Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060138	A. BUILDING: _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD AT PROVIDENCE	11945 PROVIDENCE ROAD CHARLOTTE, NC 28277

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an initial survey and complaint investigation on August 12-13, 2015. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on August 3, 2015.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure supervision for 2 of 6 sampled residents (Residents #1 and #6) in the Memory Care Unit (MCU) in accordance with each resident's assessed needs, care plan, and current symptoms resulting in a resident (Resident #1) receiving sunburn and heat-stroke in 94 degree temperature, and multiple falls (Resident #6). The findings are: Review of Resident #1's FL-2 dated 3/6/15 revealed: -Diagnoses of Alzheimer's disease, depression with anxiety features, high cholesterol, vitamin D deficiency, osteopenia, benign essential tremor,	D 270	Please see attached	9/11/15

Division of Health Service Regulation

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

Courtni Ages | Interim Executive Director | 9/9/2015

Plan of Correction Approved 2015-09-17 with Attachments (2)

Keturah E. Hawkins, MHA

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D 270	Continued From page 1 delusions and memory impairment. -Recommended level of care was indicated to be Alzheimer, secured unit. -The resident was ambulatory, intermittently disoriented, a wanderer, and was "Verbal" indicated under the communication of needs section. Review on 8/03/15 of Resident #1's Personal Care Assessment signed by the physician on 04/24/15 revealed: -Resident #1 wandered, required redirection multiple times during the day, and required supervision for ambulation/locomotion. Review on 8/03/15 of Resident #1's faciltiy Nursing Evaluation completed on 04/24/15 revealed: -Resident #1 was non-cooperative at times and wandered, the resident had impaired decision making and was confused, and needed multiple redirection. Review of Resident #1's Incident and Accident report dated 8/1/15 revealed: -At 5:00 pm, Resident #1 was found outside of the MCU courtyard by staff unresponsive. -Vitals sigms were taken by a Medication Aide (MA) as follows: -Blood Pressure-117/64, pulse-131, Respiratory Rate-16, Temperature-98.3. -The Licensed Practical Nurse (LPN) checked resiprations with a Resipartory Rate of 10. -Resident #1 was hot to touch and ice packs were applied. -Emergency Medical Services were called and the resident was transported to a local hospital. Observation on 08/03/15 at 1:45 pm of the MCU courtyard revealed:	D 270		

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D 270	Continued From page 2 -The courtyard exit door was propped open with a wooden wedge. -There was a 10 x 12 patio area with a covered roof that provided shade over the patio. -There were two black metal benches in the courtyard, one to the left side of the patio and one to the right side of the patio. -Both benches were approximately 5-6 feet from the patio with shaded covering. -A person sitting on either bench would be in direct sunlight. -There were no residents in the courtyard. According to "Weather Source" the temperature outside on 8/1/15 was 94 degrees. Interview with a first shift MA, in the MCU on 08/03/15 at 1:45 pm revealed: -She was "not sure who propped the door because it is too hot for anyone to be out there." -She thought the doors were propped open to allow the residents to come in and out from the courtyard on their own. Review of the local emergency response service (ERS) report revealed: -Resident #1 was assessed by ERS responder on 08/01/15 at 5:16 pm. -ERS arrived on the scene and was told by a local fire department responder that an elderly female was found outside unresponsive in the sun for an unknown period of time. -Resident #1 was observed by the ERS responder to be unresponsive and the initial impression of the patient was poor. -Resident #1's skin was dry and flushed red. -Resident #1 was transported to a local hospital with possible Heat Stroke. Review of Resident #1's hospital summary dated	D 270		

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D 270	Continued From page 3 8/1/15 revealed: -Resident #1 presented at the local hospital emergency room on 08/01/15 by ambulance after being found outside by nursing facility staff. -Upon arrival at local hospital emergency room, Resident #1 was confused, dehydrated, demonstrated a mild sunburn on her face, neck and upper extremities and had a temperature of 104 degrees. -Resident #1 was arousable, but did not talk, and was moving all 4 extremities. -Resident #1 was admitted to the hospital on 08/01/15 for hypotension, heat stroke, fever, burn from the sun, AKI (acute kidney injury), UTI (urinary tract infection). -Resident #1 was discharged to another Assisted Living facility on 08/07/15. Interview with Memory Care Coordinator (MCC) on 08/03/15 at 1:55 pm revealed: -The door to the courtyard should always be locked. -Staff had a key to unlock the door. -The door to the courtyard was not considered a fire exit. -Staff were previously propping the door open when there were cooler temperatures outside during the spring time. -Observed the door to be propped open last week and instructed staff that the door was not to be propped open. -Policy was for staff to be with residents at all times when they were outside in the courtyard. -The door was automatically locked from the inside when closed, but could be entered from the outside. -Residents were outside with staff for activities at least twice a day, but for no more than 15-20 minutes in the shade since it had been so hot outside.	D 270		

