	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING			
			5 14/11/0		C C	
		345166	B. WING		03/1	9/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING HOM	F		1570 NC 8 AND 89 HIGHWAY		
STORES		L		DANBURY, NC 27016		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E		COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
			-j			
F 000	INITIAL COMMENTS		F 000			
	A complaint investiga	ation was conducted from				
		dditional information was				
		Therefore, the exit date was				
		The one allegation that was				
	investigated was sub					
F 600			F 600		2	3/20/20
SS=G		rigiot	1 000			.20,20
33-6						
	8483 12 Freedom fro	m Abuse, Neglect, and				
	Exploitation	nn Ababo, Noglobi, ana				
	· ·	right to be free from abuse,				
		ition of resident property,				
		efined in this subpart. This				
	includes but is not lim	•				
		involuntary seclusion and				
		ical restraint not required to				
	treat the resident's m	•				
		,				
	§483.12(a) The facilit	y must-				
	o ()					
	§483.12(a)(1) Not use	e verbal, mental, sexual, or				
	physical abuse, corpo					
	involuntary seclusion;					
	This REQUIREMENT	is not met as evidenced				
	by:					
	Based on record revi	ew and staff interview the		Past noncompliance: no plan of		
	facility failed to protec	t a resident's right to be free		correction required.		
	from physical abuse v					
	residents during the p					
	(Resident #1 and Res	sident #3) of 5 sampled				
		r abuse. As a result of				
		ical abuse Resident #1				
		ourple bruise on her hand				
		s on her hands and arms				
	-	erienced a deep purple				
		finger with multiple bruises				
	on her arms. Findings	s included:				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	()	K6) DATE

Electronically Signed

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

03/27/2020

PRINTED: 04/20/2020

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/20/2020 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVE COMPLETED	
		345166	B. WING					C 19/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
STOKES	COUNTY NURSING HOM	E			570 NC 8 AND 89 HIGHWA DANBURY, NC 27016	Y		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	• 1	F	600				
		imulative diagnoses, some nentia, adult failure to thrive, accident.						
	9/18/19 coded Reside impaired cognition wit of care. The assessm dependent on two peo dressing, hygiene, ba	data set assessment dated ent #1 as having severely th no behaviors or rejection ent coded the resident as ople for bed mobility, thing, toilet use, in addition f both bowel and bladder.						
	Director of Nursing (D PM. The DON explain 9/30/19 she was cont facility at approximate aide (NA #1), who had AM on 9/29/19 to 9/30 behavior by a nurse a DON stated she instru NA #1 write down wha the facility to give a st indicated she informe abuse allegations tha DON indicated NA #1 her statement on 9/30 and was subsequent!	, Administrator, and the						
	dated 9/30/19, stated changing [Resident # [Resident #1]. [NA #2] the two residents, but	by NA #1, was signed and in part, "While I was 6], [NA #2] was changing] pulled the curtain between I could still see her in the ident #1] was combative per						

Facility ID: 943474

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				RINTED: 04/20/2020 FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		3) DATE SURVEY COMPLETED
		345166	B. WING			C 03/19/2020
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZI	P CODE	
		_	1	570 NC 8 AND 89 HIGHWAY		
STOKES		E		DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 600	and hit [NA #2] that sh I saw her mostly towa which seemed as if sh [Resident #1] to stop, finished with [Resider dirty linen/brief into th room to her (NA #2) sp put these pillows back honestly I don't give a she walked out." Documentation of the former DON, Adminis coordinator conducted revealed, "When we w room, [NA #2] told me could see in the mirroo trying to fight her and be touched. I heard [F and stop hitting me. I [Resident #1]. The pil [Resident #1]s] feet and there. [NA #2] comme [expletive] now" and w thought [Resident #1] NA #1 was interviewe #1 indicated that she on 9/29/19 to 9/30/19 AM shift which was th on that shift. NA #1 co written statements an Resident #1 on the ar Documentation of an PM revealed NA #2 w etiology of unknown b	[Resident #1] would swing he would swing and hit back. India her arms and hands he was trying to get but in a hateful way. When I hat #6], I went to dump the e cart. I came back into the aying, "I just realized I didn't a under her feet, but I [expletive] right now" and 9/30/19 interview by the trator, and the MDS d at 12:50 PM with NA #1 vent into [Resident #1's] e to change [Resident #6]. I r that [Resident #1] was [Resident #1] don't like to Resident #1] say get off me could see her hitting back at lows are usually under nd she had not put them ented, "I don't give a valked away. [NA # 1]	F 600			

