prevent exual abuse for 2 of 3 viewed for abuse. Resident aired resident, was observed Resident #1. Resident #3, a resident, was observed to rezed by Resident #1.  I were assessed at the facility ophysical injuries. The facility ent its policy for reporting an incident of resident to reto the state agency within rampled residents reviewed #2).  began on 10/28/18 when rent #1 roll Resident #2 in her om and the residents were ring oral sex in her room diately stopped by the staff Jeopardy began on 11/28/18 in staff observed Resident #1 rel chair to his room and he ff to squeeze her breast. was removed on 11/30/18	F 6	607	implement written policies and proceduthat:  483.12(b)(1) Prohibit and prevent abust neglect, and exploitation of residents a misappropriation of resident property, 483.12(b)(2) Establish policies and procedures to investigate any such allegations, and 483.12(b)(3) Include training as require at paragraph 483.95  On October 28, 2018, nurse removed resident #1 from resident #2□s room. Nurse completed head to toe assessm to ensure no physical harm. Resident # was monitored by staff to be free from contact from resident # 1. Family for Resident # 2 notified of incident. Police called and notified of incident. Family to resident #1 home for the night.  On October 29, 2018 Administrator started resident on one to one supervis for 24 hours, after family returned resident facility. After 24 hours, facility then started 15-minute checks ongoing on resident #1□s location. Social worker/designee in serviced all facility action plan to monitor resident #1 regarding being around female resident Administrator issued 30-day discharge notice to resident #1 for being a dange to himself and others as well as resider level of care no longer requires Skilled Nursing Care. Social Worker began	e, nd ed ent 2 cook cion cent con ts.		
	The findings included	l: ity's "Abuse Prevention			seeking ALF placement for resident #1 On October 30, 2018 Female residents hall where Resident # 2 resided were interviewed by Social Worker or design	on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED  C 11/30/2018	
		<b>345255</b> B. WING					
NAME OF F	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	730/2010	
				111 HARRILSON STREET			
CAROLINA CARE HEALTH AND REHABILITATION		REHABILITATION		CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 607	Continued From page	e 21	F 6	07			
F 607	Program" policy state revised August 2006 residents have the rig neglect, misappropria corporal property and "Policy Interpretation specified the followin committed to protecti by anyone including, to: facility staff, other volunteers, staff from services to our reside guardians, surrogate or any other individual Review of the facility "Preventing Resident April 2014, revealed not condone any form continually monitor of procedures, training assist in preventing rulnterpretation and In The facility's goal is the abuse-free environm prevention/intervention to necessarily limited Assessing, care plan residents with needs to conflict or neglect; signs and symptoms developing and imple address behavioral is Resident #1 was admentia without behavioral without behavioral without behavioral without behavioral without behavioral in the revised programment in the process of	ement, which was dated revealed the following: "Our ght to be free from abuse, ation of resident property, d involuntary seclusion." The and Implementation" g: "1. Our facility is ing our residents from abuse but not necessarily limited residents, consultants, other agencies providing ents, family members, legal s, sponsors, friends, visitors, al."  Is policy statement for t Abuse", which was revised the following: "Our facility will of resident abuse and will ur facility's policies, programs, systems, etc., to esident abuse." The policy's inplementation" specified; 1. o achieve and maintain an ent. 2. Our abuse on program includes, but is id to, the following: "j. ning and monitoring and behaviors that may lead k. Assessing residents with of behavior problems and ementing care plans to	F 6	for any signs of abuse. None wereported.  On November 5, 2018 Social Nesignee in serviced staff on far policy regarding sexual abuse resident sright to be free from On November 8, 2018 Dischar was held at 1:00pm. On Decer 2018, appeal decision received.  On November 28, 2018, nurse resident #3 from resident #1's Nurse completed head to toe at to ensure no physical harm. Rewas monitored by staff to be free contact from resident #1. Fam Resident #3 notified of incider November 28, 2018. Police canotified of incident on November 28, 2018. Police canotified of incident on November 2018. Administrator amended supervision for resident #1 unplacement is secured. Administinitiated immediate discharge with the family. Social Worker to splacement in ALF.  Social Worker/ designee in sestaff on November 28-30, 2018 abuse policy regarding sexual resident right to be free from a all times. On December 5, 201 Director began educating all reregarding resident #1 being an pushing female residents in who on November 29, 2018 Social appointed designee's and interesidented.	Norker/ acility abuse and n abuse. ge appeal mber 1, d by facility.  removed room. assessment esident 3 ee from illy for nt on lled and er 28, plan to 1:1 til ALF strator of resident seek  rviced all 3 on facility abuse and ny abuse at 8 Rehab ehab staff round or neelchair.		