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D 270	Continued From page 4 -Several residents enjoyed sitting outside in the courtyard, however due to the heat today no residents had not been outside. - Residents had been upset about not being able to go outside more frequently when it had been hot. -She received a phone call from a staff member at approximately 5:30 pm on 08/01/15, stating that Resident #1 had been found unresponsive in the courtyard of the MCU. -She arrived at the facility between 6:30 pm to 7:00 pm on 08/01/15. -She was told by staff that when 2nd shift staff came on duty there were 4 residents, including Resident #1, sitting outside on the patio under the roof in the shaded area. -Just after 3:00 pm on 8/1/15, staff were gathering residents for ice cream social and brought in the residents that were sitting outside. Resident #1 was reportedly resistant to coming in and staff allowed her stay outside. -She was told by staff that when staff were gathering residents for dinner around 5:00 pm on 8/1/15, the 2nd shift Nursing Assistant (NA) saw Resident #1 still sitting outside, on the bench in the sun. -The NA went outside to bring the resident in for dinner. -Staff reported to her that Resident #1 was unresponsive and called for help. -Staff told her they brought Resident #1 inside and called 911. -The MCC stated Resident #1 was in late stages of Alzheimer's disease. -Due to the resident's Alzheimer's she felt Resident #1 would not know or recall to come to the door if she became too hot. -When she arrived at the facility, staff were interviewed and all residents were checked to assure they were not dehydrated.	D 270		

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D 270	Continued From page 5 -There was no policy in place as to how staff were to assess residents for dehydration. -She met with staff and reinforced that residents were not be left outside in the courtyard without a staff person present. - She was unsure when the 4 residents first went outside on 08/01/15, so she was unsure how long they had been outside before three of them came in for activity around 3:00 pm. -The MCC stated 3 of the 4 residents were able to determine when it was too hot and would come inside by themselves. -The kickstand was removed from the door on Sunday 08/02/15 so the door would no longer be propped. -She called and talked to the staff that were to be working on Sunday and reinforced that residents were not to be outside in the courtyard unattended by staff. Interview with the Executive Director (ED) at 5pm on 08/03/15 revealed: -She received a phone call on 08/01/15 from the facility that Resident #1 was found unresponsive in the MCU courtyard. -She arrived at the facility at approximately 5:30 pm and instructed the facility nurse to check on all of the MCU residents. -She educated staff immediately to not leave residents in the courtyard unattended by staff. -She called third shift supervisor to make her aware, and instructed her to share the information with staff on the third shift. -She completed a work order for the kickstand to be removed from the exit door leading to the courtyard. -She communicated to staff who would be working the next day that residents were not to be left in the courtyard unattended by staff. -A new policy was implemented regarding	D 270		

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D 270	Continued From page 6 residents in the MCU going outside in the heat, and given to each staff member on 08/03/15 to sign, and the ED maintained a copy. Interview with a first shift MA, at 3pm on 08/03/15 revealed: -Residents were to be checked on every 15-20 minutes when outside in the courtyard. -She checked on residents by looking at them through the windows out into the courtyard. -Staff was to encourage the residents to come in from outside after about 20 minutes or so when it was really hot, over 98 degrees or really cold under 35 degrees outside. -Residents were always in a staff person's vision due to activities being held near the windows and door that looked out into the courtyard. -She felt Resident #1 would need prompting to come back inside and the resident really liked being outside. -Previously, Resident #1 resisted staff when they tried to bring her back inside. Staff always had to coax Resident #1 to come back inside. -After the incident with Resident #1 she was given something in writing on 8/3/15 about residents not being outside when it is too hot or too cold. -Prior to 8/1/15, residents were allowed outside unattended as long as they could be seen by staff, and staff were to encourage hydration. -She worked first shift on 08/01/15 and observed Resident #1 outside at around 1:30 pm with other residents. -Resident #1 was not on her assignment 08/01/15. Interview with a second shift NA at 3:20 pm on 08/03/15 revealed: -Residents were not to be left outside for more than an hour or two if it was too hot, but was unsure of what the outside temperature would be	D 270		

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D 270	Continued From page 7 when it was too hot for residents to go outside. -If residents asked to go outside, staff were supposed to stay with them. -She had observed residents outside in the courtyard through the windows unattended by staff. -She worked first shift on 08/01/15 and did not notice Resident #1 outside unattended by staff. -She had observed Resident #1 on the patio under the shade with 3 other residents when she came on her shift around 3:00 pm on 08/01/15. -She was aware Resident #1 was outside when the first shift NA went outside around 4:45 pm to bring the residents back inside for dinner. -She observed the first shift NA tapping the leg of Resident #1 and she wondered if Resident #1 was alright. -She went outside to help and heard staff calling Resident #1's name and she came back inside to get a wheelchair for Resident #1. - She stated that Resident #1 looked like she was asleep and was pink in color and warm to the touch and was not responding to staff. -Staff tried to get her to drink some water, but Resident #1 only opened her eyes a little bit and would not respond to staff. -Stated she is unsure of what level Resident#1's Alzheimer's disease was but thought she would be able to determine if it was too hot outside and would come inside on her own. -She was given a new policy update on 08/03/15 stating that residents are not to be outside unattended when it was too hot. Interview with a another second shift NA at 3:35 pm on 08/03/15 revealed: -She worked on 08/01/15, and was assigned to care for Resident #1. -Staff were supposed to supervise residents when they were outside, and had checked on	D 270		

