STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	01/15/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and police interviews, the facility failed to maintain 1 of 4 sampled residents' right to be free of sexual abuse. (Resident #1). Immediate Jeopardy began on 01/06/16 when Nurse #1 saw a nurse aide place his penis in Resident #1's mouth. Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective related to resident rights to be free from abuse. The findings included: Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] coded Resident #1 with severely impaired cognitive skills (unable to answer any of the questions on the Brief Interview for Mental Status), having no behaviors, and needing extensive assistance with all activities of daily living skills. She weighed 76 pounds. The Care Area Assessment (CAA) for cognition dated 11/19/15 stated she was unable to make her needs known verbally, had confusion, disorientation and forgetfulness. Staff needed to anticipate her needs and provide for her as needed. Nurse #1 was interviewed on 01/13/16 at 7:12 AM. Nurse #1 stated that on 01/06/16 at approximately 3:30 AM to 4:00 AM, she tried to enter Resident #1's room to check her Wanderguard. The door was completely closed and when she tried to open it , the door hit against Resident #1's footboard. When her second attempt to open the door was unsuccessful, she looked into the opening of the doorway, which she stated was open approximately 6 inches open, enough where she could readily see but not fit her head through the doorway. Nurse #1 stated she saw Nurse Aide (NA) #1 standing next to Resident #1's bed, with his right hand holding Resident #1's head, his left hand holding his penis and he was pushing Resident #1's head forward and placing his penis into Resident #1's mouth. Nurse #1 stated she stood there long enough to make sure she saw what she thought she saw and when he placed his penis in Resident #1's mouth a second time, she shut the door without talking to NA #1 and went to another hall to get Nurse #2 to witness the incident. Nurse #1 stated there was a light on in the room which enabled her to see the incident. Resident #2's roommate was behind the pulled curtain. Nurse #2 was interviewed on 01/12/16 at 12:06 PM. Nurse #2 stated she arrived for work at the facility on 01/06/16 at 3:00 AM. Nurse #2 stated she was working at the nursing desk on the 700 hall around 3:30 AM to 3:45 AM and saw Nurse #1 walking down the hall very fast towards her. Nurse #1 stated she needed Nurse #2 to follow her and during the walk to Resident #1's room, Nurse #1 stopped and told Nurse #2 that she had seen Nurse Aide (NA) #1 put his penis in Resident #1's mouth. Nurse #1 and #2 proceeded to Resident #1's room on the 200 hall. The door to Resident #1's room was open and NA #1 was not in the room. Nurse #2 stated she observed Resident #1 was on her back with her mouth open and there was a white liquid, foamy, milkish substance in the resident's mouth. They did not touch Resident #1 and found her to be alert, nonverbal as she always was but no signs of being distraught. NA #1 was not interviewed. An incident report dated 01/06/16 at 4 am revealed an Allegation of staff to resident sexual abuse toward Resident #1, witnessed by Nurse #1 while the resident was in bed. Review of the Nursing Home to Hospital Transfer Form dated 01/06/16, Resident #1 was transferred to the hospital on [DATE] at 7:30 AM per physician order. On 01/13/16 at 10:19 AM, interviews were conducted with two detectives from the sheriff's office. Detective #1 stated the patrol officers were called to the facility and subsequently brought NA #1 to the sheriff's office. Detective #1 stated NA #1 confessed to placing his penis in Resident #1's mouth. Surveyors observed the video taped confession given by NA #1 admitting he placed his penis in Resident #1's mouth. On 01/13/16 at 7:04 PM the Administrator, DON, corporate nurse consultant and the corporate vice president was informed of Immediate Jeopardy. The Administrator provided an acceptable credible allegation of compliance on 01/15/16 at 9:14 AM. Credible allegation of Compliance: F223 On 1/6/16 the accused CNA employee was removed from resident care areas. On 1/6/16, the resident was assessed by the director of nursing (DON). On 1/6/16, the DON notified the resident ' s physician and an order was obtained to send the resident to the ED for further evaluation. On 1/6/16 the DON notified the resident's responsible party (RP). On 1/6/16, the assistant director of nursing (ADON) contacted the police department. On 1/6/16 the accused employee was suspended from employment. On 1/6/16 the accused employee left facility property with the police. On 1/6/16 the DON called report to the hospital. Resident #1 was sent to the emergency room for assessment after an allegation of sexual abuse on 1/6/16 per MD order and has not returned to this facility. On 1/7/16 the alleged employee remains in jail. On 1/7/16 the accused employee was terminated from employment with facility. On 1/6/16, the social worker and admissions coordinator interviewed all alert and oriented residents related to abuse asking the following questions;(Do you feel anyone has intentionally harmed you since you've been at Lake Park? If yes then who harmed you and who did you tell?, Where did it occur?, When did it occur?, Why do you feel you were harmed?, How were you harmed?) resulting in no negative findings. On 1/6/16, the RN supervisors, staff facilitator, and LPNs staff nurses completed 100% body audits of all residents for evidence of abuse with no negative findings. On 1/14/16 the nurse that witnessed the incident received disciplinary action, was drug tested , and the incident was reported to the North Carolina Board of Nursing. On 1/14/16 at 11:30 AM an in-service was completed for all staff including contract staff working today on: · The abuse policy (Verbal, sexual, mental, or physical abuse, neglect, or mistreatment of [REDACTED]. · Immediately intervene and stop abuse · No employee will be allowed to work until all in-servicing is completed. · New hires will receive all training during orientation prior to taking an assignment. · Nurse #1 and Nurse #2 have completed all above in-services. Immediate jeopardy was removed on 01/15/16 at 11:06 AM when interviews with nursing staff and administrative staff and non-nursing staff confirmed they had received in-service training on the facility's policy to immediately intervene and stop abuse when witnessed, immediately remove the perpetrator from resident care areas and call the police.

