STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 03/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 2/28/20 to 3/1/20. The sixteen allegations were unsubstantiated.	F 000		
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 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, resident, and staff	F 609	The statements included are not an	3/29/20

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

Electronically Signed | 03/05/2020

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F 609	Continued From page 1 interviews, the facility failed to report a sexual abuse allegation to the state agency within a two-hour time frame of the abuse allegation being made for one (Resident #6) of three abuse investigations reviewed. Finding included: Documentation on the most recent quarterly minimum data set assessment (MDS) dated 11/28/19, coded Resident #4 as having a Brief Interview for Mental Status (BIMS) score of 15 indicating intact memory and intact cognition. Documentation on the same quarterly MDS indicated the resident had the moods of feeling down/depressed, trouble falling asleep, and feeling tired but had no behaviors. Resident #4 had the diagnoses of major depressive disorder and generalized anxiety. Documentation on a care plan, updated on 2/24/20, revealed Resident #4 had a focus area that stated, "The resident is verbally aggressive towards residents and staff when resident is not having her way, resident is known to fabricate stories, multiple room changes due to verbal aggression [relative to] ineffective coping skills." Documentation on the most recent quarterly MDS assessment dated 1/8/20 coded Resident #7 as having a BIMs score of 7 indicating he was severely cognitively impaired. The documentation on the same MDS revealed Resident #7 had verbal behaviors 1 to 3 days of the assessment period, other behaviors 1 to 3 days of the assessment period and had wandering behaviors 4 to 6 days of the assessment period. Resident #7 had the diagnosis of sexual dysfunction diagnosed on 1/2/20 in addition to the diagnoses of mild intellectual difficulties, schizophrenic disorder, and benign neoplasm of the pituitary	F 609	admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F609 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to notify the state agency within two hours of an allegation of resident to resident abuse allegation. Resident #4 alleged the resident #7 was stretched on top of resident #6 humping and wiggling on 2/22/20. Facility reported within twenty four hours to the state agency on 2/23/20. How the facility will identify other residents having the potential to be affected by the same deficient practice: All Employee□s will be educated on All Employee□s will immediately report all allegations involving abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of patient property or a crime against a patient to Administrator or DON, and report to state agency and	

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F 609	Continued From page 2 gland. Resident #7 was ambulatory and did not require any assistance with walking. Documentation on the most recent annual MDS assessment dated 12/3/19 coded Resident #6 as having memory problems and having severely impaired cognition. The documentation also revealed Resident #6 required extensive assistance of two people for bed mobility and was rarely or never understood when she spoke. Resident #6 had diagnoses of mild intellectual difficulties. Resident #4 was interviewed on 2/29/20 at 12:30 PM. Resident #4 revealed that last Saturday (2/22/20) she came back to her room from the smoking area. Resident #4 indicated she wheeled herself to the doorway of her room and saw Resident #7 (male resident) stretched out on top of her roommate (Resident #6) "humping her and wiggling." Resident #4 recounted how she declared to Resident #7, "What are you doing!" Resident #4 revealed Resident #7 "jumped" off the bed and stated to her, "Nothin!" Resident #4 emphasized that at that point she wheeled herself down to the nurse's station screaming and hollering for help. Nurse #1 was assigned to the hallway on which Resident #4, Resident #6, and Resident #7 resided on 2/22/20 for the 7:00 PM to 7:00 AM shift. Nurse #1 was interviewed on 2/29/20 at 10:18 AM. Nurse #1 recounted that he was at the facility time clock when he heard Resident #4 screaming for help. Nurse #1 continued to explain that he ran to the hallway to observe Resident #4 crying and screaming for help as Resident #7 hollered behind her down the hallway. Nurse #1 confirmed Resident #4 told him the allegation that	F 609	Police within 2 hours if involves abuse, or results in serious bodily injury in person or via telephone by the Director of Nursing or Assistant Director of Nursing or Staff Development Nurse. Any Employee that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing or Assistant Director of Nursing or Staff Development Nurse. All Employee□s, including Agency staff before their first assignment, will be educated in orientation in person by Staff Development Nurse or Director of Nursing or Assistant Director of Nursing on All Employees will immediately report all allegations involving abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of patient property or a crime against a patient to Administrator or DON, and report to state agency, and Police within 2 hours if involves abuse, or results in serious bodily injury. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Administrator or Director of Nursing will audit all abuse allegations to ensure 2-hour reporting, 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 2. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.	