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D 270	Continued From page 8 residents by looking out through the windows into the courtyard when they were in the courtyard unattended by staff. -When residents were outside staff had to provide frequent checks, at least every 15 minutes, on hot days. -The courtyard door was frequently propped open so residents can go in and out on their own. -They had high functioning residents in the MCU, so they were able to go in and out by themselves unattended by staff. -The door was not propped when it was too hot. Staff were to use their own judgment, "common sense" in determining what was too hot. -Resident #1 was a wanderer and did what she wanted to do and went in and out to the courtyard a lot. -Resident #1 would not come inside on her own if it was too hot, as she would not be able to identify for herself that it was too hot outside. -She first saw Resident #1 at the beginning of her shift around 3pm on 08/01/15 and she was sitting on the patio under the shade with three other residents. -She observed Resident #1 asleep on the black bench in the sun at some point between 3:45 pm and 4:15 pm when she was looking out the windows into the courtyard. -Resident #1 had her head leaned back, her legs outstretched in front of her and arms at her sides. -She was gathering residents for dinner at around 4:40 pm and she saw Resident #1 sitting on the black bench in the sun in the same position she previously observed her in. -She found Resident #1 to be unresponsive, very warm to the touch and her skin was red with no perspiration. -She called Resident #1 by name, and the resident eyes fluttered. -She called the MA to help her and told her to call	D 270		

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D 270	Continued From page 9 911. -The MA brought out a wheelchair and Resident #1 was taken inside and staff placed ice packs on her forehead, and underarms and her vitals were taken. -Staff were able to arouse Resident #1 enough to get her to drink a few sips of water. -She stated Resident #1 was unresponsive when she left with local emergency personnel. -She was given a new policy on 08/03/15 that stated residents were not to be left outside unattended by staff when it was too hot outside. She described the policy as "nothing new" compared to the previous policy that had been in place. Interview with a second first shift MA at 2:50 pm on 08/03/15 revealed: -She had worked on 08/01/15. -She was unaware of when Resident #1 had gone outside on first shift on 08/01/15, but remembered seeing Resident #1 outside on the patio around 1:00 pm with a few other residents. -Staff were to keep residents inside when it was too hot outside. -She would take residents outside if they insist on going. -Residents were to be offered water while sitting outside. -Staff were to supervise residents while they were outside. -Resident #1 enjoyed going outside and would frequently go outside by herself when the door was propped open. -Staff would supervise Resident #1by looking out the window, but not always physically check on her when outside in the courtyard. -Resident #1 was not able to determine when it was too hot to be safely outside. -Staff were aware Resident #1 liked to go outside	D 270		

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D 270	Continued From page 10 and checked on her every 20 minutes or so when she was outside by herself. -Staff sometimes conducted physical checks on Resident #1, but sometimes just observed her from the window that looked out into the courtyard. -She was made aware of a new policy implemented on 08/03/15 that if the temperature outside was 90 degrees or above then residents were to stay inside. -The new policy also included if residents insisted on going outside, they must be accompanied by staff and only stay outside for 15-20 minutes. Hydration must be offered to residents during the 15-20 minutes while outside in the courtyard. -Staff had been told prior to 8/1/15 that staff had to accompany residents when they were outside. Interview with a third first shift NA at 3:15 pm on 08/03/15 revealed: -She had worked on 08/01/15. -Resident #1 was a wanderer and frequently went into other resident's rooms and was very difficult to redirect. -She observed Resident #1 sitting outside on the patio with other residents around 2:30 pm on 08/01/15. -She did not know when Resident #1 was brought inside on 8/1/15. -She did not feel that Resident #1 would be able to know when it was too hot and it was no longer safe to be outside. -She had observed Resident #1 prior to 8/1/15 outside by herself and she frequently fell asleep while sitting outside. -She had attempted to bring Resident #1 back inside when she saw her outside by herself, however she was very difficult to redirect. -The policy was for residents not to be in the courtyard unattended by staff. Staff were to be	D 270		

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D 270	Continued From page 11 with residents anytime they are outside. -She was not aware of any new policy change regarding residents being in the courtyard and had not been given a copy of any new policy. B. Observation on 08/12/15 from 10:15 to 11:00 am during the initial tour of the facility revealed: -Resident #6 was sitting in the common living area in his wheelchair. -Initially, the resident was observed to sit without movement. -Several minutes later Resident #6 was observed taking both his legs off the wheelchair leg extension petal, placing them on the floor, and putting his hands on the arm rest of the wheelchair, and raising his bottom up as if he was going to stand. -The resident was shaking, and wobbling. -Staff in the area observed Resident #6 and assisted the resident with sitting back down. -The resident attempted this several times, and even caused the chair alarm to sound upon one attempt to stand. -Resident #6 had one-half inch circular black (half moon) shaped blue and black bruise underneath his left eye with red and pink scratches on his forehead. Review of Resident #6's current FL2 dated 04/16/15 revealed: -Diagnoses included Alzheimer's dementia, falls, and depression. -Disoriented status was intermittently; ambulation status was semi-ambulatory, and incontinent of bladder and bowel. Review of the Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 04/17/15.	D 270		