Facility ID: 943474

If continuation sheet Page 3 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345166 NAME OF PROVIDER OR SUPPLIER STOKES COUNTY NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			A. BUILDING	E CONSTRUCTION STREET ADDRESS, CITY, ST 1570 NC 8 AND 89 HIGHWA DANBURY, NC 27016		FORM OMB NO (X3) DATE COMP	LETED
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	response by NA #2 st name] is not really hit ordinary" and "The re are [Resident #1] and #1] has a large bruise responded that [Resid always have bruises. they don't have a brui had bruised her it wor by the hands, I use he turn her." "I don't think sleeves on to help he documentation in the 9/30/19 indicated NA interview pending a fu NA #2 was interviewe #2 revealed that on th on 9/29/19 to 9/30/19 nurse aide (NA #1). N two to three hours to and she was very tire explained that she did Resident #1 on her sk someone else had se NA #2 recalled that sk (Nurse #3) on the uni on that shift and she of again. NA #2 indicated incontinent rounds wh NA #2 indicated she of bruising on Resident is care rounds but did nu second incontinent ca early morning hours. bruising was two to the bruises on the right has	. The documentation of the ated in part, "[Resident #1 ting me, nothing out of the sidents who had bruising [Resident #3]. [Resident e on her right hand. [NA #2] dent #1] and [Resident #3] "I can't think of a time when se." For [Resident #1] "If I uld be red. I don't grab her er shoulders and waist to c she would keep [geriatric] r bruising." The interview with NA #2 on #2 was suspended after the ull investigation. d on 3/14/20 at 2:06 PM. NA te 11:00 PM to 7:00 AM shift , she was training a new IA #2 explained that it took do incontinent care rounds d on that day. NA #2 further a see the bruises on nift, but she was sure en them and reported them. the had "bothered" the nurse t about many other concerns did not want to bother him d she did her first hen she arrived at 11:30 PM. did not initially notice the #1 on the first incontinent otice the bruising on the ire rounds she made in the	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/20/2020 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345166	B. WING		_		C 19/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
STOKES	COUNTY NURSING HOM	E		1570 NC 8 AND 89 HIGHWA	AY		
OTOREO				DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	that Resident #1 would that she took the time #1 what she was doin Nurse #3, who was w 7:00 AM shift on 9/29 interviewed on 3/14/2 stated that he had see with the residents in ti seen NA #2 hit any of revealed he did not se #1 on the morning of the fact. Nurse #3 rev more verbally abusive the residents. When a anything to a supervise thought they already b An interview was com DON/MDS coordinate The interim DON/MDS after the administrativ 9/30/19 at 12:50 PM, completed for Reside DON/MDS coordinate assessment revealed arm, right hand, and t #1. The interim DON/ stated that the nursing worked on the 7:00 A 3:00 PM to 11:00 PM interviewed regarding #1 on those shifts. Th Coordinator stated no shifts stated they obse Resident #1.	 #2 on 9/30/19. NA #2 stated d hit at her sometimes but to try to explain to Resident g while providing care. orking on the 11:00 PM to /19 to 9/30/19, was 0 at 6:25 AM. Nurse #3 en NA #2 be a little rough he past, but he had never the residents. Nurse #3 ee the bruising on Resident 9/30/19 but saw them after realed he thought NA #2 was e than physically abusive to asked why he did not say sor, Nurse #3 replied that he knew. ducted with the interim or on 3/13/20 at 12:45 PM. S coordinator revealed that re interview with NA #1 on a skin assessment was nt #1. The interim or indicated the skin bruising on the right upper he left forearm of Resident MDS coordinator further g staff members who M to 3:00 PM shift and the shift on 9/29/19 were any bruising on Resident e interim DON/MDS one who worked on these erved any bruising on 	F 60		DEFICIENCY)		
	A "problem focused c	harting - altered skin					