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345255	B. WING		C		
ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS CITY STATE 7	•		
NOVIDEN ON 3011 LIEN				II CODE		
A CARE HEALTH AN	D REHABILITATION					
			CHERRYVILLE, NC 28021			
SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED	ACTION SHOULD BE COMPLET DATE	TION	
Continued From p	page 22	F 6	07			
Set (MDS) assess	sment dated 09/12/18 revealed		facility for any signs of a reported.	buse. None were		
he scored a 13 on the brief interview of mental status (BIMS) indicating that he had no cognition impairments. No inappropriate behaviors were noted during the assessment period. He required set up help only with walking in corridor. The resident was also as assessed as having no			non-interviewable reside assessed head to toe by	ents were  / Director of		
Review of Reside following "Problen 10/14/16 and was	nt #1's care plan revealed the n" which was initiated on reviewed by staff on 9/06/18:		issued 30 day discharge Resident #1.	e notice to		
reported by staff a of inappropriate to has signed a beha engage in such be goal was for Residinappropriate/disrapproaches include behavior endanger Intervene if necess begins to become him immediately a behavior will not be	and then his own self admission buching of female residents. He avioral contract that he will not enavior or risk discharge." The dent #1 will not exhibit socially uptive behavior. Care plan ded; "Assess whether the ers the resident and/or others. Is sary", "If Mr. (Resident #1) esocially inappropriate redirect and inform him that such be tolerated at CCC		randomly interviewing 4 per week for any potenti reporting to include if reexperienced abuse at fathen 3 days per week for time per week for 1 mor per month for 3 months. updated QAPI Committee	residents 5 times al abuse and sident has ever cility for 1 month r 1 month then 1 th and 2 times Administrator ee to change of		
(abbreviation for f and report socially behaviors when a Further review of revealed the follow initiated on 10/24/ reviewed by staff last name) took a significant physical when he had been	acility name)." and "Observe y inappropriate/disruptive round others."  Resident #1's care plan wing "Problem" which was 16 and was most recently on 9/06/18: "Mr. (Resident #1's female resident who had al limitation outside of facility in told that until this issues was		department managers of reporting and completing timely 12-14-18. All Lice staff will be in-serviced of within 2 hours 12-21-18.  Administrator or designer randomly monitoring staff members 5 days a	n importance of g 24/5-day report ensed Nursing on reporting abuse ee began aff for awareness interviewing 4 week for one		
	ROVIDER OR SUPPLIER  A CARE HEALTH AN  SUMMAR (EACH DEFICI REGULATORY)  Continued From p Review of Reside Set (MDS) assess he scored a 13 or status (BIMS) indi impairments. No noted during the a set up help only w resident was also limitations with ran  Review of Reside following "Problem 10/14/16 and was "Mr. (Resident #1 reported by staff a of inappropriate to has signed a beha engage in such be goal was for Reside inappropriate/disr approaches includ behavior endange Intervene if neces begins to become him immediately a behavior will not b (abbreviation for f and report socially behaviors when a  Further review of revealed the follow initiated on 10/24/ reviewed by staff last name) took a significant physica when he had beed decided by ADMII	A CARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 22 Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/12/18 revealed he scored a 13 on the brief interview of mental status (BIMS) indicating that he had no cognition impairments. No inappropriate behaviors were noted during the assessment period. He required set up help only with walking in corridor. The	ROVIDER OR SUPPLIER  A CARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 22  Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/12/18 revealed he scored a 13 on the brief interview of mental status (BIMS) indicating that he had no cognition impairments. No inappropriate behaviors were noted during the assessment period. He required set up help only with walking in corridor. The resident was also as assessed as having no limitations with range of motion.  Review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/14/16 and was reviewed by staff on 9/06/18: "Mr. (Resident #1's last name) was previously reported by staff and then his own self admission of inappropriate touching of female residents. He has signed a behavioral contract that he will not engage in such behavior or risk discharge." The goal was for Resident #1 will not exhibit socially inappropriate/disruptive behavior. Care plan approaches included; "Assess whether the behavior endangers the resident and/or others. Intervene if necessary", "If Mr. (Resident #1) begins to become socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate/disruptive behaviors when around others."  Further review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/24/16 and was most recently reviewed by staff on 9/06/18: "Mr. (Resident #1's last name) took a female resident who had significant physical limitation outside of facility when he had been told that until this issues was decided by ADMINISTRATION he was not to take	ROVIDER OR SUPFLIER  A CARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 22  Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/12/18 revealed he scored a 13 on the brief interview of mental status (BIMS) indicating that he had no cognition impairments. No inappropriate behaviors were noted during the assessment period. He required set up help only with walking in corridor. The resident was also as assessed as having no limitations with range of motion.  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The goal was for Resident #1 will not exhibit socially inappropriately enhavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate redirect him immediately and inform him that such behavior will not be tolerated at CCC (abbreviation for facility name)." and "Observe and report socially inappropriate redirect him immediately and inform him that such behavior will not be t	A BUILDING  345255  A SAMPO  A CARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST SE PRECEDED BY FULL PRECEDIAL PROPERTY AND STREET CHERRYVILLE, NC 28021  Continued From page 22  Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/12/18 revealed he scored a 13 on the brief interview of mental status (BIMS) indicating that he had no cognition impairments. No inappropriate behaviors were noted during the assessment period. He required set up help only with walking in corridor. The resident was also as assessed as having no limitations with range of motion.  Review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/14/16 and was reviewed by staff on 906/18: "Mr. (Resident #1's last name) was previously reported by staff and then his own self admission of inappropriate foliary by he havior or the final papproaches included; "Assess whether the behavior endangers the resident and/or others. Intervene if necessary", "If Mr. (Resident #1) begins to become socially inappropriate/disruptive behavior. Care plan approaches included; "Assess whether the behavior rehavior. Care plan approaches included; "Assess whether the behavior rehavior. Care plan approaches included; "Assess whether the behavior rehavior. Care plan approaches included; "Assess whether the behavior rehavior. Care plan approaches included; "Assess whether the behavior rehavior. Care plan approaches included; "Assess whether the behavior rehavior. Care plan approaches included; "Assess whether the behavior rehavior. Care plan approaches included; "Assess whether the behavior rehavior when around others."  Further review of Resident #1's care plan revealed the following "Problem" which was initiated on 10/24/16 and was was of the problem which was not totally inappropriate/disruptive behaviors when around others."  Further review of Resident #1's care plan revealed the following into the control of the problem which was not totally inappropriate/disruptive beha	