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

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.

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F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1)
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and police interview, the facility failed to immediately intervene and stop sexual abuse when observed, failed to immediately remove the perpetrator from resident areas, failed to immediately call law enforcement to report a crime and failed to immediately assess the resident for injuries. In addition the abuse policy did not include the resident involved in abuse would be assessed for injuries, when the assessment would occur, who would assess the resident, when the law enforcement would be notified of a crime and by whom. This affected 1 of 4 residents reviewed for abuse. (Resident #1). Immediate Jeopardy began on 01/06/16 when Nurse #1 observed a nurse aide place his penis in Resident #1's mouth, shut the door without intervening while the abuse was occurring, and then Nurse #1 and Nurse #2 allowed the perpetrator to move about the facility unsupervised while they called administration for instructions. Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated, no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective related to protecting residents from being abused. The findings included: The facility policy Abuse, Neglect, or Misappropriation of Resident Property Policy, with a revised date of 11/01/06, included in part: *Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred, will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator; *Measures will be initiated to prevent any further potential abuse while the investigation is in progress; *Protection: Employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property will be suspended immediately from employment pending the outcome of the investigation. The policy did not include that the resident affected by the abuse would be assessed for injuries, who would assess the resident and when, nor did it include when law enforcement would be notified and by whom. Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] coded Resident #1 with severely impaired cognitive skills (unable to answer any of the questions on the Brief Interview for Mental Status), having no behaviors, and needing extensive assistance with all activities of daily living skills. She weighed 76 pounds. The Care Area Assessment (CAA) for cognition dated 11/19/15 revealed she was unable to make her needs known verbally, had confusion, disorientation and forgetfulness. Staff needed to anticipate her needs and provide for her as needed. Nurse #1 was interviewed on 01/13/16 at 7:12 AM. Nurse #1 stated that on 01/06/16 at approximately 3:30 AM to 4:00 AM, she tried to enter Resident #1's room to check her Wanderguard. The door was completely closed and when she tried to open it, the door hit against Resident #1's footboard of her bed. When her second attempt to open the door was unsuccessful, she looked into the opening of the doorway, which she stated was approximately 6 inches open, enough where she could readily see into the room but not fit her head through the doorway. Nurse #1 stated she saw Nurse Aide (NA) #1 standing next to Resident #1's bed, with his right hand holding the Resident #1's head, his left hand holding his penis, and he was pushing Resident #1's head forward and placing his penis into Resident #1's mouth. Resident #1 made no movement, her eyes were barely open and she had no reaction. Nurse #1 stated she stood there long enough to make sure she saw what she thought she saw and when he placed his penis in Resident #1's mouth a second time, she shut the door without saying a word to NA #1 and went to another hall to get Nurse #2 to witness the incident. Nurse #1 stated there was a light on in the room which enabled her to see the incident. Nurse #1 could not recall passing any other staff member as she made her way down 200 hall, onto 100 hall and down to the end of 700 hall to find Nurse #2 at the nursing station. Nurse #1 stated on the way back to Resident #1's room, she told Nurse #2 what she saw NA #1 do to Resident #1. She stated she saw NA #1 at the 100 hall kiosk on the way back to Resident #1's room but did not speak to him. When Nurse #1 and Nurse #2 got to Resident #1's room, the resident was in bed, the bed was lowered to the floor and she was covered with linen. The two nurses then went to the 300 hall nursing station and called the Assistant Director of Nursing (ADON). Nurse #1 stated the ADON instructed her to get a drug screen, remove NA #1 from the patient care areas, and escort him out of the building. Then Nurse #1 stated she called the Administrator and explained what happened. The Administrator told her to do a drug screen and escort him out of the building. Nurse #1 stated she used her personal cell phone to make these calls and had gone into the medication room to have privacy. She stated Nurse #2 was with her during both of the phone calls. Nurse #1 checked her cell phone at this time during the interview and reported the call to the ADON was made at 3:57 AM and lasted 1 minute. The call to the Administrator was made at 4:00 AM and lasted 5 minutes. Nurse #1 stated she and Nurse #2 got the drug screen out of the medication room and walked