		D HUMAN SERVICES MEDICAID SERVICES			F	TED: 04/20/2020 DRM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345166	B. WING			C 03/19/2020
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP	CODE	
STOKES	COUNTY NURSING HOM	E		570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
			I	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 600	Continued From page	• 5	F 600			
	integrity" report by Nu PM documented Resi centimeters in length	Irse #4 dated 9/30/19 at 3:30 dent #1 had bruising 6 by 4 centimeters in width on were no other further details				
	regarding her observa assessment for Resid she was asked by the documentation on the observed on Residen was a little overwhelm authorities were takin and she knew an inve- initiated. Nurse #4 ad paperwork on the pro altered skin integrity s 9/30/19 as completely #4 elaborated and de the hand, right upper Resident #1. Nurse # focus was on a large resident's right hand. Nurse #1, who worker	e bruising the DON had t #1. Nurse #4 stated she ned because the local g pictures of Resident #1 estigation was being mitted she did not fill out the blem focused charting - sheet for Resident #1 dated y as she could have. Nurse scribed scattered bruises on arm, and left forearm of 4 stated that her major deep purple bruise on the d on the 7:00 AM to 7:00				
	resided, was interview Nurse #1 stated there Resident #1 on 9/29/7 Resident #1 sometime hands and forearms, new or any major brui on 9/29/19. Nurse #2, who worke 9/29/19, was interview	n the unit which Resident #1 ved on 3/13/20 at 2:34 PM. e was no new bruising on 19. Nurse #1 revealed that es had small bruises on her but she did not have any ising to her arms on her shift d 3:00 PM to 11:00 PM on ved on 3/13/20 at 2:00 PM.				
	Nurse #2 indicated sh bruising nor did she n	ne was not notified of any otice any bruising on				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/20/2020 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345166	B. WING			C 03/19/2020		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO	DE		
		_		1	570 NC 8 AND 89 HIGHWAY			
SIUKES		=		D	ANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B		(X5) COMPLETION DATE
F 600	Continued From page Resident #3 during he Nurse aide (NA #3), v		F	600				
	to 11:00 PM shift on 9 Resident #1 resided, at 2:08 PM. NA #3 wa	/29/19 on the hall which was interviewed on 3/13/20 s adamant that there was nt #1 during his shift on						
	to 11:00 PM shift on 9 Resident #1 resided, at 3:29 PM. NA #4 inc #3 on the hall for whic	who worked on the 3:00 PM /29/19 on the hall which was interviewed on 3/13/20 licated she worked with NA who Resident #1 resided on med that she did not notice ent #1 on her shift on						
	11:39 AM. The Admin the allegations were r Resident #1 observed made, the evidence p not be discounted. The the resident was pron extensive bruising dis right upper arm, left for the right hand could n accidental or self-inflior revealed that NA #2 w initial investigation bu after providing a state on 9/30/19.	I, and staff interviews were ointed to abuse that could e Administrator stated that e to bruising but the covered on 9/30/19 on her orearm, and the bruising on ot be explained away as cted. The Administrator /as suspended during the t was terminated on 10/7/20 ment regarding the events						
	3/14/20 at 12:47 PM. and reviewed the step of abuse of Resident	s interviewed again on The Administrator revealed os taken after the allegation #1 was made at the facility. ealed local law enforcement						

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	E CONSTRUCTION		O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	PLETED
					С	
		345166	B. WING		03	8/19/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
		_		1570 NC 8 AND 89 HIGHWAY		
SIUKES	COUNTY NURSING HOM	IE		DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	a 7	F 60			
1 000			F OU			
	0	with the state division of				
	health service regula residents in the long-					
		cility social worker by				
		orker questioned all the				
	residents regarding t	•				
		and if staff had hurt them.				
		sed by the residents were				
	followed up by the Di					
	retrospective analysis	s of the 2019 reported				
	-	of unknown origin was				
	-	9 by the risk manager to				
		erns of potential abuse could				
		sessments of the residents				
	were completed by 1	-				
	•	ved and took statements				
	-	taff members who had				
		nd 9/30/19 in the long-term additionally interviewed and				
	took statements from					
		All the interviewed staff				
		ved immediate retraining on				
		id procedures for the facility				
		ting aspect of the training.				
		/ealed all the nursing staff				
	working in the long-te	erm care unit were retrained				
	in the abuse policies	and procedures as of				
	10/4/19. The entire s	taff, to include volunteers,				
	was retrained on the	•				
	•	ber and December 2019.				
		plained that prior to the				
		e staff, the abuse policies				
	-	ng was redone and updated				
		portance of the information.				
	The Administrator ex					
	organization committ	cussion in the patient safety				
		66 D610 011 10/17/18	1	1		1
	-	unknown origin. Quality				

Facility ID: 943474

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 04/20/2020 FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(3) DATE SURVEY COMPLETED
		345166	B. WING			C 03/19/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
STOKES	COUNTY NURSING HOM	F		1570 NC 8 AND 89 HIGHWAY		
STORES		-	I	DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 600	during which discussi abuse training for the of extra elements of s residents. The Admin investigation and the abuse policies and pr of 10/4/19. 2. Resident #3, admit cumulative diagnoses dementia with behavion Documentation on the set assessment dated resident as severely of physical behavioral sy of the assessment pe same assessment	n 10/14/19 and 11/19/19 on and review of continued staff as well as the details afety for the long-term care istrator confirmed the retraining of the staff on ocedures was completed as ted on 3/16/16, had s one of which included oral disturbance. e quarterly minimum data d 12/19/19 coded the cognitively impaired with ymptoms one to three days riod. Documentation on the ecified the resident required of two staff members with s, dressing, toilet use, thing in addition to being wel and bladder. sident #3, reviewed on roblem area for behavioral veness toward staff at times throwing food, and pinching of the interventions revealed some of which included: sident calmly and unhurriedly voice" and "If appropriate, n resident is hostile and try	F 600			
	 investigation and the abuse policies and prof 10/4/19. 2. Resident #3, admit cumulative diagnoses dementia with behavior Documentation on the set assessment dated resident as severely of physical behavioral sy of the assessment personal behavioral sy of the assessment spetotal care assistance bed mobility, transfers personal hygiene, bat incontinent of both both the set aspect of the care plan for Ress 9/26/19, revealed a pisymptoms of combati with yelling, cursing, the staff. Documentation multiple interventions "Always approach resi and speak in a calm vistop giving care wher again later." 	retraining of the staff on ocedures was completed as ted on 3/16/16, had sone of which included oral disturbance. e quarterly minimum data d 12/19/19 coded the cognitively impaired with ymptoms one to three days riod. Documentation on the ecified the resident required of two staff members with s, dressing, toilet use, thing in addition to being wel and bladder. sident #3, reviewed on roblem area for behavioral veness toward staff at times hrowing food, and pinching of the interventions revealed some of which included: sident calmly and unhurriedly voice" and "If appropriate, n resident is hostile and try				