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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	ROVIDER OR SUPPLIER  A CARE HEALTH AND R	EHABILITATION		11	TREET ADDRESS, CITY, STATE, ZIP CODE 11 HARRILSON STREET HERRYVILLE, NC 28021			
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F 607	inappropriate behavior included; "Staff will do previous behavioral or sign."  Review of Resident # was signed by Reside and facility staff mem the following; "I (Resi that my previous beh 4/15/16 remains in ef resident here. That are understood that if I to inappropriate manner from Carolina Care Cothat I am signing an a agreement. I agree the resident outside of fafree to socialize with areas inside the facility understand that I can facility events with other that inappropriate tout females outside of factonsent could result in Care Center."  a. Review of Resident revealed a nursing not pM, written by Nurse (certified nursing assifeeling on another fer (Resident #2) and the	arm others secondary to be. A care plan approach of an adjustment to his contract and all parties will art's behavioral contact that the sent #1, his Power of Attorney bers on 10/26/16 specified dent #1's name) understand avioral agreement signed fect as long as I am a greement was that I unched any female in an arthat I would be discharged tenter. Today I understand addendum to that hast I will not take any female acility. I understand that I am other residents in public ty with their consent. I attend supervised out of the residents. I understand the inching of females and taking cility without administration in discharge from Carolina	F	607	time a week for one month, then 4 staff members 2 times a month for 3 months.  Administrator or designee will review Allegation log sheet daily for 3 weeks a weekly thereafter for 3 months.  Copies of reportable allegations will be given to Regional Manager or designer review for timeliness.  Reports will be reviewed in monthly Queeting monthly for 6 months. IDT tea will make any necessary changes to monitoring as needed during monthly QAPI.	and e e to API		
	front of bathroom with forth and resident wa	sitting up in wheelchair in n head moving back and s standing in front of her penis out and residents						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 607	they were doing shall other adults do. 'yeah.' Asked reside Educated resident down to her room a behavior contract. this time and went Review of Resident #2 diagnowithout behavioral disorder, anxiety darousal disorder.  Review of Resident 10/18/18 revealed Interview for Menta indicated moderate required supervisic locomotion on the assistance with on with transfers and device.  Review of Resident following "Problemt "Decision making: difficulty making hed decisions, long and noted." The goal syname) will suffer no loss." Approaches and redirect as mufurther decline in control Review of Resident Review of	outh. When I asked them what we states, 'I'm just doing what 'I He didn't say anything but ent to leave room at this time. he was not allowed to go back and that he had violated his Resident walked out of room at to his room."  It #2's medical record revealed to the facility on 06/05/17. Sees which included; dementia disturbance, major depressive forder and female sexual  It #2's quarterly MDS dated she had a BIMS (Brief al Status) score of 8 (which sely impaired cognition), on with set up help only with unit, required extensive to person physical assistance used a wheelchair as a mobility  It #2's care plan revealed the "was initiated on 10/16/18: (Resident #2's first name) has the rown safe/appropriate to short term memory deficit is to loss of dignity due to memory included; "Assist to reminisce to has possible to decrease	F 60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED		
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F 607	(certified nursing as resident feeling on resident feeling on resident feeling on resident in front of back and forth and front of her with his residents penis was them what they were doing what all other resident to leave rowanted to do it and was telling him to concern the concer	pecified the following; "CNA sistant) reported another esidents breasts and then r and took her to her room. and resident was sitting up in of bathroom with head moving the other resident standing in zipper open, penis out and in her mouth. When I asked to doing she states, 'I'm just adults do.' Asked other om at that time. She states, 'I then grabbed his arm and ome back to her bed later.' In the was not allowed to go om. Removed other resident up in her room NAD (no The note also specified	Fé	507			
	10/28/18 and he adresident's room and with resident. The ir Resident #2 was un when interviewed by Observations and a on 11/28/18 at 3:55 ambulate independents answer questions.	s interviewed by the police on mitted to being in female having inappropriate contact exestigation report specified able to remember the incident of the police.  In interview with Resident #1 PM revealed he was able to ently and was able to verbally ouring the interview with ead he remembered he had					

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propriate containing of any fendicident which occupations of Reference of the servations of Reference of the servations of the servations of Reference of the servations of the s	act with a female resident a ut denied inappropriately nale residents since this arred a month ago.  Resident #2 on 11/28/18 at 4:15 was seated in her wheel chair or confused. Resident #2 did not was or what she ate for lunch #2 also did not recall any opriate behaviors being residents or staff members  Residents or staff members  Resident #2 was cognitively unable to consent to engage in Resident #2 was cognitively unable to consent to sexual  Resident #2 was cognitively unable to consent to sexual  Resident #1 bending and touching Resident #1 bending and touching Resident #2's way and started rolling to her chair and immediately reported  1 11/30/18 at 12:05 PM with NA 0/28/18 she observed Resident #2 in her wheelchair in the fied that she was seeing the ind, so she could not see if ouching Resident #2's breasts,	F 60'	7				
	SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM PROPERTY OF THE PROPERTY OF TH	ARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ontinued From page 26 (appropriate contact with a female resident a month or so ago, but denied inappropriately buching of any female residents since this acident which occurred a month ago.  Observations of Resident #2 on 11/28/18 at 4:15 M revealed she was seated in her wheel chair and was pleasantly confused. Resident #2 did not exall what day it was or what she ate for lunch and day. Resident #2 also did not recall any acidents of inappropriate behaviors being whibited by male residents or staff members of the second or s	A BUILDING  345255  B. WING  WIDER OR SUPPLIER  CARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 26  suppropriate contact with a female resident a nonth or so ago, but denied inappropriately suching of any female residents since this cident which occurred a month ago.  Subservations of Resident #2 on 11/28/18 at 4:15  M revealed she was seated in her wheel chair and was pleasantly confused. Resident #2 did not secall what day it was or what she ate for lunch and tady. Resident #2 also did not recall any incidents of inappropriate behaviors being whibited by male residents or staff members awards her.  Interview with the facility's Social Worker (SW) on 1/30/18 at 12:40 PM revealed Resident #1 was lert and oriented and could consent to engage in exual activity, but Resident #2 was cognitively inpaired and was unable to consent to sexual ctivity.  Eview of an Investigation-employee statement ritten by Nurse Aide (NA) #1 dated and signed 0/28/18 stated NA #1 saw Resident #1 bending wer Resident #2 and touching Resident #2's reasts in the hallway and started rolling to her form in her wheelchair and immediately reported to her supervisor.  Figure 1. The sum of the provision of t	A BUILDING  345255  B. WING  A BUILDING  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, 2IP CODE  111 HARRILSON STREET  CHERRYVILLE, NC 28021  PROVIDERS PLAN OF COR  (EACH DEFICIENCY MUST BE PRECEDED BY FILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Onttinued From page 26  appropriate contact with a female resident a north or so ago, but denied inappropriately suching of any female resident #2 on 11/28/18 at 4:15  M revealed she was seated in her wheel chair and was pleasantly confused. Resident #2 did not seall what day it was or what she ate for lunch at day. Resident #2 also did not recall any cidents of inappropriate behaviors being shibited by male residents or staff members wards her.  Interview with the facility's Social Worker (SW) on 1/30/18 at 12:40 PM revealed Resident #1 was leart and oriented and could consent to engage in exual activity, but Resident #2 was cognitively apaired and was unable to consent to sexual citivity.  Eview of an Investigation-employee statement ritten by Nurse Aide (NA) #1 dated and signed 0/28/18 stated NA #1 saw Resident #2's reasts in the hallway and started rolling to her some in her wheelchair and immediately reported to her supervisor.  Uring interview on 11/30/18 at 12:05 PM with NA 1 she stated on 10/28/18 she observed Resident 1 rolling Resident #2 in her wheelchair in the allway. She specified that she was seeing the sidents from behind, so she could not see if esident #1 was touching Resident #2's breasts, ut his hand was draped over her shoulder. She lated she did not verbally tell Resident #1 to stop	A BUILDING  345255  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET CHERRYVILLE, NC 20021  PROVIDERS PLAN OF CORRECTION (EACH OPENGING MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)  Ontlinued From page 26 appropriate contact with a female resident a ontonth or so ago, but denied inappropriately suching of any female residents since this cident which occurred a month ago.  Deservations of Resident #2 on 11/28/18 at 4:15 M revealed she was seated in her wheel chair and was pleasantly confused. Resident #2 did not recall any cidents of inappropriate behaviors being whibited by male resident \$\frac{1}{2}\$ so what she ate for lunch at day. Resident #2 also did not recall any cidents of inappropriate behaviors being whibited by male residents or staff members wards her.  Iterview with the facility's Social Worker (SW) on 1/30/18 at 12:40 PM revealed Resident #1 was ert and oriented and could consent to engage in exual activity, but Resident #2 was cognitively papaired and was unable to consent to sexual citivity.  Eview of an Investigation-employee statement ritten by Nurse Aide (NA) #1 dated and signed D28/18 stated AV #1 saw Resident #1 bending ver Resident #2 and touching Resident #2's reasts in the hallway and started rolling to her own in her wheelchair and immediately reported to her supervisor.  Literview on 11/30/18 at 12:05 PM with NA 1 she stated on 10/28/18 she observed Resident 1 rolling Resident #2 in her wheelchair in the allway. She specified that she was seeing the sident she was seeing the sident #1 was touching Resident #2's breasts, ut his hand was draped over her shoulder. She is stated she did not verbally tell Resident #1 to stop		

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F 607	room. NA #1 stated so from the room's open like they were having peeked in the doorwasee what they were caround the corner in could hear it sounded oral sex. NA #1 state what she heard and say anything to the rethem, but immediated Manager (Nurse #1). Manager (Nurse #1) request to check on I #2. NA #1 stated she should have immediated Resident #1 and Residents and then returned Unit Manager.  During an interview of Nurse #1 (Unit Manager.  During an interview of Nurse #1 (Unit Manager.)  #1 touching Resident #2 room is and they were now in #1 stated she went to room's opened door Resident #2's room is and Resident #2's mouth the residents what the stopped. Nurse #1 stated she that the stopped. Nurse #1 stated she that the stopped. Nurse #1 stated she stated she that the stopped. Nurse #1 stated she stated she stated she stated she stated she stated she observed Resident #2's mouth the residents what the stopped. Nurse #1 stated she	the together in Resident #2's the could hear the residents in doorway and it sounded it oral sex. NA #1 stated she ay and she could not directly doing because they were the room, but from what she is dike they were engaged in it dishe was so shocked from could see that she did not esidents or attempt to stop by went to report it to the Unit NA #1 stated the Unit quickly responded to her Resident #1 and Resident en was now aware that she ately interrupted and stopped sident #2, separated the exported their activity to the	F	607		