to find NA #1 together. NA #1 was found on the 100 hall. Nurse #2 proceeded to take NA #1 to the bathroom to obtain a urine sample for the drug screen. As Nurse #2 was escorting NA #1 to the time clock, (he clocked out at 4:18 AM per the time card), the Administrator called Nurse #1 and told her to not let NA #1 leave the building. Nurse #1 stated she was taught to stop a perpetrator if she witnessed verbal or physical abuse. When Nurse #1 was asked why she left Resident #1 in the presence of NA #1 when she witnessed sexual abuse, Nurse #1 stated she did not feel Resident #1 was safe but did not stop NA #1 as he did martial arts and was afraid for herself and Resident #1. When asked if she would do anything differently if she had to do it over again, she stated no because she was afraid with NA #1's hand on the resident's head, NA #1 may have easily hurt the resident if she barged into the room since Resident #1 was a frail resident. Nurse #2 was interviewed on 01/12/16 at 12:06 PM. Nurse #2 stated she arrived for work at the facility on 01/06/16 at 3:00 AM. Nurse #2 stated she was working at the nursing station on the 700 hall around 3:30 AM to 3:45 AM and saw Nurse #1 walking down the hall very fast towards her. Nurse #1 stated she needed Nurse #2 to follow her and during the walk to Resident #1's room, Nurse #1 stopped and told Nurse #2 that she had seen NA #1 put his penis in Resident #1's mouth. Nurse #1 and #2 proceeded to Resident #1's room on the 200 hall. The door to Resident #1's room was open and NA #1 was not in the room. Nurse #2 stated she observed Resident #1 in bed, on her back, her mouth was open and there was a white liquid, foamy, milkish substance in the resident's mouth. Nurse #2 told Nurse #1 they had to call someone right then. Nurse #1 made multiple phone calls as Nurse #2 waited at the nurse's desk. Per administrative instructions, she and Nurse #1 obtained a drug test/urine kit, located NA #1 on the 100 hallway, and Nurse #2 walked him to the bathroom so he could give a urine sample. Once he came out of the bathroom, Nurse #2 walked him to the time clock and told him to go home. As Nurse #2 was walking him to the lobby to exit the facility, Nurse #1 came up and told Nurse #2 not to allow NA #1 to leave the premises. Nurse #2 stated they walked NA #1 to the phone where NA #1 spoke to the Administrator on the phone. Nurse #2 stated NA #1 was placed in the lobby where he could be seen until the Administrator arrived. Nurse #2 stated that she and Nurse #1 sat at the 300 hall nursing station where they could watch NA #1 as he waited in the lobby. (The 300 hall nursing station was at the end of 300 hall. The front of the 300 hall started at the lobby.) The administrator arrived at 5:12 AM. During a follow up interview with Nurse #2 on 01/13/16 at 2:19 PM, Nurse #2 stated she did not see NA #1 from the time Nurse #1 approached her at the 700 hall nurse's desk until after Nurse #1 had spoken to the ADON and the Administrator on the phone and she and Nurse #1 located NA #1 on the 100 hall to obtain the drug screen. The Assistant Director of Nursing (ADON) was interviewed on 01/12/16 at 2:57 PM. The ADON stated she was the administrative nurse on call during the 3rd shift of 01/05/16 into 01/06/16. The ADON stated at about 4:00 AM, Nurse #1 called her and stated she saw NA #1 put his penis in Resident #1's mouth. Nurse #1 repeated it again. The ADON stated she instructed Nurse #1 to get NA #1 off the floor, give him a drug test and call the Administrator. The ADON stated she asked no more questions and proceeded to go to the facility. She stated she arrived at the facility around 5:10 AM and the Administrator was already in the facility. The ADON and Nurse #1 stood at Resident #1's doorway, did not touch her and saw Resident #1 was sleeping. The ADON stated she did not talk to NA #1. The ADON stated the DON arrived at the facility around 5:30 AM to 5:45 AM and then together they completed a full head to toe assessment of Resident #1. The ADON stated there were 2 to 3 crumbs on her neck and she had a whitish shimmery substance on her collarbone about the size of a pencil eraser. The ADON stated she called the police around 6:40 AM per the Administrator's direction. The ADON stated she would have expected Nurse #1 to go and get help upon observing the abuse. The ADON stated Nurse #1 was a little woman and she needed help so it was okay to

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) leave NA #1 in the room with the door closed with Resident #1 to obtain assistance from another staff member. On 01/12/16 at 12:33 PM the Administrator was interviewed. The Administrator stated that when Nurse #1 called and told her she had seen NA #1 place his penis in Resident #1's mouth, the Administrator told Nurse #1 to secure the room and treat it as a crime scene. She did not want anyone to touch Resident #1 or take anything out of the room. The Administrator stated she arrived at the facility at 5:12 AM on 01/06/16. NA #1 was in the lobby and opened the front door for her. The Administrator took NA #1 to the conference room to interview him. When confronted with the witness report alleging sexual abuse, NA #1 acted shocked and denied any abuse. She informed NA #1 she needed to investigate and call the police. The Administrator stated she instructed the DON and the ADON