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D 270	Continued From page 12 Review of the Resident #6's Personal Care Plan signed by the physician dated 06/18/15 revealed: -The Memory Care Coordinator (MCC) completed the assessment for Resident #6 on 04/17/15. -Documentation under social and mental health history revealed the resident had a history of greater than three falls per month with no acute injuries sustained. -The MCC documented Resident #6 "shows imbalance with gait, tremors have been increased which require staff to assist with ADL (activities of daily living)." -The resident was assessed as needing supervision with eating. -The resident required limited assistance with toileting and placed on two hour incontinent program. -The resident required extensive assistance with ambulation, bathing, dressing, grooming and transferring. Review of Resident #6's Licensed Health Professional Support (LHPS) evaluation dated 07/11/15 revealed: -The tasks checked as part of the evaluation were ambulation using assistive device (rolling walker), and transferring semi-ambulatory or non-ambulatory residents. -The nurse observed the resident as having a personal alarm on and intact, and confused to time and place. -The nurse recommendations were monitor for safety related to use of ambulatory device. -Keep walkways free of clutter and debris to prevent falls. -Check the resident every 30 minutes from 9:00 pm to 7:00 am and while in bed with supporting documentation. -Make sure bed/chair alarm was on and intact.	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 Review of Incident/Accident reports for Resident #6 revealed falls on the following dates: -06/03/15 at 6:15 am "resident observed on the floor in the hallway." -06/10/15 at 1:20 pm "heard a loud sound coming from the dining room, server said resident fell." -06/14/15 at 5:45 am unwitnessed fall, staff found the resident on the floor. -07/22/15 at 8:25 am Resident #6 was found lying on the floor. -07/25/15 at 1:35 pm Resident #6 observed on the floor in the sunroom. -08/03/15 at 6:30 am Resident #6 was on the floor. No apparent injuries. -08/06/15 at 2:15 pm Resident #6 was observed on the floor. Raised area to the left side of forehead color red with no cuts, no bleeding. Review of the facility's "Resident Checks - Hourly" sheets for Resident #6 revealed: -In June 2015, staff initialed Resident #6 was checked at various times on 06/18, 19, 20, 21, 22, and 06/24/15. -Staff did not document observation of the resident every hour as recommended by the LHPS nurse. Review of the facility's "Resident Checks - Hourly" sheets for Resident #6 revealed -In July 2015, staff initialed Resident #6 was on 30 minute checks. -Documentation showed staff initialed the resident was checked at various times on 07/03, 13, 30, and 31, 2015, but not every 30 minutes, and not checked daily as recommended by the LHPS nurse. Review of the facility's "Resident Checks - Hourly" sheets for Resident #6 revealed -In August 2015, staff initialed Resident #6 was	D 270		

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	HAL060138	A. BUILDING: _____ B. WING _____	08/13/2015

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D 270	Continued From page 14 on 30 minute checks. -Documentation showed staff initialed the resident was checked at various times on 08/01, 02, 03, 05, 06, 08, 09, 10, 11,and 12, 2015, but not every 30 minutes, as recommended by the LHPS nurse. -No checks were documented on 08/04/15 and 08/07/15. Interview on 08/12/15 at 10:45 am with a first shift, Nursing Assistant (NA) revealed: -Resident #6 had frequent falls, at least two or three falls weekly. -Most falls happened when the resident was in his room alone. -During the first shift, staff on duty tried to keep Resident #6 in the common sitting area to keep an eye on the resident. -Resident #6 had a chair/bed alarm, but "he is clever at figuring out how to get the alarm off without causing it to make a sound." -Previously, Resident #6 had even taken off his shirt to keep the alarm from sounding. -Staff continually reminded Resident #6 not to get up, but the resident was impulsive and always tried to get up. -The resident's balance was unsteady and he was unable to balance his weight when standing, which caused the resident to fall. Second observation on 08/13/15 at 4:00 pm of Resident #6 revealed: -The resident was in his wheelchair, wheeling himself through the hallway. -The resident was coming from the direction of his bedroom. -No staff was near the resident or in sight. -The resident's location was about 10 feet from his bedroom, with more than 15 feet from the common living area (in the front of the building).	D 270		