Facility ID: 943474

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345166	B. WING				C / 19/2020
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING HOM	E			1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	9/30/19 she was cont facility at approximate aide (NA #1), who have AM on 9/29/19 to 9/30 behavior by a nurse at DON stated she instru- NA #1 write down what the facility to give a st indicated she informe abuse allegations that DON indicated NA #1 her statement on 9/30 and was subsequently presence of the DON minimum data set ass coordinator. The statement written dated 9/30/19, stated with [Resident #7] and help finish and put [Re (lift), so she (Residen day. Once we got her she (NA #2) asked movement went out and combed changed [Resident #3's] bec corner of my eye that hit [NA #2], but it seer [Resident #3] back sta with me today, quit hit mood."	acted by an employee of the ely 8:30 AM revealing nurse d worked 11:00 PM to 7:00 D/19, had witnessed abusive hide (NA #2). The former ucted the employee to have at happened and to return to ratement. The former DON d the Administrator of the t were made. The former returned to the facility with D/19 at approximately noon y interviewed in the , Administrator, and the sessment (MDS) A by NA #1, signed and in part, "When I finished d [Resident #8], I go into esident #3] on the Hoyer t #3) would be up for the (Resident #3) into the chair, e if she had a comb which I her hair. While she (NA #2) B] in the hall, I was making d and I could see from the [Resident #3] was trying to med as if [NA #2] was hitting ating, "You better not start tting me, I'm not in the 9/30/19 interview by the	F	600			