to complete a head to toe assessment on Resident #1. After the assessment was completed, the Administrator and the DON interviewed NA #1 who was consistent in his denial of abuse. The Administrator stated she had the ADON notify the police around 6:45 AM. Once the police arrived, the Administrator stated she had no more dealings with NA #1. The Administrator stated she spoke with Nurse #1 who stated she could not open the door all the way and once she saw the abuse, she shut the door and proceeded to find Nurse #2. During this interview, the Administrator was asked her expectations of what Nurse #1 should have done when she saw NA #1 put his penis in Resident #1's mouth. The Administrator stated she was not present when Nurse #1 walked in on NA #1, was not sure what Nurse #1 was thinking when she shut the door and left NA #1 sexually abusing Resident #1, and that she could not say what she expected Nurse #1 to do differently because she immediately got another nurse to help her. The Director of Nursing (DON) was interviewed on 01/12/16 at 3:27 PM. She stated on 01/06/16 between 4:00 AM and 4:10 AM she missed a phone call from the Administrator. The DON stated she immediately called the Administrator back who informed her there was an allegation of abuse and she was instructed to go to the facility as soon as possible. The DON arrived at the facility around 5:40 AM and was told by the Administrator to treat everything like a crime scene. She stated she and the ADON completed a head to toe assessment and found old bruising on Resident #1's right hand from previously hitting her hand on the wheelchair and found an abrasion on her coccyx area. The DON stated Resident #1's face was clean and there was a little spot on her collarbone that was not a bruise and looked a little flaky but she could not say what it was. The DON stated Resident #1 was sleeping before the examination and upon finishing the examination she fell back to sleep. The DON stated she and the Administrator interviewed NA #1 and he stated he was conducting his rounds and noticed Resident #1 had food debris in her mouth and her gown was dirty so he cleaned her mouth and changed her clothes. The DON stated they did not question any details of the story. The DON stated the police showed up around 7:00 AM. After the assessment the DON called the medical director (MD), Resident #1's physician. The MD instructed the DON to send Resident #1 to the emergency department. The DON notified Resident #1's responsible party of the abuse allegation. The DON stated that the ambulance arrived around 7:30 AM to take Resident #1 to the emergency department. The DON stated she called the hospital to give a verbal report and instructed them to do a rape kit. Police officers and a forensic investigator were in the facility when the ambulance took Resident #1 to the hospital. NA #1 was removed from the facility in handcuffs by the police. The DON stated she talked with Nurse #1 who informed her she (Nurse #1) saw NA #1's hand behind the resident's head and he was holding his penis in the resident's mouth. Nurse #1 was scared that something was going to happen to Resident #1 and she went to get help. When the nurses arrived back to the resident's room, NA #1 had already left the room. The DON stated she thought Nurse #1 reacted correctly by leaving Resident #1 in the room with NA #1 while she got help because Resident #1 was very frail and if Nurse #1 startled NA #1 he could have hurt Resident #1. Upon follow up interview with the DON on 01/13/16 at 6:23 PM, she stated the decision to call the police was up to the Administrator. NA #1 was not interviewed. An incident report dated 01/06/16 at 4:00 AM revealed an Allegation of staff to resident sexual abuse toward Resident #1, witnessed by Nurse #1 while the resident was in bed. Review of the Nursing Home to Hospital Transfer Form dated 01/06/16, revealed Resident #1 was transferred to the hospital on [DATE] at 7:30 AM per physician's orders [REDACTED].>On 01/12/16 at 5:31 PM Detective #1 from the sheriff's office was interviewed via phone. He stated the police received a call from the facility on 01/06/16 at 7:04 AM. Detective #1 stated NA #1 was in jail charged with 1 act of crime against nature, second degree sexual offense and sexual act by a custodian. On 01/13/16 at 8:50 AM, the Administrator was interviewed again. She stated she was the Abuse Coordinator and expected staff witnessing abuse to ensure the safety of the resident. She stated that the manner in which the staff ensure the resident's safety depended on the situation and time frame. She further stated that the police would be notified if the facility had reasonable suspicion of a crime. She further stated she was not aware of any policy related to calling the police and it would be determined on an individual basis. Once Resident #1 was assessed and a statement was taken from NA #1 the police was called. Another interview on 01/13/16 at 6:25 PM with the Administrator revealed she did not tell Nurse #1 to call the police when she spoke to her on the phone because she wanted to go to the facility and see what had transpired and be sure Nurse #1 saw what she reported she saw. The Administrator stated she had never called the police before unless she actually suspected a crime had been committed. She stated she did what she