STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345521	A. BUILDING _____ B. WING _____	C 07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNUG HARBOR ON NELSON BAY	272 HIGHWAY 70 SEALEVEL, NC 28577

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted. One of seven allegations was substantiated. Event ID#6DJZ11.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to protect a cognitively impaired resident from physical abuse by a staff member for 1 of 1 residents reviewed for staff to resident abuse (Resident #4). The findings included: Record review indicated Resident #4 had been admitted to the facility on 06/11/19 with diagnoses which included, in part, urinary tract infection and dementia. A review of Resident #4's initial baseline care	F 600	F600 483.45 (a)(1) 1. On June 24, 2019 the Director of Nursing examined Resident #4, with a full skin assessment. Resident #4 was found not to have any redness or skin discoloration, bruising or injury. On June 24, 2019 Nursing assistant #1 was suspended pending the completion of an investigation. 2. On June 24, 2019 all cognitively impaired residents on Nursing assistant #1'□s assignment were assessed to	7/21/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/22/2019

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F 600	Continued From page 1 plan, dated 06/12/19, revealed Resident #4 had been confused at all times, had moderately impaired vision and adequate hearing. The baseline care plan indicated Resident #4 had natural teeth, had a neurocognitive disorder and had been unable to understand due to cognitive impairment. The baseline care plan indicated Resident #4 required an assist of one staff for grooming, hygiene and bathing and had been totally dependent on staff for toileting. The admission Minimum Data Set (MDS), dated 06/18/19, revealed Resident #4 had been severely cognitively impaired and required total dependence on staff for her activities of daily living (ADLs). The MDS indicated Resident #4 had physical behavioral symptoms directed toward others 1-3 days of the assessment period and rejected care 1-3 days of the assessment period. A review of the facility's Investigative Time Line, dated 06/25/19, revealed the Director of Nursing (DON) had been informed by Nurse #1 of an abuse allegation on 6/24/19 at 8:30 a.m. The time line indicated Nurse #1 had been informed by Nursing assistant (NA) #1 on 06/18/19 she had hit Resident #4 after Resident #4 had bitten her. During an interview with NA #1 on 07/02/19 at 12:07 p.m., NA #1 stated she had been assigned to care for Resident #4 on 06/18/19 from 7:00 a.m. to 7:00 p.m. NA #1 stated she had been asked by Nurse #1 to provide morning care to Resident #4 first that morning. NA #1 stated Resident #4 had been lying on her right side in her bed and as she attempted to get a shirt over the resident's head, Resident #4 grabbed NA #1's	F 600	determine if there were any injuries of unknown origin or skin issues that would suggest any abuse of the resident. All alert and oriented residents on Nursing assistant #1'□s assignment were interviewed to determine if they had experienced any issues of mistreatment or abuse by Nursing assistant #1. 3. On June 25, 2019 Nursing assistant #1□'s employment was terminated.Charge nurses were in-serviced on June 24, 2019 on timely reporting of abuse. All staff received training and education on the facility□ abuse policy and procedures on May 27,2019. 4. All staff received re-training and in-servicing on the facility□ abuse policy and procedures, what constitutes abuse and timely reporting of abuse on July 3, 2019 and will conduct quarterly in-services for the next twelve months on resident abuse. The Quality Assurance and Performance Improvement Committee meeting was held, and the committee was notified on July 8, 2019 of this plan. The facility will continue to perform background checks and licensure, certification verifications on potential new hires at or before hire. The Quality Assurance and Performance Improvement Committees will review all new hire files monthly at the Quality Assurance and Performance Improvement Committee meetings for adherence to this practice by the facility. The Quality Assurance and Performance	