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PRINTED: 04/20/2020

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/20/2020 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMP	SURVEY LETED
		345166	B. WING			-	03/) 19/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
STOKES	COUNTY NURSING HOM	E			570 NC 8 AND 89 HIGHWA DANBURY, NC 27016	Ŷ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	[Resident #3] was any away at staff and [NA commented, "You bet NA #1 was interviewe #1 indicated that she 9/29/19 to 9/30/19 any shift was the first time shift. NA #1 confirmed statements and that s Resident #3 hitting he 9/30/19. Documentation of an PM revealed NA #2 w etiology of unknown b anything, out of the or on 9/29/19 to 9/30/19 response by NA #2 st swats but I don't hit ba residents who had bru [Resident #3]. [Reside her right hand. [NA #2 #1] and [Resident #3] can't think of a time w bruise"; and "[Resider when we are getting h The documentation in 9/30/19 indicated NA interview pending a ft NA #2 was interviewe #2 revealed that on th on 9/29/19 to 9/30/19 nurse aide (NA #1). N two to three hours to and she was very tire Resident #3 always h	gry and swings arms to swat #2] swung back at her and ter not start with me today." d on 3/13/20 at 2:18 PM. NA was in initial training on d the 11:00 PM to 7:00 AM e she had trained on that d the accuracy of her written he saw NA #2 swing at er arms and hands on interview on 9/30/19 at 7:10 ras questioned as to the rruises on Resident #2 and if rdinary occurred on her shift . The documentation of the ated in part: "[Resident #3] ack or anything"; "The using are [Resident #1] and ent #1] has a large bruise on 2] responded that [Resident always have bruises. "I hen they don't have a nt #3] always swats at us her ready in the morning." the interview with NA #2 on #2 was suspended after the	F	600				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 04/20/2020 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345166	B. WING					C 19/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZI	P CODE		
STOKES	COUNTY NURSING HOM	E			570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI		(X5) COMPLETION DATE
F 600	nurse aides. NA #2 in unfairly judged for bru was always there. NA report the bruising wh Nurse #3, who was w 7:00 AM shift on 9/29, interviewed on 3/14/2 stated that he had see with the residents in th seen NA #2 hit any of revealed he thought N abusive than physical When asked why he of supervisor, Nurse #3 already knew. Nurse # was combative at time alone to calm down. N aware of the bruising An interview was cond DON/MDS coordinato The interim DON/MDS after the administrativ 9/30/19 at 12:50 PM, completed for Resided the arms and hands of DON/MDS coordinato nursing staff members AM to 3:00 PM shift a shift on 9/29/19 were bruising on Resident # former DON lamented was the cognitively im vulnerable, who were	sident #3 was well rsing notes as hitting the sinuated that she was being tising on Resident #3 that #2 insisted that she did ten she saw it. orking on the 11:00 PM to /19 to 9/30/19, was 0 at 6:25 AM. Nurse #3 on NA #2 be a little rough the past, but he had never the residents. Nurse #3 VA #2 was more verbally ly abusive to the residents. did not say anything to a replied that he thought they #3 confirmed Resident #3 es and needed to be left Nurse #3 stated he was not on Resident #3 on 9/30/19. ducted with the interim or on 3/13/20 at 12:45 PM. S coordinator revealed that e interview with NA #1 on a skin assessment was nt #3, revealing bruising on of Resident #3. The or further stated that the s who worked on the 7:00 nd the 3:00 to 11:00 PM interviewed regarding any #3 on those shifts. The d that it was determined it inpaired residents, the most	F	600				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/20/2020 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE S COMPL	SURVEY _ETED
		345166	B. WING			C 03/1	; 19/2020
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE	, ZIP CODE		
STOKES	COUNTY NURSING HOM	E	1	570 NC 8 AND 89 HIGHWAY			
SIUKES		E		DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)		(X5) COMPLETION DATE
TAG F 600	Continued From page altered skin integrity" PM revealed, "scatter and hands" on Reside further details on the s Nurse #4 was intervie regarding her observa assessment for Resid she was asked by the documentation on the observed on Residem was a little overwhelm authorities were taking and she knew an inve- initiated. Nurse #4 rev she did not chart furth bruising. Nurse #4 de on the upper forearms saw on 9/30/19. Nurse bruises on the ring fing #3. Nurse #1, who worked PM shift on 9/29/19 o resided, was interview Nurse #1 stated Resid bruising on her arms a	e 12 report dated 9/30/19 at 3:30 ed bruising on bilateral arms ent #3. There were no other skin assessment. wed on 3/19/20 at 11:35 AM ations on 9/30/19 of the skin lent #3. Nurse #4 revealed b DON to complete b bruising the DON had t #3. Nurse #4 stated she ned because the local g pictures of Resident #3 estigation was being vealed she did not know why her documentation on the scribed scattered bruising s of Resident #3 that she e #4 stated she saw three rm and three bruises on the ted she saw a deep purple fer of left hand of Resident d on the 7:00 AM to 7:00 n the unit which Resident #1 ved on 3/13/20 at 2:34 PM. dent #3 did not have the and hands on her shift on not see the bruising on	F 600	DEF		E	
	10/2/19. Nurse #1 did would hit at the nurse to provide care. Nurse #2, who worked 9/29/19, was interview	confirm that Resident #3 aides who were attempting d 3:00 PM to 11:00 PM on ved on 3/13/20 at 2:00 PM. he was not notified of any					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345166	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES (STOKES COUNTY NURSING HOME				1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #3 during he Nurse aide (NA #3), v to 11:00 PM shift on 9 Resident #3 resided, at 2:08 PM. NA #3 co bruising on Resident # 9/29/19. NA #3 revea on his shift on 9/29/19 Nurse aide (NA #4), v to 11:00 PM shift on 9 Resident #3 resided, at 3:29 PM. NA #4 ind #3 on the hall for whid 9/29/19. NA #4 confir any bruising to Reside 9/29/19. NA #4 confir any bruising to Reside 9/29/19. The Administrator wa 11:39 AM. The Admin the allegations were r Resident #3 observed made, the evidence p not be discounted. Th that the bruising betw #3 could not be expla The Administrator rev suspended during the terminated on 10/7/20 regarding the events The Administrator wa 3/14/20 at 12:47 PM. and reviewed the step	er shift on 9/29/19. who worked on the 3:00 PM 0/29/19 on the hall which was interviewed on 3/13/20 nfirmed there was no #3 during his shift on led Resident #3 was calm 0. who worked on the 3:00 PM 0/29/19 on the hall which was interviewed on 3/13/20 dicated she worked with NA ch Resident #3 resided on med that she did not notice ent #3 on her shift on s interviewed on 3/13/20 at istrator indicated that after nade, the bruising on 1, and staff interviews were ointed to abuse that could the Administrator indicated een the fingers of Resident ined away as accidental. ealed that NA #2 was i initial investigation but was 0 after providing a statement	F	600			
		ealed local law enforcement with the state division of ion on 9/30/19. The					