always did which was to assess and determine whether the situation warranted the call to the police. The Administrator then stated it was obvious the police needed to be called because of what she saw. When asked what she saw, she said she saw a white crusty something on Resident #1's neck. She further stated her job was to protect the resident, protect evidence and call the police and she secured NA #1 so he was in the building when the police arrived. On 01/13/16 at 10:19 AM, an interview was conducted with two detectives from the sheriff's office. Lieutenant #1 stated the patrol officers were called to the facility and subsequently brought NA #1 to the sheriff's office. Lieutenant #1 stated NA #1 confessed to placing his penis in Resident #1's mouth. Review of a video tape of NA #1's interview by Lieutenant #1 revealed that NA #1 admitted he put his penis in Resident #1's mouth. On 01/13/16 at 3:50 PM, the Corporate Nurse Consultant was interviewed. She stated that she expected staff to report abuse to their supervisor and protect the resident. She stated that Nurse #1 went to obtain help from another nurse when she saw the abuse taking place and that was appropriate as she immediately left to obtain assistance. On 01/13/16 at 7:04 PM the Administrator was informed of Immediate Jeopardy. The Administrator provided an acceptable credible allegation of compliance on 01/15/16 at 9:14 AM. Credible allegation of Compliance; F 226 On 1/6/16 the accused NA employee was removed from resident care areas. On 1/6/16, the resident was assessed by the Director of Nursing (DON). On 1/6/16, the DON notified the resident's physician and an order was obtained to send the resident to the ED (hospital's Emergency Department) for further evaluation. On 1/6/16 the DON notified the resident ' s responsible party (RP). On 1/6/16, the Assistant Director of Nursing (ADON) contacted the police department. On 1/6/16 the accused employee was suspended from employment. On 1/6/16 the accused employee left facility property with the police. On 1/6/16 the DON called report to the hospital. On 1/7/16 the accused employee was terminated from employment with facility Resident #1 was sent to the emergency room for assessment after an allegation of sexual abuse on 1/6/16 per MD order and has not returned to this facility. On 1/7/16 the alleged employee remains in jail. On 1/6/16 the administrator submitted the 24 hour report to DHSR (Division of Health Service Regulation) heath care registry and followed up with the 5 day report submission on 1/8/16. On 1/6/16, the Social Worker and Admissions Coordinator interviewed all alert and oriented residents related to abuse asking the following questions;(Do you feel anyone has intentionally harmed you since you've been at Lake Park? If yes then who harmed you and who did you tell?, Where did it occur?, When did it occur?, Why do you feel you were harmed?, How were you harmed?) resulting in no negative findings. On 1/6/16, the RN supervisors, staff facilitator, and LPN's (Licensed Practical Nurses) staff nurses completed 100% body audits of all residents for evidence of abuse with no negative findings. On 1/6/16, the social worker, MDS nurses, RN nursing supervisor, and LPN staff nurses contacted, by phone or in person, 100% of the responsible parties of residents, to notify that there had been an allegation of sexual abuse from an employee to resident. On 1/6/16, the administrator contacted the ombudsman to notify there had been an allegation of staff to resident sexual abuse. On 1/6/16 the ADON completed a 100% audit to verify current licensing/certification of all licensed nurses and certified nursing assistants are current, all licenses found to be current. On 1/6/16 completed an audit on all current personnel files for pre-hire background checks, reference checks, signed resident abuse policy on orientation at 100 %. On 1/14/16 the nurse that witnessed the incident received disciplinary action, was drug tested , and the incident was reported to the North Carolina Board of Nursing. On 1/14/16 the nurse on call at time of allegation, (assistant director of nursing) received drug testing and disciplinary action for failure to direct nurse #1 to call the police and keep alleged employee supervised, and failing to assess

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) resident immediately after she entered the building. On 1/14/16 at 11:30 AM an in-service was completed for all staff including contract staff working today by the director of nursing and assistant director of nursing on: · The abuse policy (Verbal, sexual, mental, or physical abuse, neglect, or mistreatment of [REDACTED]. It is every employee's responsibility to immediately report any incident of resident abuse or suspected abuse to his or her supervisor. The supervisor and/or employee must report immediately to the administrator. If the immediate supervisor is the alleged perpetrator, the report is to be made to the administrator or director of nursing. Any employee who fails to immediately report suspected mistreatment, abuse including injuries. · On 1/14/16 all staff including contract staff working were in-serviced on the elder abuse act policy and how to report to the local law enforcement related to the elder justice act including the following; If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator. · On 