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D 270	Continued From page 15 -The resident had his chair/bed alarm in his lap, the alarm was not connected to the resident or the chair, and no sounds was coming from the alarm. -Resident #6 had one white sock on his left foot, but no sock on the right foot. Attempted interview on 08/13/15 at 4:02 pm with Resident #6 revealed: -The resident was unable to respond when asked, what he was doing or where he was going. Interview on 08/13/15 at 3:01 pm with Resident #6's family member revealed: -Resident #6 lived at the facility since April 2015, and had at least 15 falls. -The facility notified the family member about each fall and she was sure of 15 falls, and maybe more. -The family member said injuries sustained from falls were never more than a skin tear and/or bruises, with the exception of the last fall, which happened on 08/06/15. -The resident fell hitting his face which caused a black eye and small scrapes to the resident's forehead. -The family member said if no one was there to help Resident #6 when getting up, the resident always fell. -The family member said before admission to the MCU, and prior to the Alzheimer's dementia setting in Resident #6 already had an imbalance in his gait, due to inner ear damage. -The damage to the inner ear happened several years prior to Resident #6 coming to the facility, and had always caused the resident to lose his balance and fall. -Prior to the Alzheimer's dementia Resident #6 was able to balance himself, which prevented a lot of falls.	D 270		

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D 270	Continued From page 16 -Now that Resident #6 had Alzheimer's dementia he was unable to control his gait, and fell every time he tried to ambulate without staff assistance. -Resident #6 had falls during the daytime, but most falls happened at night when in the room alone. -She had requested that Resident #6 not nap in his room alone. -She had also asked that Resident #6 be moved closer to the nurse's station, so staff could keep a closer eye on the resident when in the bed. -She was told Resident #6 would be moved when a bed was available. -She would "love it if staff checked the resident more frequently, at least every 15 minutes to help reduce falls." Interview on 08/13/15 at 3:45 pm with the MCC revealed: -Resident #6 had frequent falls, at least one or more fall a week. -The resident had not had a fall since 08/06/15, and prior to that had fallen more frequent. -The facility had tried various techniques like lowering the bed, chair/bed alarm to keep Resident #6 from falling. -The resident's physician was aware of the falls and had ordered a bed/chair alarm. -The resident's bed had been lowered. -The resident was on Hospice for failure to thrive, and after the last fall she asked their assistance to help eliminate or reduce Resident #6's falls. -Hospice got Resident #6 a wheelchair, because the resident was unsteady with his balance and gait. -Resident #6's room was not in the front of the facility (near the nurse station), it was about 15 to 20 feet away, around the corner. -Sometimes Resident #6 took his bed/chair alarm off and threw it across the room.	D 270		

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D 270	Continued From page 17 -Yesterday, Resident #6's family member observed a vacant room in the front of the facility, and asked to move Resident #6 near the nurses station. -A resident was in the hospital and they were not sure of the resident's return; so until 08/07/15; they had no room available in the front of the facility near the nurses station. -Staff had been instructed to toilet Resident #6 every two hours, and to observe or supervise the resident at least every hour. -In July 2015, the 1 hour observation was changed to every 30 minutes when the resident was in bed. -When doing 30 minute checks on a specific resident it was the facility's protocol for staff to document they had observed the resident. -She did not review the 30 minute check sheets and was unaware staff were not documenting they observed Resident #6 every 30 minutes. -Based on the 30 minute check sheets she could not be sure Resident #6 was observed or supervised when in bed. -She had not discussed with the staff to supervise Resident #6 more often than every 30 minutes. -She had discussed with Resident #6's family member the possibility of getting a sitter, but the family member declined due to cost. Interview on 08/13/15 t 4:15 pm with Resident #6's physician revealed: -He was aware Resident #6 had frequent falls. -The physician said the falls were a result of the resident's dementia. -He had made some changes to the resident's medications, and two or three weeks ago he ordered a bed/chair alarm for the resident. -He had not discussed frequently supervising of Resident #6, but moving the resident closer to the nurse's station would be a good idea so staff	D 270		

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D 270	Continued From page 18 could observe the resident more often. Interview on 08/13/15 at 5:03 pm with the Regional Nurse revealed: -It was the facility's protocol after a resident had a fall, staff was to check on the resident at least every 2 hours. -Resident's that fell frequently, like Resident #6, were put on 1 hour or 30 minute checks. -Staff were required to document those checks had been done. -If staff did not document they had checked on a resident, then they could not be sure the resident was checked. -The facility had never required a resident to be checked more frequently than every 30 minutes. Interview on 08/13 at 4:20 pm with a second shift Medication Aide revealed: -Resident #6 had a bed/chair alarm. -The resident was on 30 minute checks, and staff was to document every 30 minutes when they observed Resident #6 in the room. -If there was no documentation, she was unable to validate 30 minute checks were being done. -The resident's gait was unsteady, so they watched the resident more than other residents, and tried not leave Resident #6 alone in the common sitting area. -Most falls happened when the resident was in his room. -The resident was mostly found on the floor in his room. -She thought for some reason Resident #6 was trying to get out of bed and unable to balance his weight caused the resident to fall. -Sometimes the resident was found in the bathroom. The facility provided the following Plans of	D 270		

