STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	01/13/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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 medical record review, staff and resident interviews the facility failed to protect a resident ' s right to be free from physical abuse for 1 of 1 Residents (#1). Immediate jeopardy began on 12/27/15 when Resident # 1 was slapped by two nursing assistants. Immediate jeopardy was removed on 1/7/16 when an acceptable credible allegation was provided. The facility remains out 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 ensure monitoring systems put into place are effective related to resident rights to be free from abuse. Findings included: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Assessment 10/22/15 revealed that the resident was understood and understood others. The resident was coded as having a score of 3 on the Brief Interview of Mental Status (BIMS). BIMS is a brief snapshot of how well a resident is functioning cognitively at the moment. A BIMS score of three indicates that the resident had problems with memory and recall of events. The resident was coded as not displaying physical behavioral symptoms. He was coded as displaying verbal behavior such as threatening or screaming during the past 1-3 days. Medical record review revealed a care plan goal 12/17/15 which stated will have 1 or less combative/verbal abuse behavior through next review. Interventions included, approach resident warmly and positively, talk with resident in calm voice when behavior is disruptive. Review of the statement written on 12/27/15 by nursing assistant (NA) #1 revealed, I (NA #1), went into (Resident #1 ' s) room around 9:30am-10 am. (Resident #1) was already fussy this morning before proceeding into his room. I went into his room to perform ADL (activity of daily living) care. (Resident #1) started to fuss at me. As I went to go get him dressed, Resident #1 was still fussing calling me pathetic and all other names. He then raised his hand and slapped me across the face. I then proceeded to go get my nurse but she was on break. The statement revealed that she requested that 2 other nursing assistants help her get the resident ready. The statement continued, Once inside the room, (Resident #1) continued to be combative. I was in the room but did not proceed getting him ready. NA #3 dressed him since he was more calmer at the moment. NA #2 helped but morely observed. Once finished, he was pushed down to activities and I did report to (nurse supervisor) about the situation that had occurred. During interview with (NA) #1 at 4:20 pm on 12/31/15 she stated, Resident #1 was agitated during breakfast. As I was getting ready to do activity of daily living care, he hit me in my face. NA #1 reported that she went to get the nurse and asked two other NAs to come help her. NA #1 reported that Resident #1 was basically given care by NA #3 when they returned to the room. She said, No one touched him but NA #3 when we went back to the room. NA #1 further stated that the resident had calmed down and that there was no abuse. NA #1 reported that Resident #1 hit her when she first attempted to give him morning care. She stated, It wasn't even a purposeful hit. He was already in a rant, his hand came up and I left the room. Interview with NA#2 at 3:25 pm on 12/31/15 revealed that she saw NA #1 coming down the hall. NA #1 was upset about (Resident #1). I said what's wrong? She said (Resident #1) is getting on my damn nerves. NA #2 said she told NA #1 that she would help and went down the hall with her. NA #2 reported that (Resident #1) was sitting on the side of the bed with NA #1 on one side and NA #3 on the other side. NA #2 said she saw NA #1 swing and hit (Resident #1) in the face. Then NA #3 swung on the other side. She stated that she helped (Resident #1) stand up and put on his shoes and went out of the room. NA #2 reported that NA#1 and #3 were saying a bunch of curse words. NA #2 said that she did not know the other two nursing assistants outside of the facility. Review of the written statement by NA #2 revealed the following, NA #1 was coming down from 200 Hall towards nursing station saying she was gonna clock out and go home. I asked her what was wrong. She said that (Resident #1) was getting on her damn nerves. We was at nursing station then NA#3 came up and we all went to (Resident #1)'s room. He was very agitated sitting on the side of the bed. NA #1 and #3 were antagonizing him (Resident #1) verbally. NA#1 was on the right side of (Resident #1) jerking his arm as she was putting his shirt on and NA#3 was on the left side. (Resident #1) was swinging his arms towards both of them saying they were mean girls. NA #1 hit (Resident #1) in the face on his right side, then he swung again and NA #3 hit him in the face on his left side. I helped put his pants and shoes on and made sure he was in his chair then I left the room. During follow up telephone interview with NA #2 on 1/5/16 at 8:45 pm she stated that she was standing right in front of (Resident #1) in the room. She said NA #1 was on her left side and NA #3 was on her right side. She stated that NA #1 hit (Resident #1) in the face and NA#3 was in a boxing stance when she hit the resident. NA #2 reported that (Resident #1) was swinging but she did not see him hit either NA #1 or #3. NA #2 said that she told NA #1 and #2 to stop. NA #2 said that she reported the incident to the nurse #1 about an hour later. Review of written statement written by nurse aide # 3 revealed: At or around 8:30, 9:00am another CNA (certified nursing assistant) came to me which was (NA#1) and asked for help. (NA #2) was