1/14/16 all staff including contract staff working were trained that any staff member can call local law enforcement with any type of observed abuse · Immediately intervene and stop abuse · Immediate removal of the employee or perpetrator, immediate notification to the Administrator, DON, and law enforcement. · The employee or perpetrator must remain supervised 1:1 until the Administrator, DON, or law enforcement arrives. · On 1/14/16 the ADON, DON, and Administrator were in-serviced on enforcing the policies of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the following; If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator · On 1/14/16 an in-service was completed that when there is an allegation of abuse the resident involved and roommate are to be assessed immediately for injury and the resident involved in allegation is to be immediately sent to hospital emergency department for further evaluation and treatment. · On 1/14/16 an in-service related to action check list for allegation of abuse neglect was completed for all licensed staff. The action check list includes the following: 1. Remove involved employee. 2. Notify Administrator and/or DON immediately. Document notification in chart 3. Assess resident. Document assessment in chart. 4. Notify attending MD. Document notification in chart. 5. Implement MD orders as indicated. 6. Notify resident representative. Document notification in chart. 7. Obtain employee witness statement of incident. 8. Drug test employee per personnel policy as applicable or as instructed by administrator or DON. 9. Punch out employee. 10. Implement corrective measures to protect resident. 11. Completion of resident QUI reporting form. 12. Continue to monitor resident. · No employee will be allowed to work until all in-servicing is completed. · New hires will receive all training during orientation prior to taking an assignment. · Nurse #1 and Nurse #2 have completed all above in-services. Immediate jeopardy was removed on 01/15/16 at 11:06 AM when interviews with nursing staff and administrative staff and non-nursing staff confirmed they had received inservice training on the facility's policy to immediately intervene and stop abuse when witnessed, immediately remove the perpetrator from resident care areas and call the police.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on record review, staff interviews and police interviews, the administration failed to impose expectations related to immediately intervening when sexual abuse is witnessed, failed to impose expectations related to immediately removing a perpetrator from resident care areas, failed to impose expectations related to immediately calling law enforcement when a crime is witnessed, failed to empower staff to make the call to law enforcement when a crime is witnessed or when staff have knowledge of such crime, failed to recognize that a nurse that witnessed a crime to a resident reacted in a manner that was not in the best interest of all the residents. Immediate Jeopardy began on 01/06/16 when Nurse #1 failed to intervene when she witnessed a sexual abuse incident, failed to immediately call law enforcement, and when she called administrative staff, administrative staff failed to provide her the direction to call law enforcement immediately. Immediate Jeopardy was removed on 01/15/16 at 11:06 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated, no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective related to protecting residents from being abused. The finding included: Cross refer to F 223: Based on record review, staff interviews and police interviews, the facility failed to maintain 1 of 4 sampled residents' right to be free of sexual abuse. (Resident #1). Cross refer to F 226: Based on record review, staff interviews and police interview, the facility failed to immediately intervene and stop sexual abuse when observed, failed to immediately remove the perpetrator from resident areas, failed to immediately call law enforcement to report a crime and failed to immediately assess the resident for injuries. In addition the abuse policy did not include the resident involved in abuse would be assessed for injuries, when the assessment would occur, who would assess the resident, when the law enforcement would be notified of a crime and by whom. This affected 1 of 4 residents reviewed for abuse. (Resident #1). On 01/13/16 at 7:04 PM the Administrator, DON, corporate nurse consultant and the corporate vice president was informed of Immediate Jeopardy. The Administrator provided an acceptable credible allegation of compliance on 01/15/16 at 9:14 AM. Credible allegation of Compliance: F490 On 1/6/16 the accused CNA employee was removed from resident care areas. On 1/6/16, the resident was assessed by the director of nursing (DON). On 1/6/16, the DON notified the resident's physician and an order was obtained to send the resident to the ED for further evaluation. On 1/6/16 the DON notified the resident's responsible party (RP). On 1/6/16, the assistant director of nursing (ADON) contacted the police department. On 1/6/16 the accused employee was suspended from employment. Resident #1 was sent to the emergency room for assessment after an allegation of sexual abuse on 1/6/16 per MD order and did not return. On 1/6/16 the accused employee left