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 607	4:35 PM revealed du Nurse #1 called her a Resident #1 and Res having oral sex in Restated Resident #1 hinappropriate touchir he was aware of his placed Resident #1 cobservation for 24 hin an effort to protect residents. The DON an abuse investigation police department at Review of the police revealed the police round of a sexual as 10/28/18 at 6:21 PM "Suspect engaged in listed Resident #2 as During interview with 11/29/18 at 8:40 AM informed of Resident observed engaged in room on 10/28/18 sh facility. The administ notified of the incider 10/28/18 and an officinvestigate. The adm #1's family was notifif for the night. Upon hin 10/29/18 the resident mon and then was placed monitor the resident.	cility's DON on 11/28/18 at ring the evening of 10/28/18 and informed her that sident #2 were observed esident #2's room. The DON ad previously exhibited ag of a female resident and actions. So, the facility on 1 on 1 direct staff ours to monitor his behaviors. Resident #2 and other specified the facility started on and notified the local cout the incident.  Incident/investigation report esponded in reference to a sault at the facility on The report specified; a sex act with victim" and at the victim.  In the Administrator on she stated when she was at 1 and Resident #2's being a oral sex in Resident #2's e immediately came to the rator stated the police were at during the evening of the came to the facility on the stated Resident ed and they took him home is return to the facility on the stated on 1 on 1 direct attoring for the first 24 hours on 15 minute staff checks to	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 607	10/28/18 NA #1 sl and Resident #2 v together in Reside they were having of going to report were doing to Nur Resident #1 shou resident's in their observed doing th stated Resident # been shared with morning stand up by department ma stated her expecta managers to shar Resident #1's inap female residents a their wheel chairs department to pro The administrator remain on 1 on 1 discharged from th facility.  b. Review of Resi revealed a social 12:15 PM which s notified of incident #3) at approximate this was grounds that he needed to states she is at wo At approximately interviewed regard that this is reporta called, and this wa discharge. Resident	PM, the administrator stated, on mould have stopped Resident #1 when she heard the residents ent #2's room and she thought inappropriate relations instead what she thought the residents se #1. The administrator stated, id not be allowed to roll wheel chairs and if he was is staff should stop him. She 1's inappropriate behaviors had department managers at meetings which are attended inagers. The administrator ation was for the department e any concerns, such as propriate behaviors of touching and rolling other residents in with the employees in their tect the residents in the facility. stated Resident #1 would direct staff monitoring until he is the facility to an assisted living the dent #1's progress notes service note dated 11/28/18 at pecified, "Resident family the with female resident (Resident ely 9:55 am. Family was told for immediate discharge and be picked up today. Daughter ork, but she would call his sister. 12:15 PM, resident was ding incident. He was notified ble to the state, the police were as grounds for immediate ent states understanding. RP by was also notified that it was	F	607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  CAROLINA CARE HEALTH AND REHA	BILITATION		STREET ADDRESS, CITY, STATE, ZIP C 111 HARRILSON STREET CHERRYVILLE, NC 28021	;ODE		
PREFIX (EACH DEFICIENCY MU	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA		
Review of Resident #3's is she was admitted on 5/31 diagnoses which included disorder, anxiety disorder.  Review of Resident #3's is 10/05/18 revealed she had Interview for Mental Status indicated severely impaired of walking in room and coutilized a wheel chair as a required supervision with assistance with locomotics.  Review of Resident #3's is a social services note dat which specified. "Resider incident with male resider was notified that we report police were called. Reside police when they came. It was reported to state an with resident. RP appreciatives time."  Review of the facility's intrevealed on 11/28/18 at 9 (Resident #1) pushed fer #3) in his room and Licent behind them and (Reside female resident sitting in the breast. Nurse immediated resident from situation.  Review of the facility's invince in the facility is invinced in the facility is invinced in the facility in the sident from situation.	medical record revealed 1/16. Resident #3 had 1/16. Resident walking.  Annual MDS dated 1/16 date and	F 6	07			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345255	B. WING			1	30/2018
ROVIDER OR SUPPLIER			11	1 HARRILSON STREET	1 117-	30/2016
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				,		(X5) COMPLETION DATE
Resident #3 on 11/28 following; "Resident so room, male resident wanted to show her a resident pushes her in room. At this time, (Rothe male resident ask she gave him permiss forehead. Male reside forehead, and nurse of the room. At this time, and the resident ask she gave him permiss forehead, and nurse of the room. At this time, and the resident and the resident and was pleasantly on the recall any incidents was and was pleasantly on the recall any incidents was acted or touched her recall any incidents was acted or touched her recall any incidents was acted or touched her recall any incidents with Resident #1 on following; "Resident showed interest in set his room, so he went and pushed her to his 'nothing else happen name) walked in and name) in exasperate (DON's first name) (Resident #1's last naw the was that he did not anyway."	states the she was in her came to her room and a picture in his room. Male in her wheelchair to his esident #3's name) states and sion to kiss her on the came in and pushed her out me, she remembers going to recall who pushed her out of the exame in and pushed her out me, she remembers going to recall who pushed her out of the exame in and pushed her out me, she remembers going to recall who pushed her out of the exame in and pushed her out of the exame in and pushed her out of the exame in and pushed her out of the exame in the exame in the example of th	F	607			
