STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 000}	Initial Comments The Adult Care Licensure Section and the Transylvania County Department of Social Services conducted a follow-up survey and complaint investigation on September 1, 2015 to September 3, 2015 with an exit conference via telephone on September 4, 2015. The Transylvania County Department of Social Services initiated complaint investgations on July 21, 2015 and August 11, 2015.	{D 000}		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to follow expert recommendations in a complete and timely manner for scabies. The findings are: Summary of findings: In early June, 2015, the facility was notified by the local hospital of residents who, reporting for other conditions, were secondarily diagnosed and treated for scabies. Investigation revealed that in spite of facility acknowledgement of this finding and expert guidance provided by the county Health Department, preventative medication treatment, environmental controls and communication of	D 338		

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D 338	Continued From page 1	D 338		

education to staff and family was delayed and incomplete, resulting in prolonged treatment and definitive control of scabies.

Review of an e-mail dated 06/05/15 from the corporate Regional Director of Operations to the former Executive Director (ED) and with the contracted Corporate Consultant copied revealed:
- A subject line of "FW" [Forwarded].
- An attachment listed and titled "SCABIES INFO-081811.pdf" (a copy of the attachment was not provided).
- The text "Here are the recommendations for dealing with possible cases of scabies."
- "Health Department is coming next Wednesday" [no specific date mentioned].

Review of a summary of notes provided by the county Health Department revealed:
- A note dated 06/10/15 (Wednesday) that the Health Department received a complaint that multiple residents (exact number not mentioned) were sent to the local hospital for unrelated concerns and all were noted to have scabies.
- The Health Department visited the facility and met with the former ED on 06/10/15.
- The Health Department recommended the whole facility be treated for scabies and not just those residents who presented to the hospital.
- The Health Department provided information from the Centers for Disease Control and Prevention (CDC) for reference, discussed environmental cleaning, monitoring resident's skin and treatment modalities for both residents and staff.
- The facility was encouraged to contact the Health Department for any needs or concerns.

Review of the most current CDC information on the control of scabies, obtained from their web

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D 338	Continued From page 2	D 338		

site, revealed:
- "A scabies outbreak suggests that transmission has been occurring within the institution for several weeks or months- thus increasing the likelihood that some infected staff or patients may have had time to spread scabies elsewhere in the community."
- Control measures for multiple cases of non-crusted scabies included "confirmation of the diagnosis of scabies, early and complete treatment and follow-up of cases, and prophylactic treatment of staff, other patients, and household members who had prolonged skin-to-skin contact with suspected and confirmed cases."
- "In addition, an institution-side information program should be implemented to instruct all management, medical, nursing, and support staff about scabies ..."
- Long-term surveillance for scabies is imperative to eradicate scabies from an institution."

Review of a summary of notes provided by the county Health Department revealed:
- A note dated 06/15/15 documenting a call from the Health Department to the former ED regarding treatment of all residents and environmental cleaning.
- The Health Department documented the former ED as "awaiting the go-ahead from her boss."

Review of notes provided by the county Health Department revealed:
- A note documenting the former ED sending an e-mail reply on 06/24/15 to a Health Department message that the facility was "planning a full building precautionary, beginning with obtaining prescriptions by in-house doctor on 6-25 [2015]."

Review of notes provided by the county Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 3	D 338		

Department revealed:
- A note dated 06/29/15 that the former ED informed the Health Department that the in-house physician had provided treatment orders for scabies for all of their residents and other physicians were notified about their residents.
- The former ED was documented as stating "all would be in place no later than 06/30/15" and orders for medications were being faxed to the pharmacy.

A summary review of the pharmacy report from the contract pharmacy, for the period of 06/29/15 through 09/02/15, revealed:
- Ivermectin 3 milligram tablet orders were filled for 34 residents on 07/01/15, 2 residents on 07/06/15 and 6 residents on 07/07/15 (these totals were corroborated with a list of residents in the facility on 06/30/15 and sampled resident medication adminstration records documented the medication as given).
- Permethrin 5% cream (indicating continued treatment for scabies) was filled for 6 specific residents on the following dates: 07/15/15, 07/21/15, 07/28/15, 08/10/15, 08/18/15, 08/20/15, 08/27/15 and 08/31/15.