facility property with the police. On 1/6/16 the DON called report to the hospital. On 1/7/16 the accused employee was terminated. On 1/7/16 the accused employee is in jail. On 1/6/16, the social worker and admissions coordinator interviewed all alert and oriented residents related to abuse asking the following questions;(Do you feel anyone has intentionally harmed you since you've been at Lake Park? If yes then who harmed you and who did you tell?, Where did it occur?, When did it occur?, Why do you feel you were harmed?, How were you harmed?) resulting in no negative findings. On 1/6/16, the RN supervisors, staff facilitator, and LPNs staff nurses completed 100% body audits of all residents for any evidence of abuse with no negative findings. On 1/6/16, the social worker, MDS nurses, RN nursing supervisor, and LPN staff nurses contacted, by phone or in person, 100% of the responsible parties of residents, to notify that there had been an allegation of sexual abuse from an employee to resident. On 1/6/16,

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	345502	A. BUILDING _____ B. WING _____	01/15/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) the administrator contacted the ombudsman to notify there had been an allegation of staff to resident sexual abuse. On 1/6/16 the ADON completed a 100% audit to verify current licensing/certification of all licensed nurses and certified nursing assistants are current, all licenses found to be current. On 1/6/16 completed an audit on all current personnel files for pre-hire background checks, reference checks, signed resident abuse policy on orientation at 100 %. On 1/6/16 the administrator submitted the 24 hour report to DHSR heath care registry and followed up with the 5 day report submission on 1/8/16. On 1/14/16 the nurse that witnessed the incident received disciplinary action, was drug tested , and the incident was reported to the North Carolina Board of Nursing. On 1/14/16 the administrator was drug tested and received disciplinary action for failure to provide proper direction to a nurse who reported an allegation of sexual abuse. On 1/14/16 the nurse on call at time of allegation, (assistant director of nursing) received drug testing and disciplinary action for failure to direct nurse #1 to call the police and keep alleged employee supervised, and failing to assess resident immediately after she entered the building. On 1/14/16 the following in-services were completed by the corporate vice president of operations. related to the elder justice act including the following; If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator. · On 1/14/16 the administrator was in-serviced by the corporate vice president of operations related to as the administrator of the nursing home you are the leader and required to enforce the policy on abuse. You must establish a no tolerance for an abusive environment. You must also enforce the elder abuse act policy. · On 1/14/2016 the administrator was trained on enforcing the policies of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations including related to the elder justice act including the following; If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator. All staff including contract staff were trained that any staff member can call local law enforcement with any type of observed abuse · On 1/14/2016 the administrative staff, (administrator, director of nursing, and assistant director of nursing) were trained on enforcing the policies of protection, identification and reporting abuse, the elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the following; If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator. · On 1/14/2016 the departments heads were trained,(secretary, dietary manager, housekeeping manager, accounts receivable book keeper, payroll book keeper, maintenance director,, admissions coordinator, activities director, social worker, and therapy director) on enforcing the policies of protection, identification and reporting abuse elder abuse act, and notification by the corporate vice president of operations related to the elder justice act including the following; If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator. · ON 1/14/16 the ADON trained all staff including contract staff working today on the elder abuse act policy and how to report to the local law enforcement related to the elder justice act including the following; If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately to law enforcement, but not later than 2 hours after forming the suspicion. If the reportable event does not result in serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Staff must report the suspicion of an incident to their supervisor, who will report the incident to the administrator. All staff including contract staff working today were trained that any staff member can call local law enforcement with any type of observed abuse · On 1/14/16 the elder abuse act instructions was posted at each nurse station and employee break room. · No employee will be allowed to work until all training is received. · New hires will receive all training during orientation prior to taking an assignment. · Nurse #1 and Nurse #2 have completed all above in-services. Immediate jeopardy was removed on 01/15/16 at 11:06 AM when interviews with nursing staff and administrative staff and non-nursing staff confirmed they had received inservice training on the facility's policy to immediately intervene and stop abuse when witnessed, immediately remove the perpetrator from resident care areas and call the police.