	CORRECTION  ROVIDER OR SUPPLIER  A CARE HEALTH AND R  SUMMARY ST (EACH DEFICIENC REGULATORY OR I  Continued From page Resident #3 on 11/28 following; "Resident so room, male resident of wanted to show her a resident pushes her i room. At this time, (Rother male resident ask she gave him permiss forehead. Male reside forehead, and nurse of the room. At this time BINGO but does not there."  Observations of Resident #3 at this time recall any incidents was and was pleasantly on the recall any incidents was acted or touched her.  Review of the facility's with Resident #1 on following; "Resident showed interest in see his room, so he went and pushed her to his 'nothing else happendiame) walked in and name) in exasperated (DON's first name) (DON's fi	A CARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31  Resident #3 on 11/28/18 which revealed the following; "Resident states the she was in her room, male resident came to her room and wanted to show her a picture in his room. Male resident pushes her in her wheelchair to his room. At this time, (Resident #3's name) states the male resident asked if he could kiss her, and she gave him permission to kiss her on the forehead. Male resident kissed her on the forehead, and nurse came in and pushed her out of the room. At this time, she remembers going to BINGO but does not recall who pushed her there."  Observations of Resident #3 on 11/29/18 at 10:24  AM revealed she was seated in her wheel chair and was pleasantly confused. Interview with Resident #3 at this time revealed she did not recall any incidents where a male resident had acted or touched her inappropriately.  Review of the facility's investigation revealed an interview the facility's Social Worker conducted with Resident #1 on 11/28/18 which revealed the following; "Resident states that female resident showed interest in seeing the Christmas tree in his room, so he went to get her out of her room and pushed her to his room and states that 'nothing else happened'. Nurse (Nurse #2's first name) walked in and said (Resident #3's first name) in exasperated tone, and nurse went to (DON's first name) (DON) office and Mr. (Resident #1's last name) went to BINGO alone. When asked, Mr. (Resident #1's last name) states that he did not touch female resident in	A BUILDI  ROVIDER OR SUPPLIER  A CARE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31  Resident #3 on 11/28/18 which revealed the following; "Resident states the she was in her room, male resident came to her room and wanted to show her a picture in his room. Male resident pushes her in her wheelchair to his room. At this time, (Resident #3's name) states the male resident asked if he could kiss her, and she gave him permission to kiss her on the forehead, and nurse came in and pushed her out of the room. At this time, she remembers going to BINGO but does not recall who pushed her there."  Observations of Resident #3 on 11/29/18 at 10:24  AM revealed she was seated in her wheel chair and was pleasantly confused. 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WING STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31  Resident #3 on 11/28/18 which revealed the following; "Resident states the she was in her room, male resident came to her room and wanted to show her a picture in his room. Male resident pushes her in her wheelchair to his room. At this time, (Resident #3's name) states the male resident asked if he could kiss her, and she gave him permission to kiss her on the forehead. Male resident kissed her on the forehead, and nurse came in and pushed her out of the room. At this time, she remembers going to BINGO but does not recall who pushed her there."  Observations of Resident #3 on 11/29/18 at 10:24  AM revealed she was seated in her wheel chair and was pleasantly confused. Interview with Resident #3 at this time revealed she did not recall any incidents where a male resident had acted or touched her inappropriately.  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WING  STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET CHERRYVILLE, NC 28021  SUMMANY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY WILL TE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31  Resident #3 on 11/28/18 which revealed the following: "Resident states the she was in her room, male resident came to her room and wanted to show her a picture in his room. Male resident pushes her in her wheelchair to his room. At this time, (Resident #3's name) states the male resident asked if he could kiss her, and she gave him permission to kiss her on the forehead. Male resident kised her on the forehead, and nurse came in and pushed her ot the room. At this time, she remembers going to BINGO but does not recall who pushed her there."  Observations of Resident #3 on 11/28/18 at 10:24 AM revealed she was seated in her wheel chair and was pleasantly confused. 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WING  STREET ADDRESS, CITY, STATE, ZIP CODE 111  HARRILSON STREET CHERRYVILE, NC 28021  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 31  Resident #3 on 11/28/18 which revealed the following: "Resident states the she was in her room, male resident came to her room and wanted to show her a picture in his room. Male resident pushes her in her wheelchair to his room. At this time, (Resident #3 on and urse came in and pushed her out of the room. At this time, she remembers going to BINGO but does not recall who pushed her there.'  Observations of Resident #3 on 11/29/18 at 10-24 AM revealed she was seated in her wheel chair and was pleasantly confused. Interview with Resident #3 on the facility's investigation revealed an interview the facility's investigation revealed the following: "Resident states that female resident showed interest in seeing the Christmas tree in his room, so he went to get her out of her room and pushed her to his room and states that 'nothing else happened'. Nurse (Nurse #2's first name) in exasperated tone, and nurse went to (DON's first name) (DON) office and Mr. (Resident #1's last name) eand nurse went to (DON's first name) (DON) office and Mr. (Resident #1's last name) experiment to BINGO alone. When asked, Mr. (Resident #1's last name) states that he did not touch female resident in anyway.'  Observations and an interview with Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345255	B. WING _			C 11/30/2018
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 111 HARRILSON STREET CHERRYVILLE, NC 28021	ODE	11/30/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	answer questions. E Resident #1 he state inappropriate contact month or so ago, but touching of any female	ently and was able to verbally buring the interview with ed he remembered he had et with a female resident a t denied inappropriately ale residents since this	F	607		
	#1 did admit to push wheel chair from he morning of 11/28/18	rred a month ago. Resident ning a female resident in her r room to his room during the , but stated that he did not sident inappropriately while was in his room.				
	conducted with the f who interviewed Re- as part of the facility stated Resident #1 v could consent to en- Resident #3 was co- unable to consent to stated that when she denied touching Re- 11/28/18, but admitt her wheel chair into SW stated the facility	PM an interview was facility's Social Worker (SW), sidents #1 and Resident #3 's investigation. The SW was alert and oriented and gage in sexual activity, but gnitively impaired and was a sexual activity. The SW e interviewed Resident #1 he sident #3 inappropriately on led to pushing Resident #3 in his room on 11/28/18. The y was in the process of a Resident #1 at an assisted				
	written statement from "Informed by therapy name) pushing a fer Went immediately to noted (Resident #1's side of female reside her. Walked in and rebreast. Asked (Resident #1's side of female resident #1's side of femal	o's investigation revealed a com Nurse #2 which specified, ist she noticed (Resident #1's male resident into his room. To room. Door was open and is name) standing on the left ent's wheel-chair leaning over noted hand fondling her right dent #1) what he was doing.				