standing in the hallway and followed NA #1 and into (Resident #1 ' s) room. Upon entering (Resident #1 ' s) room (Resident #1) already was being loud and combative. (Resident #1) was swearing, swinging and kicking at (NA #1), so she stepped back. NA #2 was just standing at the door. I stepped in and started talking to (Resident #1). At first he started swinging and kicking again. I put my hands up and told (Resident #1) that that kind of behavior would not be tolerated. And told him he wouldn ' t lie for anyone to hit him. (Resident #1) looked at me and said yes. I then told (Resident #1 to let ' s finish getting his clothes on and he said okay. I began to put his pants on, (NA #1) was still in the room, but just standing there. (NA#2) then tried to help once I had gotten (Resident #1) calm and putting his clothes on. Once (Resident #1) was dressed, I took him out of the room and to church (activities) and reported to the nurse that he was being combative. During interview on 12/31/15 at 3:36 pm with NA #3, she reported that on Sunday 12/27/15 around 9/9:30 NA #1 said to her you better come down and stated that (Resident #1) was being combative. Soon as we walked to the door he was already combative. He was waving his hands. I took his hands in mine and said you need to calm down. I told him that he needed to put his clothes on and get dressed for the day. I said will you do that for me? He calmed down, I put his clothes on. NA #3 reported that no one helped her dress him. I told them (NA#1 and #2) to just let me do it. The NA stated that when the resident was agitated she put her hands up and called his name several times. She said she has worked with (Resident #1) before and he can get a little rowdy. NA #3 reported that NA #1 was standing behind her, NA #2 was at the door and (Resident #1) was sitting on the side of the bed when they were all in the room. She reported that the resident was upset for no reason.

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) During telephone interview at 4:52 pm on 1/5/16 with the Nurse #1 (nurse assigned to the resident ' s hall at the time of the incident) she reported that she did not know about the incident when she went in to give Resident #1 his morning medication. She said that his face was a little red at that time but was not red at all when she went in with the nurse supervisor. Nurse #1 reported that Resident # 1 was a very confused resident. She said she saw Resident #1 up in his wheelchair in the hallway when she asked him if someone hit him. Nurse #1 reported that Resident #1 said Yeah, there were two of them but she helped me and pointed to NA #2. The nurse further stated that when she went to talk to the resident with the nurse supervisor he was mumbling and a little out of it. Review of the statement written by Nurse #1 (nurse assigned to the resident ' s hall on 12/27/15) revealed the following, CNA #2 reported to me (Nurse #1) that this morning around 9:45-10:15 am another CNA (certified nursing assistant) asked her to help with (Resident #1). NA #2 stated while she was in (Resident #1) room with (NA #1 and NA #3), the two cna's listed above stood on either side of the resident as she was assisting place his pants on him, one CNA (NA#1) slapped resident in his face, then immediately after (NA#3) slapped him as well. NA #2 also stated both CNA's were causing resident to become more agitated and combative. I spoke with resident and he said two women were in his room and they hit him, but that he hit them back, then he pointed to NA #2 saying she was there, but she was the one that helped me. Resident did not have any marks at that time. During telephone interview with the nursing supervisor on 1/6/16 at 2:32 pm she stated that she saw the resident around 3:30 pm on Sunday 12/27/15. She said that when she went to the room he was kind of asleep and she had to wake him up. She asked Resident #1 if anyone hit him and he said no. The supervisor said that the girl who witnessed it reported the incident at shift change. The supervisor said that she has not known the resident to have any lucid moments and that he talks stuff that doesn't make sense. The nurse supervisor reported that she has worked with the nursing assistant who reported the abuse (NA #2) for 8 years and only know her to be outstanding. During interview with Resident #1 on 12/31/15 at 2:50 pm the resident said that someone hit him on the hand 2-3 times and that he hit them back. The resident stated she (the resident was unclear regarding who she was) doesn't belong here or anywhere, she went away. He stated, I was so angry. Resident #1 said this happened a couple days ago. Review of the Director of Nurses (DON) statement revealed, It was reported to me on Sunday December 27, 2015 at around 3pm that 2 CNA's (Certified Nursing Assistant) slapped a resident during morning ADL (activity of daily living care). When I arrived at facility on Monday December 28, 2015 I went and did a skin assessment on resident at 9:30 am. There was no evidence of any bruising or red marks noted on resident. I also asked the resident if he remembered at any time anyone being mean to him or hitting him and he stated no. Interview with the Director of Nurses (DON) on 12/31/15 at 3:09 pm revealed that she went down to see the resident on Monday and the resident did not have any redness or bruising. The DON said that she asked the resident, Did anything happen yesterday that you need to tell me about? The resident said no. The DON reported that NA #2 worked every other weekend and that she had no complaints from residents regarding the nursing assistant. Telephone interview with the Director of Nurses on 1/6/16 at 10:51 