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PRINTED: 04/20/2020

	OF DEFICIENCIES			PLE CONSTRUCTION		10. 0938-039
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	TE SURVEY MPLETED
			A. BUILDING	3		0
		345166	B. WING			С
		345166	B. WING			3/19/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
STOKES	COUNTY NURSING HOM	IE		1570 NC 8 AND 89 HIGHWAY		
				DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 1 <i>1</i>	EG	20		
F 000			F 60	JU		
	residents in the long-					
	-	cility social worker by				
		vorker questioned all the				
	residents regarding t					
		and if staff had hurt them.				
		sed by the residents were				
	followed up by the Di	•				
		s of the 2019 reported				
		of unknown origin was				
	-	9 by the risk manager to				
		erns of potential abuse could				
		sessments of the residents				
	were completed by 1					
	-	ved and took statements				
	-	taff members who had				
		nd 9/30/19 in the long-term				
		additionally interviewed and				
	took statements from	5				
		All the interviewed staff				
		ved immediate retraining on				
		nd procedures for the facility				
		rting aspect of the training.				
		vealed all the nursing staff				
		erm care unit were retrained				
		and procedures as of				
		taff, to include volunteers,				
	was retrained on the					
	1 •	ber and December 2019.				
		plained that prior to the				
	-	e staff, the abuse policies				
		ng was redone and updated				
		portance of the information.				
	The Administrator ex					
		cussion in the patient safety				
		7/19 regarding bruising of				
		lity assurance performance				
		tee meetings were held on				
		9 during which discussion				
		led abuse training for the				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVE	8-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					С	
		345166	B. WING		03/19/2020	
NAME OF PI	ROVIDER OR SUPPLIER	•	STE	REET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING HOM	E	_	70 NC 8 AND 89 HIGHWAY NBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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 COME	(X5) PLETIO DATE
F 600	safety for the long-ter Administrator confirm retraining of the staff	etails of extra elements of rm care residents. The led the investigation and the on abuse policies and	F 600			
F 609 SS=D	procedures was com Reporting of Alleged CFR(s): 483.12(c)(1)	Violations	F 609		3/27/	20
		se to allegations of abuse, or mistreatment, the facility				
	involving abuse, negl mistreatment, includin source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to adult protective servin for jurisdiction in long	e that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve sult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides i-term care facilities) in e law through established				
	designated represent accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective	the results of all administrator or his or her tative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken.				

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		MEDICAID SERVICES				r –	NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	I Y	TE SURVEY MPLETED
						с	
		345166	B. WING			03/19/2020	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES (-		15	570 NC 8 AND 89 HIGHWAY		
SIUKES	COUNTY NURSING HOM	E		D	ANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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)		(X5) COMPLETION DATE
F 609	Continued From page	e 16	F 60	09			
		iew and record review the		00	Corrective action to be accomplished	for	
		t to the state agency within			the residents found to be affected by the		
	•	I time frame allegations of a			deficient practice:		
	staff member physica	Illy abusing two (Resident #1			-		
		ive sampled residents			Residents #1 and Resident #3- It was		
	reviewed for abuse. F	Findings included:			determined that the facility failed to rep		
					alleged abuse immediately, but not late	er	
		umulative diagnoses, some			than 2 hours after the allegation was		
	and cerebral vascular	nentia, adult failure to thrive,			made, since the events that caused the allegation involved abuse.	9	
		accident.			allegation involved abuse.		
	Documentation on a			It was determined the facility policy and	b		
		18/19 coded Resident #1 as			procedure was not followed for Reside		
		ired cognition with no			1 and Resident #3. The Administrator,		
	-	of care. Documentation on			DON and MDS coordinator participated		
		t coded the resident as			the initial witness interview and procee		
	dependent on two pe	opie for bed mobility, ithing, toilet use, in addition			to contact law enforcement and conduct additional interviews and assessments		
		of both bowel and bladder.					
					The report was completed and attempt	ed	
	An interview was con	ducted with the former			to fax within 8 hours and unable to get		
	Director of Nursing (E	DON) on 3/13/20 at 12:17			through after 2 attempts. The report w	ent	
	-	ned that on the morning of			through the next am at 19 hours. The		
		tacted by an employee of the			corrective action for these residents is		
		ely 8:30 AM revealing nurse			policy has been updated to state 1 per-	son	
	. ,	d worked 11:00 PM to 7:00 0/19, had witnessed abusive			will pull apart from the continued investigation to complete the initial rep	ort	
		aide (NA #2). The former			This will be completed immediately, bu		
		ucted the employee to have			not later than 2 hours after the allegation		
		at happened and to return to			is made, if the events that cause the		
		tatement. The former DON			allegation involve abuse or result in		
		ent into a meeting with the			serious bodily injury and faxed per		
	-	which she revealed the			guidelines. After the immediate, but no		
	-	t were made. The former			later than 2 hour report is complete and		
		returned to the facility with			submitted, the team member can rejoin	ו	
		0/19 at approximately noon			the ongoing investigation.		
	and was subsequent	, Administrator, and the			Address how the facility will identify oth	her	
	minimum data set as				residents having the potential to be		