AND DUAN OF CODDECTION		1 ' '	PLE CONSTRUCTION  IG	` ′	COMPLETED	
		345255	B. WING _			C 11/30/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET  CHERRYVILLE, NC 28021		11/30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	ready to go to Bingo reached over picked nurse and stated 'he both residents they and immediately after resident from room. Nursing)."  Interview with Nurse revealed on 11/28/18 her that Resident #1 his room. Nurse #2 s responded and when room Resident #1 w. Resident #3's wheel a blanket that was o stated she then obse hand to squeeze Re Nurse #3 stated she what he was doing a away from Resident getting ready for bing #1 then picked up a Nurse #2 stated she they should not be in removed Resident # and reported the incomplete the incomplete from the facility written statement from specified, on 11/28/19 passing by room #2.00 Resident #3 and Reside	nan. Stated 'we were getting .' (Resident #1's name) banana up and gave to this re this is for you.' Instructed were not to be in the room erward removed female Reported to DON (Director of  #2 on 11/29/18 at 11:30 AM B Therapy staff #1 reported to had rolled Resident #3 into stated she immediately n she entered Resident #1's as standing to the side of chair and was straightening n Resident #3's lap. Nurse #2 erved Resident #1 use his left sident #3's right breast twice. then asked Resident #1 and he immediately stepped #3 and he said they were go. Nurse #2 stated Resident banana and gave it to her. informed the residents that in the room together and she 3 from Resident #1's room	F 6	07		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345255	B. WING_			C 1/30/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021	•	1/30/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 607	the staff member ren Resident #1 pushed toward the 100 hall. "When I checked to so (Resident #1's name direction toward BIN resident (Resident #3's name reported to staff with (Resident #3's name #1's name) room."  Interview with Theral 11:55 AM revealed so act inappropriately, both male resident to be if female residents, so staff. Therapy staff Resident #1 had a hir resident inappropriate incident of inappropriate incident of inappropriate incident (Resident #1 stated she also we should not be pushing wheelchairs.  An interview with the 11/29/18 at 2:10 PM alert and oriented and The NP stated follow where Resident #1 are observed having inal #1 he was placed on monitoring for a 24 hinitial 24 hour period minute checks by states.	Resident #1 stated "yes" and nained in the room until Resident #3 out of room The statement specified; see if that the resident ) was headed in the right GO, resident was not, 1 name) pushed resident ) into his room. I then staff removing resident ) from residents (Resident ) from residents (Resident #1 out thought it was odd for a in the room occupied by two she reported it to the nursing #1 stated she was unaware story of touching female ately and that he was being minutes by staff for an interior behaviors with a female 2) on 10/28/18. Therapy staff as not aware Resident #1 ag other residents in their Nurse Practitioner (NP) on revealed Resident #1 was d was aware of his actions. Fing the 10/30/18 incident and Resident #2 were oppropriate contact Resident	F	507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345255	B. WING		C 11/30/2018
	ROVIDER OR SUPPLIER  A CARE HEALTH AND	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE I11 HARRILSON STREET CHERRYVILLE, NC 28021	1 11100/2010
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 607	monitoring and was decision. The NP's second occurrence contact with another #3) on 11/28/18 he monitoring which we discharged to an as Resident #1 no long. Interview with the E 11/28/18 at 4:35 PM not be allowed to pushelchairs. The Discharged previously exhibited female resident and The DON stated if spushing another restaff member should the resident and resident #3 in her was observed by a resident #3 in her was observed by a resident #1 should resident #1 shou	ge 35 If on 15 minute staff Is in agreement with this stated since Resident #1 had a of having inappropriate or female resident (Resident was placed back on 1:1 staff ould continue until he was seisted living facility because ger required skilled level care.  Director of Nursing (DON) on the revealed Resident #1 should ush any resident in their ON stated Resident #1 had the inappropriate touching of a staff observed Resident #1 sident in their wheel chair the dinstruct him to stop pushing port the behavior to a nurse.  In the interval of the interval of the was staff monitoring after he rolled wheel chair into his room and nurse to touch the female  In the administrator on the female of the was staff should stop him. She is staff should stop him. She is inappropriate behaviors had be allowed to roll heel chairs and if he was a staff should stop him. She is inappropriate behaviors had be partment managers at neetings which are attended lagers. The administrator ion was for the department any concerns, such as	F 607		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION		E SURVEY IPLETED
		345255	B. WING		4.	C
NAME OF PROVIDER OR SUPPLIER  CAROLINA CARE HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  111 HARRILSON STREET  CHERRYVILLE, NC 28021		11/30/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	Continued From pag	e 36	F 60	7		
	female residents and their wheel chairs, w department to protec The administrator sta remain on 1 on 1 dire	opriate behaviors of touching I rolling other residents in ith the employees in their it the residents in the facility. ated Resident #1 would ect staff monitoring until he is facility to an assisted living				
	informed of the Imme provided an acceptal Immediate Jeopardy	AM the administrator was ediate Jeopardy. The facility ble credible allegation of removal on 11/30/18 at 8:40 dible allegation of IJ removal				
	Allegation of Immedi For the purpose of the Health and Rehabilits substantial complian forth, this plan of cor- credible allegation of removal. On October 28, 2018 2 to her room and re- on resident # 1. Nur- from resident # 2's ro- to toe assessment to Resident # 2 will be a from contact from resident # 2 notified 2018. Police called a October 28, 2019 in Resident # 2 will be a On November 28, 20 with resident # 3 tous	and Rehabilitation Credible ate Jeopardy removal: allegation Carolina Care ation (CCHR) is not in ce with the regulation set rection constitutes CCHR Immediate Jeopardy  Bresident # 1 took resident # sident # 2 performed oral sex se # 1 removed resident #1 from. Nurse completed head the ensure no physical harm. Immonitored by staff to be free sident # 1. Family for of incident on October 28, and notified of incident on regards to resident # 2. performed to resident # 1 was seen ching her breast. Nurse #2 from resident #1's room.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345255	B. WING _			C 1/30/2018
NAME OF PROVIDER OR SUPPLIER  CAROLINA CARE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP C  111 HARRILSON STREET  CHERRYVILLE, NC 28021		1/30/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	ensure no physical hamonitored by staff to resident # 1. Family incident on November notified of incident or regards to resident # protected from abus Facility identified other all female residents allegation. Social work interviewed all intervitorial throughout facility as non interviewable renursing staff to ensurable head to toe by Direct November 30, 2018.  Family took resident avoid further incident on 0otober 29, 2018	ad to toe assessment to narm. Resident # 3 will be be free from contact from for Resident # 3 notified of er 28, 2018. Police called and n October 28, 2019 in # 3. Resident # 3 will be e. Her residents to be at risk as due to the nature of the orker/ appointed designee's riewable female residents is of November 29, 2019. All sidents will be monitored by re they are free from abuse. The residents will be assessed tor of Nursing or designee by	F	607		