am revealed that the resident was alert and oriented to person. The DON further stated that sometimes in the mornings the resident is more alert. The administrator was notified of immediate jeopardy on 1/6/16 at 4:45 pm. Credible Allegation: To insure the safety of the identified resident, The Charge Nurse was informed of an abuse allegation on 12-27-15 around 9:45am to 10:15am. The Charge Nurse went to the identified resident ' s room and completed a skin assessment on 12-27-15 at 12:32pm. This skin assessment showed some redness but no markings or bruising on the face area identified in the abuse allegation. The Charge Nurse notified the RN supervisor around 3:00pm of the abuse allegation at that time the RN Supervisor removed the CNAs (NA # 1 and NA # 3) from the building and suspended them until investigation was completed. The RN supervisor went to the room at 3 pm to perform an interview and skin assessment on the identified resident, during the interview the RN supervisor ask the identified resident if anyone had slapped him, his comment was NO. The RN supervisor performed another skin assessment on identified resident ' s facial area and was unable to identified any markings or bruising. At this time the RN supervisor contacted the Director of Nursing. The Director of Nursing contacted the Administrator at 3:05 pm on 12-27-15. The Director of Nursing submitted a 24 hour report on 12-28-15 at 11:12 am. The Director of Nursing performed an interview and a skin assessment to the facial area identified in the abuse allegation at 9:45 am on 12-28-2015. During this interview the identified resident denied any abuse and were no noted bruising or marks on the facial area in the abuse allegation. The Responsible Party for the identified resident was notified by the Director of Nursing on 12-29-15 at 4 pm concerning the abuse allegation. The Medical Director was notified on 12-31-15 at 7:30 am that identified resident needed a physical examination. The Medical Director performed the evaluation that morning around 9 am. The Medical Director noted old skin tears but did not note anything about bruising or markings to the facial area. The Responsible Party for the identified resident requested that the resident be sent out to the emergency room for complaints of left shoulder pain. The Responsible Party signed the resident out and arrived at the emergency room at 3:59 pm on 1-1-16. The Responsible Party explained to the physician on duty that the resident was assaulted by some of the staff at the facility about a week ago. The physician ordered x-rays and notified Department of Social Services. There were no acute fractures noted. The physician will send all x-rays to Department of Social Services by 1-6-16. Resident returned to the facility at 7:45 pm on 1-1-16 with no acute changes. CNA 1 (NA # 1) that was involved in abuse allegation was terminated on 12-30-15 for accepting money from a family member to wash the resident 's clothes and she never returned to work. CNA 2 (NA # 2) returned to work on 12-30-15, she was not assigned to the identified resident and was forbidden by the Director of Nursing to be in contact with the identified resident. CNA 2 (NA # 2) was terminated on 1-6-16 due to the abuse allegation substantiated. A police report was filed on 1-6-16 in regards to this abuse allegation, Police interviewed identified resident and will be interviewing all parties involved. The Police Report number is . The Police officer hand delivered his findings on 1/7/16 of his investigation that concluded there was not enough evidence to prove that an assault did occur and he closed the case. The 5 day investigation was completed and submitted by Director of Nursing on 12-30-15 at 3:37 pm. 100% of full time, part time and PRN staff were in serviced on combative and agitated residents from 1-1-16 to 1-7-16. The identified resident was seen by Nurse Psychiatrist on 1-7-16 to see if there are any interventions to help with the identified resident ' s behaviors. The interventions that she recommended were to redirect resident if agitated and be careful when touching resident around the wrist, when resident is touched around the wrist area it can cause him to be more agitated. The resident will always have two people in the room when care is being performed. These interventions have been added to the resident ' s Kardex and care plan on 1-7-16. All CNAs (NAs) must go to the Kardex before each shift to see how to perform care on residents. The identified resident will be continued to be monitored by the Nurse Psychiatrist. Both CNAs (NA # 1 and # 3) that were involved in this abuse allegation have been terminated and are banned from coming on the facility grounds. For those residents having the potential to the affected by the same alleged deficient practice: · Resident still resides in facility, all alleged employees involved in abuse allegation have been terminated or have been disciplined. Resident has been interviewed by psychiatry for any emotional distress from the incident and none has been noted. Resident continues to have behaviors but all staff and new hires have and will be educated on how to deal with behavior issues. With all interventions in place the identified resident is comfortable and safe at the facility. · The NH performs background checks on all potential employees before hiring them. The Administrator reviews all backgrounds to insure there is no abuse or criminal charge that could lead to abuse. If the background check reports any criminal items that could be consider abusive, the individual is never hired. The abuse policy covers what types of abuse, who to report abuse to, to report abuse immediately when notified or when you see abuse, notify family immediately, notify physician immediately and remove the alleged persons from the facility immediately. · 100% active, part time and as needed staff were educated from 1-1-16 thru 1-6-16 on how to deal with combative and agitated residents. 