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F 609	Continued From page 3	F 609	Completion date: March 29, 2020	

she saw Resident #7 was on top of Resident #6 while she was in bed "humping and moving on top of her" as stated by Nurse #1. Nurse #1 revealed, after separating Resident #4 and Resident #7 in addition to checking on Resident #6, he notified his supervisor (Nurse #2) about what Resident #4 had said. Nurse #1 indicated Nurse #2 called the Director of Nursing (DON). Nurse #1 confirmed he told both Nurse #2 and the DON the allegation as he heard it from Resident #4.

Nurse #2 was interviewed on 2/29/20 at 4:11 PM. Nurse #2 indicated she heard arguing on another unit prompting her to go to that unit. Nurse #2 related she heard the allegation from Nurse #1, and she called the DON to notify her of the circumstances.

The DON was interviewed along with Administrator on 2/29/20 at 4:30 PM. The DON stated that she spoke with both Nurse #1 and Nurse #2 on the phone on 2/22/20 and confirmed she was told the same allegation that Resident #4 saw Resident #7 making movements on top of Resident #6 in the bed. The Administrator confirmed that the DON called him on 2/22/20 and relayed to him that same allegation made by Resident #4. The Administrator stated he called his vice president in the corporation to relay the circumstances. The DON added that she called her regional nursing corporate consultant on the evening of 2/22/20 to relay the allegation. The Administrator indicated that the next day, 2/23/20, discussions were held with the vice president, the nursing corporate consultant, and the DON regarding the validity of the allegation. The Administrator indicated that it was decided on 2/23/20 that the allegation should be reported

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before the 24-hour time requirement had passed. The Administrator revealed the police were called and notification to the state agency of the allegation was faxed on 2/23/20.

Documentation in a FAX sent to the Division of Health Service Regulation revealed the allegation regarding Resident #6 and Resident #7 was sent on 2/23/20 at 3:21 PM and again at 3:24 PM. Documentation on the form stated the incident occurred on 2/22/20 but the facility became aware of the incident on 2/23/20 around 11:00 AM. Documentation of the allegation details stated, "[Resident #7] was alleged to have crawled into bed with [Resident #6] on the night of 2/22. [Resident #7] was fully clothed, and both patients have intellectual disabilities. Resident #7 is being kept separate from [Resident #6] as options are reviewed." Documentation under the notification of other agencies revealed law enforcement was called on 2/23/20 at 12:51 PM.

The corporate nurse consultant and the Administrator were interviewed on 2/29/20 at 5:10 PM. The corporate nurse consultant declared that the allegation lodged by Resident #4 was not an allegation that needed to be reported in 2 hours because there was no injury, no skin to skin contact, all the residents involved have questionable cognition, there was no way to ascertain if the allegation was true, and Resident #4 was unreliable. The Administrator confirmed this was his belief as well and that this was the discussion that he had with his corporate consultants on the evening of 2/22/20.

The DON was interviewed again on 3/1/20 at 7:45 AM. The DON was adamant that Resident #4 had lied on several occasions in multiple

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circumstances and could not be a trusted source. The DON reiterated that she spoke with Nurse #1 and Nurse #2 on 2/22/20 and they told her Resident #4 stated, "[Resident #7] was in my room, on top of my roommate, making movements." The DON emphasized that she immediately after speaking with her nurses called the administrator and her corporate nurse consultant. The DON related that she knew the administrator had called his vice president in the corporation on the evening on 2/22/20. The DON maintained that the discussion she had with her nursing corporate consultant was focused on the priority of safety, security, and well being of the residents. The DON revealed that a three-way call was conducted on 2/23/20 with herself, the administrator, and the corporate nurse consultant to decide if the allegation needed to be reported to the authorities and the state agencies. The DON stated that the decision was made that the allegation needed to be reported so law enforcement was called on the afternoon on 2/23/20.