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F 600	Continued From page 2 right hand and wrist with both of her hands and pulled NA #1's hand to her mouth and bit her. NA #1 stated she took her left hand and popped the resident's right hand. NA #1 stated it had been a knee-jerk reaction to get Resident #4 to release her bite before her skin had been broken by the resident's teeth. NA #1 stated she had not meant Resident #4 any harm. NA #1 stated the pop on the hand had startled Resident #4 and she had opened her mouth and released the bite. NA #1 stated she had completed dressing Resident #4 and left the room and immediately told Nurse #1. During an interview with Nurse #1 on 07/02/19 at 1:15 p.m., Nurse #1 stated NA #1 had reported the incident to her on 06/20/19 or 06/21/19 and stated she could not remember the exact day. Nurse #1 stated NA #1 reported Resident #4 had bitten her and in response to the bite she had slapped Resident #4. Nurse #1 stated she questioned NA #1 about the slap and NA #1 stated she had not slapped the resident but actually "flicked" the resident and stated NA #1 demonstrated a flicking/thumping action with her fingers as the gesture she had made. Nurse #1 stated she had informed NA #1 the incident would have to be reported. When asked, Nurse #1 stated NA #1 had not informed her of the date of the incident and she had not asked. When asked why she had waited until 06/24/19 to report the incident, Nurse #1 stated she had not believed NA #1 would have hit a resident. Nurse #1 stated she had a hard time believing someone would report they had hit a resident and stated she had felt as if NA #1 had been bragging she had hit a resident. Nurse #1 stated she had planned to have further conversation with NA #1 about the incident but as the day went on she became busy with her duties. Nurse #1 stated she had	F 600	Improvement Committee will review all incident reports at the monthly meetings for any trending of incidents of bruises or injuries of unknown origin that could potentially be related to resident abuse. The Quality Assurance and Performance Improvement Committee will ensure that training and education is provided to all employees at the time of hire and quarterly to raise awareness of the facility zero tolerance for abuse. The Quality Assessment and Performance Improvement Committee and the facility administrator will be responsible for ensuring that compliance is achieved and sustained. 5. Completion Date: July 21, 2019	

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F 600	Continued From page 3 reported the incident to the Assistant Director of Nursing (ADON) when she returned to work on 06/24/19. During an interview with the ADON on 07/02/19 at 1:36 p.m., the ADON stated she had been informed of the abuse allegation on 06/24/19 at 7:00 a.m. The ADON stated Nurse #1 had informed her NA #1 had told her she had hit Resident #4 in response to Resident #4 having bit her. The ADON stated Nurse #1 could not remember the exact date NA #1 had reported the incident to her and thought it had been on 06/20/19 or 06/21/19. The ADON stated she immediately reported the abuse allegation to the DON. The ADON stated she and Nurse #1 then went to Resident #4's room and completed a skin assessment which had been negative for any marks or bruises. During an interview with the Administrator on 07/02/19 at 2:25 p.m., the Administrator stated she had been made aware of the abuse allegation on 06/24/19 by the DON and she had immediately begun an investigation. The Administrator stated she had substantiated the allegation of abuse and NA #1's employment had been terminated.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		7/21/19

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F 609	Continued From page 4 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an abuse allegation of a resident being hit by a staff member immediately to the administrator for 1 of 1 staff to resident abuse investigations reviewed (Resident #4). The findings included: Record review indicated Resident #4 was admitted to the facility on 06/11/19 with diagnoses which included, in part, urinary tract infection and dementia. The admission Minimum Data Set (MDS), dated 06/18/19, revealed Resident #4 had been severely cognitively impaired and required total	F 609	F600 483.12 (c)(1)(4) 1. Nurse #1 was disciplined and re-educated on June 24, 2019 on facility abuse policy and timely reporting to administrator and Director of Nursing that the incident occurred, so that timely reporting could be completed to the North Carolina Health Care Registry. Charge nurses were in-serviced on June 24, 2019 on timely reporting of abuse. 2. No other residents were affected by untimely reporting. 3. All staff received re-training and	