1st step is try to figure out what is making the resident agitated, 2nd see if you can redirect the resident away from what is making them combative or agitated. 3rd if you are unable to calm the person, go get someone else and let them try to calm the resident, 4th always take your time and speak clearly and slowly to the resident, and 5th always be kind and respectful . Resident ' s rights were included in the in service on 1-6-16 that included the resident always has the right to refuse service. The two CNAs (NA # 1 and # 3) that were involved in this abuse allegation were terminated. The terminations were completed by 1-6-16. · All employees are educated on the company abuse policy on hire date, at each alleged incident of abuse or neglect and

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) annually. · The Social Worker contacted all responsible parties of residents that cannot speak for themselves to inquire of any concerns or changes in resident ' s behavior that could indicate possible abuse on 1-6-15. These interviews included those residents that the two accused CNAs (NAs) were assigned & performed care on. There were no concerns voiced by responsible parties, no report of any behaviors or physical signs reported by any of the responsible parties. · The Nursing staff completed skin audits for injuries of unknown origin for 100% of residents, this includes 100% of residents that the two accused CNAs (NA # 1 and # 3) were assigned and performed care on. These skin audits were completed from 1-1-16 to 1-7-16. No injuries of unknown origin were found. · The Social Worker, Admissions Coordinator, Director of Nursing and Clinical Supervisors asked all residents capable of being interviewed if they had ever felt mistreated by a staff member of the facility, this included all residents including the ones that were cared for by accused CNA ' s (NA # 1 and # 3) that were named in the abuse allegation. All residents interviewed denied feeling mistreated by any member of the staff. All interviews were completed on 1-6-16 at 8pm. The credible allegation was verified on 1/13/16 at 3:00 PM as evidenced by staff interviews on abuse policy and procedures, different types of abuse, what to do if a resident displayed aggressive behaviors and actions to be taken if abuse was observed and/or suspected. Review of in-service records revealed 100% of facility staff (licensed nursing staff, unlicensed nursing staff, housekeeping, dietary, maintenance, transportation, administrative staff, activities, social worker) had been in-serviced by 1/7/16 on the abuse policy and procedures to be initiated if abuse was observed/suspected.
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 staff interviews, resident interview and record review it was determined that the facility failed to operationalize abuse policies and procedures in the areas of intervening when physical abuse was witnessed, immediately reporting physical abuse so that protection could be implemented, identification (immediately assessing a resident, immediately assessing if other residents could have been affected, reporting (notifying law enforcement). The abuse policy did not empower any staff person to notify law enforcement for 1 of 1 residents (#1). Immediate jeopardy began on 12/27/15 when Resident # 1 was slapped by two nursing assistants and staff witness did not intervene or immediately report. Immediate jeopardy was removed on 1/7/16 when an acceptable credible allegation was provided. The facility remains out 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 ensure monitoring systems put into place are effective related to resident rights to be free from abuse and abuse policies are operationalized. Findings included: Review of the facility guidelines for investigating allegations of resident abuse, neglect or misappropriation of property included the following instructions (undated), Notify the appropriate State agencies as required, Call Director of Operations, in regards to the notification of the department of social services/adult protective services. The policy stated, Notification of Law Enforcement Agencies requires the approval of the Director of Operations. Review of the facility abuse policy revealed: Allegations of abuse, neglect or misappropriation of property or injuries of unknown origin must be investigated thoroughly and timely. The investigation phase of the policy includes the following, · Notify the Administrator and Director of Nursing immediately. · Call Director of Ops. (Operations), in regards to the notification of DSS/APS (Department of Social Service/Adult Protective Services). · Notification of Law Enforcement Agencies requires the approval of the Director of Ops. The facility policy included miscellaneous points to remember. This portion of the policy stated, if abuse or potential abuse has not been reported timely to the facility: · Take steps to assess if abuse could have occurred in the building elsewhere · Review, conduct, and document resident physical assessments as necessary (one hall, or entire facility), as appropriate. Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Assessment 10/22/15 revealed that the resident was understood and understood others. The resident was coded as having a score of 3 on the Brief Interview of Mental Status (BIMS). BIMS is a brief snapshot of how well a resident is functioning cognitively at the moment. A BIMS score of three indicates that the resident had problems with memory and recall of events. The resident was coded as not displaying physical behavioral symptoms. He was coded as displaying verbal behavior such as threatening or screaming during the past 1-3 days. Medical record review revealed a care plan goal 12/17/15 which stated will have 1 or less combative/verbal abuse behavior through next review. Interventions included, approach resident warmly and positively, talk with resident in calm voice when behavior is disruptive. Review of the statement written on 12/27/15 by nursing assistant (NA) #1 revealed, I (NA #1), went into (Resident #1 ' s) room around 9:30am-10 am. (Resident #1) was already fussy this morning before proceeding into his room. I went into his room to perform ADL (activity of daily living) care. (Resident #1) started to fuss at me. As I went to go get him dressed, Resident #1 was still fussing calling me pathetic and all other names. He then raised his hand and slapped me across the face. I then proceeded to go get my nurse but she was on break. The statement revealed that she requested that 2 other nursing assistants help her get the resident ready. The statement continued, Once inside the room, (Resident #1) continued to be combative. I was in the room but did not proceed getting him ready. NA #3 dressed him since he was more calmer at the moment. NA #2 helped but morely observed. Once finished, he was pushed down to activities and I did report to (nurse supervisor) about the situation that had occurred. During interview with (NA) #1 at 4:20 pm on 12/31/15 she stated, Resident #1 was agitated during breakfast. As I was getting ready to do activity of daily living care, he hit me in my face. NA #1 reported that she went to get the nurse and asked two other NAs to come help her. NA #1 reported that Resident #1 was basically given care by NA #3 when they returned to the room. She said, No one touched him but NA #3 when we went back to the room. NA #1 further stated that the resident had calmed down and that there was no abuse. NA #1 reported that Resident #1 hit her when she first attempted to give him morning care. She stated, It wasn't even a purposeful hit. He was already in a rant, his hand came up and I left the room. Review of the written statement by NA #2 revealed the following, NA #1 was coming down from 200 Hall towards nursing station saying she was gonna clock out and go home. I asked her what was wrong. She said that (Resident #1) was getting on her damn nerves. We was at nursing station then NA#3 came up and we all went to (Resident #1)'s room. He was very agitated sitting on the side of the bed. NA #1 and #3 were antagonizing him (Resident #1) verbally. NA#1 was on the right side of (Resident #1) jerking his arm as she was putting his shirt on and NA#3 was on the left side. (Resident #1) was swinging his arms towards both of them saying they were mean girls. NA #1 hit (Resident #1) in the face on his right side, then he swung again and NA #3 hit him in the face on his left side. I helped put his pants and shoes on and made sure he was in his chair then I left the room. Interview with NA #2 at 3:25 pm on 12/31/15 revealed that she saw NA #1 coming down the hall. NA #1 was upset about (Resident #1). I said what's wrong? She said (Resident #1) is getting on my damn nerves. NA #2 said she told NA #1 that she would help and went down the hall with her. NA #2 reported that (Resident #1) was sitting on the side of the bed with NA #1 on one side and NA #3 on the other side. NA #2 said she saw NA #1 swing and hit (Resident #1) in the face. Then NA #3 swung on the other side. She stated that she helped (Resident #1) stand up and put on his shoes and went out of the room. NA #2 reported that NA#1 and #3 were saying a bunch of curse words. NA #2 said that she did not know the other two nursing assistants outside of the facility. During follow up telephone interview with NA #2 on 1/5/16 at 8:45 pm she stated that she was standing right in front of (Resident #1) in the room. She said NA #1 was on her left side and NA #3 was on her right side. She stated that NA #1 hit (Resident #1) in the face and NA#3 was in a boxing stance when she hit the resident. NA #2 reported that (Resident #1) was swinging but she did not see him hit either NA #1 or #3. NA #2 said that she told NA #1 and #2 to stop. NA #2 said that she

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) reported the incident to the nurse #1 about an hour later. Review of written statement written by nurse aide # 3 revealed: At or around 8:30, 9:00am another CNA (certified nursing assistant) (NA) came to me which was (NA#1) and asked for help. (NA #2) was standing in the hallway and followed NA #1 and into (Resident #1 ' s) room. Upon entering (Resident #1 ' s) room (Resident #1) already was being loud and combative. (Resident #1) was swearing, swinging and kicking at (NA #1), so she stepped back. NA #2 was just standing at the door. I stepped in and started talking to (Resident #1). At first he started swinging and kicking again. I put my hands up and told (Resident #1) that that kind of behavior would not be tolerated. And told him he wouldn ' t lie for anyone to hit him. (Resident #1) looked at me and said yes. I then told (Resident #1 to let ' s finish getting his clothes on and he said okay. I began to put his pants on, (NA #1) was still in the room, but just standing there. (NA#2) then tried to help once I had gotten (Resident #1) calm and putting his clothes on. Once (Resident #1) was dressed, I took him out of the room and to church (activities) and reported to the nurse that he was