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D 270	Continued From page 19 Protection on 8/3/15 and 8/13/15 as follows: -Immediately, all staff will be informed no resident in the memory care unit was allowed outside unaccompanied. -All residents in the MCU will be checked to ensure no sun burn or other heat damage done, and all okay. -The door-stops/kickstand was removed from the courtyard door. -A policy was put in place for extreme weather condition and going outside for residents in the memory care. -A sign will be posted the door to the memory care unit courtyard was not allowed to be propped open under any circumstance, no exceptions. -Education will be done to all staff regarding this policy and documentation the education was completed. -A pendant will be given to Resident #6 to wear around his neck. -When staff completed 30 minute checks on Resident #6 they were to press the button on the pendant to record their presence in the resident's room. -Management will print the log daily, and review at the morning standup meeting to ensure Resident #6 was being observed every 30 minutes. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2015.	D 270		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and	D 287		

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D 287	Continued From page 20 non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure beverages were served in non-disposable beverage containers for 2 of 18 sampled residents (#6 and #7). The findings are: A. Review of Resident #6's current FL2 dated 04/16/15 revealed: -Diagnoses included Alzheimer's dementia, falls, and depression. -Disoriented status was intermittently; ambulation status was semi-ambulatory, and incontinent of bladder and bowel. -The diet ordered was regular and nectar thickened liquids. Observation on 08/13/15 from 7:30 am to 8:30 am of the breakfast meal served to residents in the MCU revealed: -At 7:40 am Resident #6 was served 6 ounces of nectar pre-thickened milk, and 6 ounces of nectar pre-thickened water. -The beverages were served to the resident in thin (able to see through the plastic), bendable, disposable plastic cups. Based on record review and observations, it was determined that Residents #6 was not interviewable.	D 287	Please see attached	9/11/15

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D 287	Continued From page 21 Interview on 08/13/15 at 9:21 am with a dietary aide revealed: -Resident #6's beverages were not served in a glass like the other residents beverages because some days the resident was very agitated and would throw the glass across the room. -The facility did not have hard plastic beverage containers, so plastic disposable cups were used. Confidential interviews with two staff members revealed: -Sometimes Resident #6 got really agitated and threw things, including his beverages. -The resident's beverages were not served in breakable glasses like the other residents because they were afraid the resident would throw the glass hurting himself or someone else. -The staff members said Resident #6's physician had changed the resident's medications, and he was less agitated lately, but staff continued to serve the resident's beverages in disposable plastic cups for caution. -Both staff members said to their knowledge the facility did not have non-disposable plastic cups. Interview on 08/13/15 at 3:01 pm with Resident #6's family member revealed: -The family member was unaware Resident #6's beverages were served in disposable plastic cups. -The family member said staff may have used plastic cups due to Resident #6's previous history of severe agitation. -The family member stated the physician changed some of Resident #6's medications and the agitation had subsided tremendously for the past several weeks. Refer to interview on 08/13/15 at 3:43 pm with the Director of Culinary Services (DCS).	D 287		

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D 287	Continued From page 22 B. Review of Resident #7's current FL2 dated 04/15/15 revealed: -Diagnoses included Alzheimer's dementia. -Disoriented status was intermittently, non-ambulatory, and incontinent of bladder and bowel. -The diet ordered was nectar thickened liquids. Review of Resident #7's record revealed the following diet orders: -On 05/21/15 diet was changed to mechanical soft meals with nectar thickened liquids. -On 07/24/15 diet was changed to pureed meal with nectar thickened liquids. Observation on 08/13/15 from 7:30 am to 8:30 am of the breakfast meal served to residents in the MCU revealed: -At 7:55 am Resident #7's meal was served in the resident's room. -Resident #7's beverages consisted of 6 ounces of nectar pre-thickened milk, 6 ounces of nectar pre-thickened water, and 6 ounces of nectar pre-thickened orange juice. -The beverages were served to the resident in thin (able to see through the plastic), bendable, disposable plastic cups. -16 other residents in the MCU dining room received their beverages in non-disposable glasses. -Each beverages was served in a 7 ounce glass. Based on record review and observations, it was determined that Residents #7 was not interviewable. Interview on 08/13/15 at 9:21 am with a dietary aide revealed: -Resident #7's beverages were served in plastic	D 287		

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D 287	Continued From page 23 disposable cups because the resident was unable to feed himself and meals were served in the resident's room. -Staff threw the plastic cups away after feeding the resident. Interview on 08/13/15 at 9:41 am with a first shift Nursing Assistant (NA) feeding Resident #7 revealed: -All Resident #7's meals were served to the resident in his room because the resident was non-ambulatory, frail, and under Hospice care. -She served the resident's beverages in the plastic disposable cups because the resident's nose sometimes got in the way of tilting the cup forward to the resident's mouth. -The plastic cup was bendable and moved around the resident's nose. -The NA stated she had not discussed this issue with the MCC or the DCS because she did not know plastic cups were not allowed. Interview on 08/13/15 at 8:11 am with a first shift Medication Aide revealed: -She was the supervisor on duty and observed staff serve Resident #7's beverages in plastic cups. -The resident's beverages were in plastic cup because the resident received all meals in his room. -She was unaware beverages served with the meal should not be in plastic disposable cups. Refer to interview on 08/13/15 at 3:43 pm with the Director of Culinary Services. Interview on 08/13/15 at 3:43 pm with the DCS revealed: -She was unaware staff used disposable plastic cups when serving Residents #6 and #7	D 287		