	Facility then started resident # 1 whereal worker/designee in so October 29, 2018 or resident #1 in regard residents. Social Wo staff on November 3 policy in regards to sright to be free from Administrator issued resident # 1 on Octobeing a danger to his resident level of care Nursing Care. Famil appeal held on Nove	15 minute checks ongoing on				

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 OR SUPPLIER  CAROLINA CARE HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021			11700/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 607	2018 Administrator a supervision for reside ensure that a staff or resident # 1 at all tin secured. Nursing wi ensure they are free in serviced all rehab 1 being around or purchasing with the secured and potential to the secure and potential to the	amended plan to 1:1 lent # 1. Administrator will lent # 1. Administrator w	F6	507			

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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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	immediately stop any observe, separate the protect the residents review of facility docus in audits were come credible allegation who truising or injuries an interviews conducted felt safe at the facility mistreated.  2. Review of the facility mistreated.  2. Review of the facility mistreated.  2. Review of the facility mistreated.  1. Review of the facility mistreated.  2. Review of the facility mistreated.  2. Review of the facility mistreated.  3. Review of the facility mistreated.  4. Review of the facility mistreated.  5. Review of the facility mistreated.  7. Review of the facility mistreated.  8. Review of the facility mistreated.  8. Review of the facility mistreated.  9. Review of Resident # a nursing note dated by Nurse #1 which stassistant) reported resident # a sessistant) reported resident # a sessistant # a sessis	rere aware they should form of resident abuse they e residents involved to and then report the abuse, imentation revealed resident pleted as specified on the nich revealed no suspicious in deview of resident by staff revealed residents and had not been by staff revealed residents and had not been ty's policy entitled; "Abuse porting" policy, which was 2017, revealed the following all reports of resident abuse, misappropriation of resident and/or injuries of unknown be promptly reported to all agencies (as defined by and thoroughly investigated int. Findings of abuse to be reported." Review of a "Reporting" revealed the pation of abuse, neglect, atment (including injuriesof misappropriation of resident arted immediately, but no hours if the alleged violation as resulted in serious bodily our (24) hours if the alleged olive abuse AND has not	F 6	07			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  CAROLINA CARE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021		1/30/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Nurse went to room sitting up in wheelch head moving back a standing in front of hout and residents peasked them what the just doing what all o anything but 'yeah.' at this time. Educate allowed to go back thad violated his beh walked out of room."  Review of the facility signed by the Direct Resident #1 was ale with a BIMS of 13 with a BIMS of 8 memory problems. It having a BIMS of 8 memory problems. That Resident #1 was 10/28/18 and he addresident's room and with resident. The in Resident #2 was un when interviewed by Interview with the fa 11/30/18 at 12:40 Plalert and oriented and sexual activity, but Fimpaired and was un activity.  During an interview Nurse #1 (Unit Management and was un activity.	r and took her to her room. and female resident was aair in front of bathroom with and forth and resident was her with his zipper open, penis enis was in her mouth. When I eay were doing she states, 'I'm ther adults do.' He didn't say Asked resident to leave room and resident he was not down to her room and that he avior contract. Resident at this time and went to his  at this time and went to his  are "Investigation and Report" or of Nurses (DON) revealed art and oriented in all spheres ith no short term or long term are Resident #2 was assessed as with short term and long term are investigation specified s interviewed by the police on mitted to being in female having inappropriate contact are the resident westigation report specified able to remember the incident	F6	507			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345255	B. WING _			C 1/30/2018	
NAME OF PROVIDER OR SUPPLIER  CAROLINA CARE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CO 111 HARRILSON STREET CHERRYVILLE, NC 28021		1730/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TIED C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	#1 touching Resider and they were now i #1 stated she went to room's opened door Resident #2's room and Resident #2's room and Resident #2's mouth the residents what the stopped. Nurse #1 signs to his room and signs to the Director of Nuradministrator.  Review of the police report of a sexual as 10/28/18 at 6:21 PM "Suspect engaged ir listed Resident #2 as During interview with 11/29/18 at 8:40 AM evening of 10/28/18 Resident #1 and Reengaged in oral sex she immediately car administrator stated incident during the epolice officer came to During another inter 11/29/18 at 4:05 PM this incident of resid which occurred during within two hours to the administrator stated in administrator stated incident of resid which occurred during within two hours to the administrator stated incident stated incident of resid which occurred during within two hours to the administrator stated incident stated incident stated incident of resid which occurred during within two hours to the administrator stated incident stated incident of resid which occurred during within two hours to the administrator stated incident of resid which occurred during within two hours to the administrator stated incident of resid which occurred during within two hours to the administrator stated incident of resid which occurred during within two hours to the administrator stated incident of residual which occurred during within two hours to the administrator stated incident of residual which occurred during within two hours to the administrator stated incident of residual which occurred during within two hours to the administrator stated incident of residual which occurred during within two hours to the administrator stated incident of residual which occurred during the engaged in or and the administrator stated incident of residual which occurred during the engaged in or and the administrator stated incident of residual which occurred the administrator stated incident of residual which occurred the administrator stated incident of the administrator stat	because she saw Resident Int #2's breasts in the hallway In Resident #2's room. Nurse In the room, knocked on the Int and when she entered Int she observed Resident #1's Int gaged in oral sex. Nurse #1 Int Resident #1's penis in Int. Nurse #1 stated she asked Interest were doing and they It tated she told Resident #1 to Interest to she immediately reported this Interest in a sex act with victim" and	Fé	507			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  G	(X3) DA <sup>-</sup> COM	(X3) DATE SURVEY COMPLETED	
	345255	B. WING			C 11/30/2018	
NAME OF PROVIDER OR SUPPLIE		1	STREET ADDRESS, CITY, STATE, ZIP CODE		1/30/2018	
CAROLINA CARE HEALTH A	ND REHABILITATION		111 HARRILSON STREET CHERRYVILLE, NC 28021			
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
thought she had resident abuse i	page 42 29/18 at 4:08 PM because she 24 hours to report an incident of f there was no physical harm to rolved in the incident.	F 60				