Facility ID: 943474

		MEDICAID SERVICES				1	D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING	;			
		345166	B. WING			С	
	ROVIDER OR SUPPLIER	343100			REET ADDRESS, CITY, STATE, ZIP CODE	03	/19/2020
INAIVIE OF P	ROVIDER OR SUPPLIER						
STOKES	COUNTY NURSING HOM	E			70 NC 8 AND 89 HIGHWAY ANBURY, NC 27016		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETIO DATE
F 609	Continued From page	e 17	F 60	9			
		ner DON revealed that NA #2			affected by the same deficient practice	<i>.</i> .	
		ling the investigation on					
	9/30/19.	5 5			For all other residents, it was determin	ned	
					that the facility failed to report alleged		
		e statement written by NA			abuse immediately, but not later than		
	#1, signed and dated			hours after the allegation was made, s	ince		
	"While I was changing			the events that caused the allegation			
	0 01	1]. [NA #2] pulled the curtain			involved abuse.		
		dents, but I could still see her			It was determined the facility ratios on	d	
	in the mirror. Althoug				It was determined the facility policy an procedure was not followed for reporti		
	combative per usual, I noticed when [Resident #1] would swing and hit [NA #2] that she would				abuse. The Administrator, DON and N		
		saw her mostly towards her			coordinator participated in the initial		
		h seemed as if she was			witness interview and proceeded to		
	trying to get [Residen	t #1] to stop, but in a hateful			contact law enforcement and conduct		
		with [Resident #6], I went to			additional interviews and assessments	5.	
		prief into the cart. I came			All members of this group are trained		
		her (NA #2) saying, "I just			report abuse per the state guidelines a		
	'	ese pillows back under her			facility policy and procedure. The team	n	
		on't give a [expletive] right			investigating realized the 2 hour		
	now" and she walked	out.			timeframe had been missed and immediately worked to complete and		
	Documentation of the	9/30/19 interview by the			submit. The team also discussed that	1	
	former DON, Adminis	-			team member should have pulled awa		
		d at 12:50 PM with NA #1			complete and submit the report while		
		went into [Resident #1's]			other members of the team continued		
		e to change [Resident #6]. I			forward with the investigation.		
		or that [Resident #1] was					
		[Resident #1] don't like to			The report was completed and attemp		
		Resident #1] say get off me			to fax within 8 hours and unable to get		
		could see her hitting back at			through after 2 attempts. The report v		
		lows are usually under			through the next am at 19 hours. The		
	there. [NA #2] comme	nd she had not put them			corrective action for these residents is policy has been updated to state 1 per		
		/alked away. [NA # 1]			will pull apart from the continued	3011	
	thought [Resident #1]				investigation to complete the initial rep	ort.	
					This will be completed immediately, but		
	Documentation on a	fax receipt for the initial			not later than 2 hours after the allegati		
	report sent the Division	•			is made, if the events that cause the		1

Facility ID: 943474

		MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED
		245466	B. WING	С	
		345166	D. WING		03/19/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	JODE
STOKES	COUNTY NURSING HOM	E		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 609	Continued From page	a 18	F 60	10	
F 009	Regulation revealed t physical abuse allega sent on 9/30/19 at 8:2 a result, resent on 9/3	the report regarding the ation for Resident #1 was 24 PM with a busy signal as 30/19 at 8:50 PM with a busy 01/19 at 8:04 AM with the	F 60	allegation involve abuse or serious bodily injury and fa guidelines. After the imme later than 2 hour report is o submitted, the team memb the ongoing investigation. Address what measures w	xed per diate, but not complete and er can rejoin
	Administrator explain with NA #1 she was in explained that her ad	/20 at 12:47 PM. The ed that after the meeting n "shock." The Administrator ministrative nursing staff		place or systemic changes ensure that the deficient pr recur:	made to actice will not
	interviews and skin as were conducted. The after the bruises were the local law enforcer Administrator stated,	Iff members to conduct ssessments of the residents Administrator revealed that e discovered on Resident #1, ment was contacted. The "It didn't seem like we could we uncovered everything."		The facility policy and proc updated to state 1 person of from the investigation to co initial report. This will be c immediately, but not later t after the allegation is made that cause the allegation in	will pull apart omplete the ompleted han 2 hours e, if the events
	have been a good ide administrative staff se prepare an initial repo Administrator explain	d in retrospective it would ea to have someone from the eparate from the group and ort for the state. The ed she had never called law ong-term care portion of her		result in serious bodily inju per guidelines. After the in not later than 2 hour report and submitted, the team m rejoin the ongoing investiga	is complete ember can
	happen in her facility the necessity of send the state.	ever had anything like this before causing her to forget ing a 2-hour initial report to		All staff and investigating to have been educated regard and procedure revision, sp regarding the need to repo abuse immediately, but not	ding the policy ecifically rt alleged t later than 2
	cumulative diagnoses dementia with behavi			hours after the allegation is the events that cause the a involve abuse or result in s injury.	allegation
	set assessment dated resident as severely o behavioral symptoms	e quarterly minimum data d 12/19/19 coded the cognitively impaired with s one to three days of the Documentation on the same		The investigating team will one person who will compl the report immediately, but hours after the allegation is	ete and submit not later than 2