Interview on 09/01/15 at 9:30AM with the interim ED revealed:
- He had started working at the facility on 08/13/15.
- There were additional staff coming that same day to do a deep clean of the facility, including resident rooms, due to "similar reasons" he experienced at a "sister facility."

Observation on 09/01/15 at 10:15AM of the 100 hallway revealed:
- Staff members putting on yellow disposable gowns and gloves and entering a resident room.

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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D 338	Continued From page 4	D 338		

- These staff members were placing linens and clothing in clear plastic bags and removing them from a room.
- Medication Aide (MA) Staff A placed a tied bag in a plastic garbage can, covered it with a lid and moved it down the hallway.

Interview on 09/01/15 at 10:15AM with MA Staff A, from a "sister facility", revealed she was rolling the bagged items in the garbage can to the laundry room.

Interview on 09/01/15 at 10:15AM with Personal Care Aide (PCA) Staff B revealed:
- She and the other staff in the gowns worked at "sister facilities" in the area and were directed to come the facility to bag up linens for laundering due to scabies.
- She was not sure which resident or room had scabies but the staff was just starting at the observed room.
- She and the other staff were directed (she did not say by whom) to "work their way" through the facility to bag up linens.

Confidential interview with a resident on 09/01/15 at 10:30AM revealed:
- No report of skin rashes or scabies.
- When asked if medications were administered for scabies replied "I don't know."
- The resident reported that when staff wearing yellow gowns were in his room they did not state why they were bagging up personal clothing items and linens.

Observations 09/01/15 at 10:42AM and at 10:58AM of the 100 hallway revealed staff in yellow disposable gowns and gloves moving down the hallway from room to room, removing linens and placing them in covered garbage cans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

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D 338	Continued From page 5 Observations 09/01/15 at 12:00PM and again at 1:15PM of the 100 hallway and main lobby revealed staff in yellow disposable gowns wiping down walls, baseboards and handrails with a product having a strong smell of chlorine. Interview on 09/01/15 at 4:45PM with MA, Staff C revealed: - One named resident had been sent to the hospital for evaluation following a fall and was diagnosed with scabies by the hospital provider, but she could not remember the date. - She was told that all the residents had been treated for scabies (she did not reveal the source of this information). - Some residents received permethrin cream which was applied to all skin from under their neck to their feet. - She was not aware that any residents received any oral medications for scabies. Interview on 09/02/15 at 9:22AM with the Interim Memory Care Manager (MCM) revealed: - She had recently come from a "sister facility" and although she was still learning facility-specific processes, she was aware of corporate policies and procedures. - She did not know anything about scabies at the facility. - She could recall seeing on her medication cart one or two tubes of medication used for scabies, but could not recall who they were for. - She knew that all the residents had been treated for scabies, which included having their linens and clothing washed, as of the previous day (09/01/15). Interview on 09/02/15 at 3:00PM with MA, Staff E revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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D 338	Continued From page 6	D 338		

- "No one [staff] had been given a definite response if it was scabies" but all residents in the building were treated as if it was scabies.
- She could not recall when scabies first appeared but it did so all of a sudden.
- She had not been asked by Personal Care Aides to look at rashes.
- Staff assisting with showers were required to fill out a body evaluation sheet to note significant skin findings and this form was "routine."
- Staff did not receive any emphasis on completing this form with regard to scabies.
- The previous day (09/01/15) was not the first day resident's clothes were washed due to scabies.

Interview on 09/02/15 at 3:45PM with the attending FNP revealed:
- A named resident (no longer at the facility) was mentioned as possibly having scabies in February 2015.
- As the spring season progressed "others" developed a rash, with two named residents mentioned.
- The entire resident population was treated, at first some specific residents with lidane or permethrin cream, then all residents with oral medication.
- One named resident had recently gone to a dermatologist and was diagnosed with scabies.
- Another named resident was mentioned as the latest person with a discreet popular rash that might not be scabies as she was not "100 percent certain."
- A "sister facility" had a similar outbreak and in both cases the facility response was "appropriate."