being combative. During interview on 12/31/15 at 3:36 pm with NA #3, she reported that on Sunday 12/27/15 around 9/9:30 NA #1 said to her you better come down and stated that (Resident #1) was being combative. Soon as we walked to the door he was already combative. He was waving his hands. I took his hands in mine and said you need to calm down. I told him that he needed to put his clothes on and get dressed for the day. I said will you do that for me? He calmed down, I put his clothes on. NA #3 reported that no one helped her dress him. I told them (NA#1 and #2) to just let me do it. The NA stated that when the resident was agitated she put her hands up and called his name several times. She said she has worked with (Resident #1) before and he can get a little rowdy. NA #3 reported that NA #1 was standing behind her, NA #2 was at the door and (Resident #1) was sitting on the side of the bed when they were all in the room. She reported that the resident was upset for no reason. Review of the statement written by Nurse #1 (nurse assigned to the resident's hall on 12/27/15) revealed the following, CNA #2 reported to me (Nurse #1) that this morning around 9:45-10:15 am another CNA (certified nursing assistant) asked her to help with (Resident #1). NA #2 stated while she was in (Resident #1) room with (NA #1 and NA #3), the two cna's listed above stood on either side of the resident as she was assisting place his pants on him, one CNA (NA#1) slapped resident in his face, then immediately after (NA#3) slapped him as well. NA #2 also stated both CNA's were causing resident to become more agitated and combative. I spoke with resident and he said two women were in his room and they hit him, but that he hit them back, then he pointed to NA #2 saying she was there, but she was the one that helped me. Resident did not have any marks at that time. During telephone interview at 4:52 pm on 1/5/16 with the Nurse #1 (nurse assigned to the resident ' s hall at the time of the incident) she reported that she did not know about the incident when she went in to give Resident #1 his morning medication. She said that his face was a little red at that time but was not red at all when she went in with the nurse supervisor. Nurse #1 reported that Resident # 1 was a very confused resident. She said she saw Resident #1 up in his wheelchair in the hallway when she asked him if someone hit him. Nurse #1 reported that Resident #1 said Yeah, there were two of them but she helped me and pointed to NA #2. The nurse further stated that when she went to talk to the resident with the nurse supervisor he was mumbling and a little out of it. During telephone interview with the nursing supervisor on 1/6/16 at 2:32 pm she stated that she saw the resident around 3:30 pm on Sunday 12/27/15. She said that when she went to the room he was kind of asleep and she had to wake him up. She asked Resident #1 if anyone hit him and he said no. The supervisor said that the girl who witnessed it reported the incident at shift change. The supervisor said that she has not known the resident to have any lucid moments and that he talks stuff that doesn't make sense. The nurse supervisor reported that she has worked with the NA who reported the abuse (NA #2) for 8 years and only know her to be outstanding. Review of the Director of Nurses (DON) statement revealed, It was reported to me on Sunday December 27, 2015 at around 3pm that 2 CNA's (Certified Nursing Assistant) slapped a resident during morning ADL (activity of daily living care). When I arrived at facility on Monday December 28, 2015 I went and did a skin assessment on resident at 9:30 am. There was no evidence of any bruising or red marks noted on resident. I also asked the resident if he remembered at any time anyone being mean to him or hitting him and he stated no. Interview with the Director of Nurses (DON) on 12/31/15 at 3:09 pm revealed that she went down to see the resident on Monday and the resident did not have any redness or bruising. The DON said that she asked the resident, Did anything happen yesterday that you need to tell me about? The resident said no. Interview with the DON revealed that NA #1 and #3 were taken off the schedule during the investigation. Per the DON, NA #1 was terminated due to an unrelated incident. (NA # 3 was observed working on 12/31/15 at 2:30 pm). The DON reported that no other residents had been interviewed regarding mistreatment during the abuse investigation. Telephone interview with the Director of Nurses on 1/6/16 at 10:51 am revealed that the resident was alert and oriented to person. The DON further stated that sometimes in the mornings the resident is more alert. The DON said that that the police were not notified of the allegation of abuse after discussion with the administrator. During interview with Resident #1 on 12/31/15 at 2:50 pm the resident said that someone hit him on the hand 2-3 times and that he hit them back. The resident stated she (the resident was unclear regarding who she was) doesn't belong here or anywhere, she went away. He stated, I was so angry. Resident #1 said this happened a couple days ago. During telephone interview with the facility administrator on 1/6/16 at 10:55 am the administrator reported that he was in contact with the DON and the registered nurse (RN) supervisor. The RN supervisor could not find any markings on the resident ' s face. Two nurses observed the resident with no markings and he did not notify the police because there was no physical evidence or bruising. Review of a statement written by the facility administrator (undated) revealed, (Resident #1 is a long term resident at (facility). (Resident #1) was admitted to