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	IG	· · ·	DMPLETED	
						С	
		345166	B. WING			03/19/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
STOKES	COUNTY NURSING HOM	IF		1570 NC 8 AND 89 HIGHWAY			
0.01120		-		DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 609	Continued From page	e 19	F 6	09			
		I the resident required total		the other team members of	continue the		
	care assistance of tw	o staff members with bed		investigation.			
		essing, toilet use, personal					
	of both bowel and bla	ddition to being incontinent adder.		No other abuse investigati occurred at the facility since			
	An interview was con	ducted with the former		The proper reporting time	frames will be		
		DON) on 3/13/20 at 12:17		reviewed with all team me			
		ned that on the morning of		monthly QAPI meeting and	d with the		
		tacted by an employee of the		housewide quality improve	ement		
		ely 8:30 AM revealing nurse		committee.			
		d worked 11:00 PM to 7:00 0/19, had witnessed abusive		Indicate how the facility wi	Il monitor our		
		aide (NA #2). The former		performance to make sure			
	-	ucted the employee to have		are sustained:			
		at happened and to return to					
		tatement. The former DON		All reports of abuse will be			
		ent into a meeting with the		immediately by the staff di			
		which she revealed the		witnessing an event. This			
	•	was made. The former DON ned to the facility with her		to the Administrator and C DON immediately for invest			
		around lunch time and was		reporting per state regulati			
		ewed in the presence of the		policy and procedure.			
		and the minimum data set					
		oordinator. The former DON		Performance will be monit			
		was suspended pending the		reported monthly to the Nu			
	investigation on 9/30/	/19.		QAPI meeting as well as the Quality Improvement Com			
	Documentation on the	e statement written by NA		to the committee will be m			
		9/30/19, stated in part,		reports of abuse are made			
	"When I finished with	[Resident #7] and [Resident		month in order to remind a	all members of		
		sh and put [Resident #3] on		the policy and reporting tin			
		e (Resident #3) would be up		reporting will continue mor			
		got her (Resident #3) into) asked me if she had a		to make sure the solution i	is maintained.		
		ut and combed her hair.		Dates when corrective act	ion will be		
		anged [Resident #3] in the		completed: March 27, 202			
		[Resident #3's] bed and I		, , , , , , , , , , , , , , , , , , , ,			
	could see from the co						

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-	MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		FORM	0: 04/20/2020 1 APPROVED 0: 0938-0391
AND PLAN OF CORRECT		IDENTIFICATION NUMBER:	· · ·			· /	LETED
		345166	B. WING		_		C 19/2020
NAME OF PROVIDER C	OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
STOKES COUNTY	NURSING HOM	E		1570 NC 8 AND 89 HIGHW DANBURY, NC 27016	AY		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
[Reside seemed back st quit hitt Docum former coordin reveale started and [N/ [Reside away a comme Docum report s Regula physica sent on a result signal r result b An inte Adminis Adminis uvith NA Adminis nursing conduc residen reveale	d as if [NA #2] ating, "You bet ing me, I'm no entation of the DON, Adminis lator conducted d, "The other I "hitting them." A #2] said bring ent #3] was any t staff and [NA ented, "You bet entation on a f sent the Division tion revealed t al abuse allega 9/30/19 at 8:2 t, resent on 9/3 result, and 10/0 being "okay." rview was con- strator on 3/14 strator explained aff started of that after the ident #3, the lo ident #3, the lo red everything ective it would	e 20 ng to hit [NA #2], but it was hitting [Resident #3] tter not start with me today, t in the mood." 9/30/19 interview by the trator, and the MDS d at 12:50 PM with NA #1 hall is when she (NA #2) [Resident #3] - Put shirt on g the comb to do her hair. gry and swings arms to swat #2] swung back at her and ter not start with me today." ax receipt for the initial on of Health Service he report regarding the tion for Resident #3 was 24 PM with a busy signal as 10/19 at 8:50 PM with a busy 10/19 at 8:04 AM with the ducted with the /20 at 12:47 PM. The ed that after the meeting 9 she was in "shock." The ed that her administrative ontacting staff members to d skin assessments of the cted. The Administrator a bruises were discovered ocal law enforcement was histrator stated, "It didn't ome up for air until we ." The Administrative staff	F 60				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/20/2020 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345166	B. WING					C 19/2020
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE	E, ZIP CODE		
STOKES C	OUNTY NURSING HOM	E			1570 NC 8 AND 89 HIGHWAY			
		ATEMENT OF DEFICIENCIES			DANBURY, NC 27016			(15)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT) CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 000								
F 609	Continued From page	21 up and prepare an initial	F	609				
		he Administrator explained						
	she had never called	law enforcement for the						
		n of her facility and she had ke this happen in her facility						
		forget the necessity of						
	sending a 2-hour initia	al report to the state.						

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