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D 287	Continued From page 24 beverages with their meal. -She did not observe meals to ensure plastic disposable cups were not used.	D 287		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 17 of 18 residents in the Memory Care Unit (MCU) dining room were treated with respect, dignity of individuality and full recognition by not being served a complete meal according to the week-at-a-glance menus. The findings are: Review of the 7 day week-at-a-glance menu revealed: -The breakfast meal on 08/13/15 was to consist of: -whole grain hot or cold cereal, fresh season fruit, scrambled eggs, sausage patty or link, toast, muffin or pastry, choice juice, milk, coffee/tea. Review of the altered "pick a choice" menu prepared by the facility revealed: -Food item choices on the breakfast menu called the "feature" meal was scrambled eggs, sausage, and toast. -The menu also included food items called "Always available" that were oatmeal or hot	D911	Please see attached	9/11/15

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D911	Continued From page 25 cereal, fruit cup, breakfast pastry, and variety of cold cereal. -The protocol was for residents to pick the food item they wanted for breakfast. Based on record review and observation on 08/12/15 and 08/13/15 the 18 residents in the MCU were determined not to be interviewable. Observation on 08/13/15 from 7:30 am to 8:30 am of the breakfast meal in the MCU dining room revealed: -17 residents were seated in the dining room for the meal. -1 resident received feeding assistance from staff and meals were served in the resident's room. -The 17 residents' present for the breakfast meal in the dining room were served sausage and scrambled eggs. -One resident was served a muffin and melon mix of cantaloupe and honey dew prior to being served the sausage and eggs. -The 18 residents' in the MCU were all determined not to be interviewable and unable to make choices regarding their meal. Interview on 08/13/15 at 9:21 am with the dietary aide revealed: -The meal that he served to residents in the MCU was decided by staff in the MCU. -The staff picked the food items for the residents in the MCU from the facility's prepared menu. Interview on 08/13/15 at 9:23 am with the cook revealed: -The meal served to residents in the MCU was decided by the staff working in the MCU. -The kitchen plated meals for residents according to food items picked by the staff in the MCU.	D911		

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D911	Continued From page 26 Interview on 08/13/15 at 9:37 am with two first shift Nursing Assistants (NA) revealed: -Most residents in the MCU were unable to pick food items from the menu, so staff decided what the residents would eat. -The staff decided it would be easier to serve all 18 residents in the MCU the same food items for breakfast, with exception of one resident that always wanted fruit and a muffin before breakfast. -They were unaware the menu prepared by the dietitian had more food items choices than the facility's menu. -They were also unaware what was on the menu prepared by the dietitian, because the food option given by the Food Service Director (FSD) was the facility's menu that included feature items, which was the main meal. -They were told the always available items were not part of the meal, because those items were available at each meal. Confidential interviews with three residents' family members revealed: -Two family members were unaware the meals served residents in the MCU was less and not the same meal as recommended by the dietitian. -The family members said they had not noticed any weight loss with their family members residing in the MCU. -One family member said they were not happy with the dining services and meals in the MCU. -The family member said they had observed meals served to residents in the MCU and the meals were "less than equitable" with less food items compared to meals served to residents in the Assisted Living (AL) dining room. -The family member said about one and one-half months ago there was a meeting with facility management, residents, and family members. The family members raised questions at that	D911		

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	HAL060138	A. BUILDING: _____ B. WING _____	08/13/2015

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D911	Continued From page 27 time as to why residents in the MCU did not receive the same service and smaller amounts of food compared to the residents in the AL. -They were told the issue would be addressed, but they had not noticed any changes. Interview on 08/13/15 at 3:40 pm with the FSD revealed: -She was aware residents in the MCU were unable to make food item choices from the facility's prepared "feature and always available" menu. -Staff in the MCU picked the food item choices for the residents. -Initially, the meal served to residents in the MCU was what the dietitian wrote on the menu, but a staff person in the MCU (no longer worked at the facility), told her meals served were too many food items and residents were refusing to eat their meals. -She was aware of a group of residents and family members that were unhappy with meal service, and the issues were being worked on.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant	D912	Please see attached	9/11/15

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D912	Continued From page 28 federal and state laws and rules and regulations related to Personal Care and Supervision. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure supervision for 2 of 6 sampled residents (Residents #1 and #6) in the Memory Care Unit (MCU) in accordance with each resident's assessed needs, care plan, and current symptoms resulting in a resident (Resident #1) receiving sunburn and heat-stroke in 94 degree temperature, and multiple falls (Resident #6). [Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision, (Type A1 Violation)]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and	D935	Please see attached	9/11/15

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D935	Continued From page 29 procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 4 of 5 sampled Medication Aides (MA) (Staff A, Staff B, Staff C and Staff D) had successfully completed Medication Clinical Skills Checklist prior to administering medications. The findings are: A. Review of Staff A's personnel file revealed: -Staff A was hired as a Medication Aide (MA) on 3/4/15. -Staff A passed the written Medication Aide Exam on 5/22/12. -Staff A completed the 15 hour medication	D935		