our facility on 7/7/15. (Resident #1) suffers from multiple [DIAGNOSES REDACTED]. Resident is alert and oriented X 1. Resident is able to make his needs know (known). A CNA (Certified Nursing Assistant) on the east wing brought an incident to the charge nurse on 12-27-15 around 10am. This incident was accusing two CNAs of slapping a resident in the face. Due to the severity of this incident, the charge nurse went down and performed a skin assessment on the resident. Per this skin assessment and nurse statement, no bruising or red marks were noted to the area addressed in the incident. The charge nurse had the RN supervisor to perform a skin assessment on (Resident #1) and she was unable to find any bruising or red marks to the areas noted in the incident report. The RN Supervisor interviewed the resident and she asked resident if anyone had hit him today and (Resident #1) stated no. The two accused CNAs were asked to write a statement before they left and both CNAs denied hitting (Resident #1). They did state that (Resident #1) was combative and he hit them but they got help from another CNA to perform care on (Resident #1). The DON performed a skin assessment on 12-28-2015 at 9:30 am and was unable to locate any bruising or red areas to the locations noted in the incident report. She performed an interview with the resident and the resident did not remember anyone being mean to him or hitting him. Based on the information provided by the accuser, the accused and the investigation that followed, the administrator and DON concluded that there is not enough evidence to substantiate this allegation. The administrator was notified of immediate jeopardy on 1/6/16 at 4:45 pm. Credible Allegation To insure the safety of the identified resident, The Charge Nurse was informed of an abuse allegation on 12-27-15 around 9:45 am to 10:15 am. The Charge Nurse went to the identified resident ' s room and completed a skin assessment on 12-27-15 at 12:32 pm. This skin assessment showed some redness but no markings or bruising on the face area identified in the abuse allegation. The Charge Nurse notified the RN supervisor around 3:00 pm of the abuse allegation at that time the RN Supervisor removed the CNAs (NA # 1 and NA # 3) from the building and suspended them until investigation was completed. The RN supervisor went to the room at 3 pm to perform an interview and skin assessment on the identified resident, during the interview the RN supervisor ask the identified resident if anyone had slapped him, his comment was NO. The RN supervisor performed another skin assessment on identified resident's facial area and was unable to identified any markings or bruising. At this time the RN supervisor contacted the Director of Nursing. The Director of Nursing contacted the Administrator at 3:05 pm on 12-27-15. The Director of Nursing submitted a 24 hour report on 12-28-15 at 11:12 am. The Director of Nursing performed an interview and a skin assessment to the facial area identified in the abuse allegation at 9:45 am on 12-28-2015. During this interview the identified resident denied any abuse and were no noted bruising or marks on the facial area in the abuse allegation. The Responsible Party for the identified resident was notified by the Director of Nursing on 12-29-15 at 4 pm concerning the abuse allegation. The Medical Director was notified on 12-31-15 at 7:30 am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	**01/13/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINEHURST HEALTHCARE & REHAB	**300 BLAKE BOULEVARD PINEHURST, NC 28374**

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) that identified resident needed a physical examination. The Medical Director performed the evaluation that morning around 9 am. The Medical Director noted old skin tears but did not note anything about bruising or markings to the facial area. The Responsible Party for the identified resident requested that the resident be sent out to the emergency room for complaints of left shoulder pain. The Responsible Party signed the resident out and arrived at the emergency room at 3:59 pm on 1-1-16. The Responsible Party explained to the physician on duty that the resident was assaulted by some of the staff at the facility about a week ago. The physician ordered x-rays and notified Department of Social Services. There were no acute fractures noted. The physician will send all x-rays to Department of Social Services by 1-6-16. Resident returned to the facility at 7:45 pm on 1-1-16 with no acute changes. CNA 1 (NA # 1) that was involved in abuse allegation was terminated on 12-30-15 for accepting money from a family member to wash the resident's clothes and she never returned to work. CNA 2 (NA # 2) returned to work on 12-30-15, she was not assigned to the identified resident and was forbidden by the Director of Nursing to be in contact with the identified resident. CNA 2 (NA # 2) was terminated on 1-6-16 due to the abuse allegation being substantiated. A police report was filed on 1-6-16 in regards to this abuse allegation, a police officer interviewed identified resident and will be interviewing all parties involved. The Police Report number is . The police officer hand delivered his findings on 1/7/16 of his investigation that concluded there was not enough evidence to prove that an assault did occur and he closed the case. The 5 day investigation was completed and submitted by Director of Nursing on 12-30-15 at 3:37 pm. 100% of full time, part time and as needed staff were in serviced on combative and agitated residents from 1-1-16 to 1-7-16. The identified resident was seen by Nurse Psychiatrist on 1-7-16 to see if there are any interventions