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F 609	Continued From page 5 dependence on staff for her activities of daily living (ADLs). The MDS indicated Resident #4 had physical behavioral symptoms directed toward others 1-3 days of the assessment period and rejected care 1-3 days of the assessment period. A review of the Initial Allegation Report revealed the Administrator had been informed on 06/24/19 of an abuse allegation in which nursing assistant (NA) #1 had "flicked" Resident #4 after having been bit by Resident #4. The Initial Allegation Report indicated Nurse #1 had been informed of the incident on 06/20/19 and the Administer submitted the Initial Allegation Report to the State Agency on 06/24/19 via fax at 10:12 a.m. A review of the facility's Investigative Time Line, dated 06/25/19, revealed the Director of Nursing (DON) had been made aware of the abuse allegation on 06/24/19 at 8:30 a.m. The time line indicated the incident occurred on 06/18/19 at 9:30 a.m. The time line indicated the DON had informed the Administrator immediately of the abuse allegation. During a telephone interview with NA #1 on 07/02/19 at 12:07 p.m., NA #1 stated she was assigned to care for Resident #4 on 06/18/19 from 7:00 a.m. to 7:00 p.m. NA #1 stated she had been asked by Nurse #1 to provide morning care to Resident #4 first that morning. NA #1 stated Resident #4 had been lying on her right side in her bed and as she attempted to get a shirt over the resident's head, Resident #4 grabbed NA #1's right hand and wrist with both of her hands and pulled NA #1's hand to her mouth and bit her. NA #1 stated she took her left hand and "popped" the resident's right hand. NA #1	F 609	in-servicing on the facility abuse policy and procedures, what constitutes abuse and timely reporting of abuse on July 3, 2019. The Charge nurses will call the Director of Nursing at the conclusion of each shift, and give report on any happenings on the shift to include incidences that are not routine patient care. This will continue for a period of three months, to raise awareness to the nurses that the Director of Nursing has to be notified of anything not routine. The Director of Nursing will be responsible to report to the Administrator any unusual occurrences, any nurse not reporting (at the time of occurrence) of any abuse will be disciplined up to and including termination. 4. The Quality Assurance and Performance Improvement Committee will review the shift reports given to the Director of Nursing for three months, and then it will be reevaluated for committee to decide if there is a need to continue. The Quality Assurance and Performance Improvement Committee will review all incident reports at the monthly meetings for any trending of incidents of bruises or injuries of unknown origin that could potentially be related to resident abuse. The Quality Assessment and Performance Improvement Committee and the facility administrator will be responsible for ensuring that compliance is achieved and sustained. 5. Completion Date: July 21, 2019	

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F 609	Continued From page 6	F 609		

stated it was a knee-jerk reaction to get Resident #4 to release her bite before her skin was broken by the resident's teeth. NA #1 stated she had not meant Resident #4 any harm. NA #1 stated the pop on the hand startled Resident #4 and she opened her mouth and released the bite. NA #1 stated she completed dressing Resident #4 and left the room and immediately told Nurse #1. NA #1 stated she worked at a nursing home in the past where she had been told incidents such as that had to be reported within 2 hours. NA #1 stated Nurse #1 informed her the incident would have to be reported.

During an interview with Nurse #1 on 07/02/19 at 1:15 p.m., Nurse #1 stated NA #1 reported the incident to her on 06/20/19 or 06/21/19 and stated she could not remember the exact day. Nurse #1 stated NA #1 reported Resident #4 had bitten her and in response to the bite she slapped Resident #4. Nurse #1 stated she questioned NA #1 about the slap and NA #1 stated she had not slapped the resident but actually "flicked" the resident and stated NA #1 demonstrated a flicking/thumping action with her fingers as the gesture she had made. Nurse #1 stated she informed NA #1 the incident would have to be reported. When asked, Nurse #1 stated NA #1 had not informed her of the date of the incident and she had not asked. When asked why she waited until 06/24/19 to report the incident, Nurse #1 stated she had not believed NA #1 would have hit a resident. Nurse #1 stated she had a hard time believing someone would report they hit a resident and stated she felt as if NA #1 was bragging she hit a resident. Nurse #1 stated she planned to have further conversation with NA #1 about the incident but as the day went on she became busy with her duties. Nurse #1 stated

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F 609	Continued From page 7	F 609		

she reported the incident to the Assistant Director of Nursing when she returned to work on 06/24/19.

During an interview with the Administrator on 07/02/19 at 2:25 p.m., the Administrator stated she had been made aware of the abuse allegation on 06/24/19 by the DON and she immediately began an investigation and filed the Initial Allegation Report to the State Agency within two hours of being informed of the abuse on 06/24/19. The Administrator stated she substantiated the allegation of abuse and NA #1's employment had been terminated. The Administrator stated it was her expectation staff follow the facility's abuse policy which specified any employee is required to report it immediately to their supervisor or any member of administration.

During an interview with the DON on 07/02/19 at 1:56 p.m., the DON stated he participated in the investigation of the abuse allegation. When asked if he had questioned Nurse #1 about her waiting to report the abuse allegation, the DON stated Nurse #1 had told him she just could not believe NA #1 had done what she had said she had done. The DON stated it was his expectation that when abuse is suspected, it is reported to the supervisor immediately. The DON stated when abuse is reported to a supervisor, it is his expectation the supervisor report it to administration immediately.