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D935	Continued From page 30 training on 3/20/15. -There was no documentation that Staff A completed a Medication Clinical Skills Checklist. Interview with Staff A on 8/13/15 at 4:05 pm revealed: -Staff A works mainly in the Memory Care Unit (MCU), but had worked in the Assisted Living Unit when needed. -Staff A had worked in other facilities and was familiar with the Medication Clinical Skills Checklist and has been checked off elsewhere. -Medication Clinical Skills Checklist was not completed at this facility. -She did take the 15 hour Medication Aide Training with the nurse from the pharmacy on 3/20/15. -She had administered oral medications, nasal sprays, eye drops and transdermal patches on a regular basis at this facility. -She had applied a Bilevel Positive Airway Pressure device (BIPAP) at this facility and applied clean dressing changes and obtained finger stick blood sugars on a regular basis at this facility. Review of Resident Medication Administration Records revealed Staff A: -Administered medications on both the Assisted Living and the MCU. -Administered medications on 27 shifts in June 2015. -Administered medications on 24 shifts in July 2015. -Administered medications on 7 shifts from 8/01/15 to 8/11/15. -Administered oral medications, nasal sprays, eye drops and transdermal patches. -Applied a BIPAP and obtained finger stick blood sugars.	D935		

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D935	Continued From page 31 Refer to interview with the Administrator on 8/13/15 at 2:15 pm. B. Review of Staff B's personnel file revealed: -Staff B was hired as a Medication Aide (MA) on 3/4/15. -Staff B passed the written Medication Aide Exam on 3/26/15. -No documentation of the Medication Clinical Skills Checklist in Staff B's personnel file. -Staff B completed the 15 hour medication training on 3/20/15. -Medication Clinical Skills Checklist dated 7/13/15 was then supplied by the Administrator. Interview with the administrator on 8/13/15 at 2:20 pm revealed that the Medication Clinical Skills Checklist for Staff B, dated 7/13/15, was found filed at the nurse's station. Review of Resident Medication Administration Records (MAR) revealed Staff B: -Administered medications and obtained finger stick blood sugars in the MCU for 22 shifts in June 2015. -Administered medications and obtained finger stick blood sugars in the MCU for 11 shifts between 7/01/15 and 7/13/15 prior to her Medication Clinical Skills Check dated 7/13/15. Attempted interview with Staff B on 8/13/15 was unsuccessful. Refer to interview with the Administrator on 8/13/15 at 2:15 pm. C. Review of Staff C's personnel file revealed: -Staff C was hired as a Medication Aide (MA) on 3/4/15.	D935		

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D935	Continued From page 32 -Staff C passed the written Medication Aide Exam on 01/06/15. -Staff C completed the 15 hour medication training on 3/20/15. -No documentation of the Medication Clinical Skills Checklist in Staff C's personnel file. Interview with Staff C on 08/13/15 revealed: -She was not exactly sure what the Medication Aide Clinical Skills Check List was. -She did not recall being checked off by the facility nurse or pharmacy nurse with return demonstration because she was trained back in March 2015. -She did report that she took a two day class with the pharmacy nurse and suggested this may have been the check off. -She did administer oral medications, eye drops, transdermal medications, nasal sprays and inhalants on a regular basis at this facility. Review of Resident Medication Administration Records revealed Staff C: -Administered medications 17 shifts in June 2015. -Administered medications 18 shifts in July 2015. -Administered medications 9 shifts from 8/01/15-8/13/15. -Administered oral medications, eye drops, transdermal medications, nasal sprays and inhalants during June, July and August 2015. Refer to interview with the Administrator on 8/13/15 at 2:15 pm. D. Review of Staff D's Personnel File revealed: -Staff D was hired as a Medication Aide (MA) on 3/14/15. -Staff D passed the written Medication Aide Exam on 6/26/08.	D935		

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D935	Continued From page 33 -Staff D completed the 15 hour medication training on 3/20/15. -No documentation of the Medication Clinical Skills Checklist in the employee file. Review of Resident Medication Administration Records revealed Staff D: -Administered medications 2 shifts in June 2015. -Administered medications 5 shifts in July 2015. -Administered medications 2 shifts from 8/01/15-8/13/15. Attempted interview on 8/13/15 with Staff D was unsuccessful. Refer to interview with the Administrator on 8/13/15 at 2:15 pm. _____ Interview with the Administrator on 8/13/15 at 2:15 pm revealed: -She was aware there were missing training requirements and other documents as a result of an audit that they had started last week. -She was new to this position and had just discovered weaknesses within staff files and resident records. -There was no system in place to alert pharmacy nurse or the facility nurse to initiate and complete the Medication Clinical Skills Checklist because there was a period of time they had been without a management leader for nursing. -The Resident Care Manager was responsible for scheduling and implementing the Medication Clinical Skills Checklist's going forward. -The Resident Care Manager was hired 7/13/15 per the Administrator.	D935		