to help with the identified resident ' s behaviors. The interventions that she recommended were to redirect resident if agitated and be careful when touching resident around the wrist, when resident is touched around the wrist area it can cause him to be more agitated. The resident will always have two people in the room when care is being performed. These interventions have been added to the resident's Kardex and care plan. All CNAs must go to the Kardex before each shift to see how to perform care on residents. The identified resident will be continued to be monitored by the Nurse Psychiatrist. Both CNAs (NA # 1 and # 3) that were involved in this abuse allegation have been terminated and are banned from coming on the facility grounds. For those residents having the potential to the affected by the same alleged deficient practice: · The Abuse Policy: states all residents also have the right to be free from verbal or physical abuse or other mistreatment by other residents and staff. Incidents of aggressive, sexual, or abusive behavior by one resident toward another resident or staff member toward a resident. This must be reported immediately to the supervisor and the resident must be protected from harm. · The NH performs background checks on all potential employees before hiring them. The Administrator reviews all backgrounds to insure there is no abuse or criminal charge that could lead to abuse. If the background check reports any criminal items that could be consider abusive, the individual is never hired. · The Director of Nursing and Administrator were educated on 1-6-16 by the Nursing Consultant on the company abuse policy, the Elder Justice Act and reporting abuse to the state agency and police immediately when notified. · 100% active, part time and as needed staff were educated from 1-1-16 thru 1-6-16 by the Director of Nursing, Clinical Supervisors and Administrator. The in-service covered the company's abuse policy, what types of abuse, who to report the abuse to and to report the abuse immediately when told or seen and how to identify signs and symptoms of abuse to nonverbal resident. The steps that we take to report, protect and prevent abuse in the facility. The in-service included that the medical director, responsible party and Administrator of the building must be informed immediately when abuse is reported. 100% full time, part time and as needed staff were educated on the elder justice act and received a copy to review and keep on 1-6-16 by Administrator, Director of Nursing, Social Worker and Clinical Supervisors. · 100% active, part time and as needed staff were educated from 1-1-16 thru 1-6-16 on how to deal with combative and agitated residents. 1st step is try to figure out what is making the resident agitated, 2nd see if you can redirect the resident away from what is making them combative or agitated. 3rd if you are unable to calm the person, go get someone else and let them try to calm the resident, 4th always take your time and speak clearly and slowly to the resident, and 5th always be kind and respectful . Resident's rights were included in the in-service on 1-6-16 that included the resident always has the right to refuse service. · The Social Worker, Admissions Coordinator, Director of Nursing and Clinical Supervisors asked all residents capable of being interviewed if they had ever felt mistreated by a staff member of the facility, this included all residents including the ones that were cared for by accused CNA's (NA # 1 and # 3) that were named in the abuse allegation All residents interviewed denied feeling mistreated by any member of the staff. All interviews were completed on 1-6-16 at 8pm. · A Resident Council Meeting was conducted Thursday, January 7, 2016. The residents will be reminded of their rights to be free from abuse, different types of abuse and how and who to report it to. · The Social Worker contacted all responsible parties of residents that cannot speak for themselves to inquire of any concerns or changes in resident ' s behavior that could indicate possible abuse on 1-6-15. These interviews included those residents that the two accused CNAs (NA # 1 and # 3) were assigned & performed care on. There were no concerns voiced by responsible parties, no report of any behaviors or physical signs reported by any of the responsible parties · The Nursing staff completed skin audits for injuries of unknown origin for 100% of residents, this includes 100% of residents that the two accused CNAs (NA # 1 and # 3) were assigned and performed care on. These skin audits were completed from 1-1-16 to 1-7-16. No injuries of unknown origin were found · All employees are educated on the company abuse policy on hire date, at each alleged incident of abuse or neglect and annually. · The CNA that reported the abuse (NA # 2) was in serviced on 1-1-16, she admitted there was an hour delay in telling her supervisor. She was disciplined on 1-7-16. · The Charge Nurse involved in the abuse allegation was terminated due to breaking company abuse policy and endangering the life of a resident on 1-7-16. · The CNA (NA # 2) that reported the abuse was in serviced on 1-1-16, she admitted there was an hour delay in telling her supervisor. She was disciplined on 1-7-16. The credible allegation was verified on 1/13/16 at 3:00PM as evidenced by staff interviews on abuse policy and procedures, different types of abuse, what to do if a resident displayed aggressive behaviors and actions to be taken if abuse was observed and/or suspected. 100% of facility staff had been in-serviced by 1/7/16 on the abuse policy and protocol which included notification of law enforcement in cases of alleged abuse.