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to have documentation in the resident's medical record concerning a sexual abuse incident for 1 of 1 sampled resident who subsequently was transferred to the hospital for an evaluation. (Resident #1). The findings included: Resident #1 was originally admitted to the facility on [DATE] and most recently on 08/07/14. Her [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] coded Resident #1 with severely impaired cognitive skills (unable to answer any of the questions on the Brief Interview for Mental Status), having no behaviors, and needing extensive assistance with all activities of daily living skills. She weighed 76 pounds. The Care Area Assessment (CAA) for cognition dated 11/19/15 stated she was unable to make her needs known verbally, had confusion, disorientation and forgetfulness. Staff needed to anticipate her needs and provide for her as needed. Nurse #1 was interviewed on 01/13/16 at 7:12 AM. Nurse #1 stated that on 01/06/16 at approximately 3:30 AM to 4:00 AM, she tried to enter Resident #1's room to check her Wanderguard. The door was completely closed and when she tried to open it , the door hit against Resident #1's footboard. When her second attempt to open the door was unsuccessful, she looked into the opening of the doorway, which she stated was open approximately 6 inches open, enough where she could readily see but not fit her head through the doorway. Nurse #1 stated she saw Nurse Aide (NA) #1 standing next to Resident #1 and sexually assaulting the resident. Review of Resident's clinical record revealed no nursing notes after 01/02/16 at 1:14 PM until the following: *On 01/06/16 at 5:45 AM, the Director of Nursing (DON) wrote a Skin/Wound/Treatment note which stated Resident head to toe skin assessment completed. A shearing to the coccyx area was noted and several old bruises to the right hand. No others (sic) areas noted. *On 01/06/16 at 6:00 AM, the DON wrote a Health Status note which stated Per MD resident needs to be sent out to the ER (emergency room) for further assessment. RP (responsible party) notified. *On 01/06/16 at 8:52 PM, Nurse #3 wrote a Health Status note which stated Resident remains out of facility. The only telephone order received for Resident #1 on 01/06/16 was not timed as when take by the DON and stated May transfer to ER for evaluation. This was noted per verbal order. Review of the Nursing Home to Hospital Transfer Form dated 01/06/16 at 7:30 AM revealed Resident #1 was transferred to the hospital on [DATE] at 7:30 AM per physician order. The physical details related to Resident #1 on this transfer form were the resident's vital signs, a note she was in no pain, a note she was dependent for activities of daily living skills, and

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE PARK NURSING AND REHABILITATION CENTER	**3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079**

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) had contractures. The reason for transfer was Other--per MD order. On 01/13/16 at 3:00 PM the Administrator stated they filled out an incident report concerning the allegation of abuse and nurse's account of the incident but the incident report was not part of the medical record. She stated she would have expected something in the nursing notes related to some type of skin assessment but that was all. She stated the details were in her red file, again not part of the medical record, and she did not want such an allegation to be in the medical record where uninvolved persons would have access to the information. She stated the information should be vague due to the nature of the incident. She further stated that any professional needing to know about the abuse, i.e. psychologist would be informed verbally. She further stated that staff may have been waiting on direction from the legal department to write a nursing note. She stated she did not like written addendums in the nursing notes and it was such a crazy day, the resident was out of the facility before a nursing note could be written. She ended by stating that Nurse #1 did not ask her about writing a nursing note. She stated she expected the physician to note something about Resident #1's transfer to the hospital in his discharge summary which was not yet available as they are dictated. On 01/14/16 at 12:02 PM, the DON stated the assessment she completed on Resident #1 included looking in her mouth which she found clean and her face was clean except for the one spot on her collarbone. She did not say why she did not include the observations of Resident #1's mouth and collarbone in her progress note. On 01/13/16 at 4:07 PM, Administrator provided a fax copy of the physician's hand written Discharge Summation dated 01/06/16. This note indicated he was called around 7:10 AM on 01/06/16 by the DON to notify him that the resident been sexually assaulted as witnessed by a staff nurse. The abuser was an employee. The physician noted he informed the DON to urgently send the resident to the emergency department to allow proper legal documentation and clinical testing.