Phone interview on 09/03/15 at 10:00AM with the former MCM revealed:

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	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

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D 338	Continued From page 7	D 338		

- She was a relatively new employee before she left employment.
- When she started employment she did not know there was scabies in the facility.
- She mentioned one resident by name who may have had scabies and they had been seen by a dermatologist.
- All residents received oral treatment for scabies but no date was given.
- During her tenure no linens or clothing were bagged up.
- The presence of scabies in the facility was not really "broadcasted."
- She had one friend/fellow employee with itching, but she did not think this friend/fellow employee ever sought treatment.

Interview on 09/03/15 at 10:50AM with MA, Staff F revealed:
- She was not sure when scabies first started and "no one really said anything."
- 2 to 3 residents (not named) were recently treated.
- Everything was cleaned with bed linens removed.
- She was not sure if cleaning was done at any other time before the current week.
- She recalled a "stand-up" meeting about the issue with the current leadership (no date given), but the former Executive Director "did not say much."

Interview on 09/03/15 at 11:45AM with the Regional Director of Operations and contracted Corporate Consultant revealed:
- They were not aware of any corporate policy that addressed scabies, nor were they certain if an infection control policy addressed it.
- They expected facility leadership to follow Centers for Disease Control and Prevention

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	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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D 338	Continued From page 8 (CDC) guidelines on treatment and control of scabies. Interview on 09/03/15 at 1:15PM with an attending provider for a sampled resident revealed: - His review of his electronic notes revealed this resident was seen 3 weeks prior for a rash, at first it was cleared up and then it reappeared and was spreading. - He had heard scabies "was going around the facility" and he ordered permethrin cream to be applied for 12 hours then washed off. - He would not say the scabies was a serious issue, but that the resident could be made uncomfortable by it. - Scabies was hard to diagnose but required a "very benign" treatment. - His review of a note by a palliative nurse also documented a rash suspected to be scabies. Interview with the corporate Regional Director of Operations on 09/03/15 at 2:15PM revealed: - There was no policy regarding scabies, just the CDC guidelines. - He had first become aware of scabies around June and believed it was reported by the former Executive Director at that time. - He knew diagnosis required a skin scrape and residents could be treated prophylactically for it. - He gave the former Executive Director a "handout" and would have sent it by e-mail. - The "handout" would have addressed prophylactic medications, housekeeping, and drying clothes at a high temperature. - "Not to my knowledge were linens changed for all residents, just a few." - He would have expected the former Executive Director to follow the "handout" he provided. - At various times (no frequency provided) he	D 338		

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	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 9	D 338		

followed up with the facility concerning the situation.
- He was told there was no positive confirmation of scabies and the rashes could have possibly been due to a reaction with laundry detergent.
- At some point the rashes may have or may not have been scabies, but at some point with a resident being treated, the facility now had to "nip it."
- The former Executive Director left employment on 08/13/15 and left no documentation regarding the management of the scabies in the facility.
- He did not know if staff received communication regarding scabies.

Phone interview on 09/04/15 at 8:35AM with the Program Specialist of the county Department of Health, Environmental Health Division revealed:
- The former Executive Director did initially contact the Health Department and received advice on treatment options and environmental controls.
- The Health Department had received reports from the local hospital of residents who presented for care and had scabies treatment ordered there.
- "Part of the problem was they [facility] did not think it [scabies] was house-wide."
- The Health Department's communicable disease nurse had made periodic calls to the facility.
- The Health Department had received some inquiries from individuals in the community regarding scabies at the facility, but as it is not a reportable disease they were instructed to call the facility directly for information.
- The facility was instructed to bag linens and wash them for all residents.
- She expressed concern about chairs and sofas with cloth coverings by the front door of the facility, where many residents would sit.

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	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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D 338	Continued From page 10 Confidential interviews with seven alert and oriented residents revealed: - One resident who did not personally complain of a rash, but reported that other residents "broke out" with rashes and a doctor ordered all residents to take pills, which this resident stated he took. - Another resident who denied a rash and as receiving no pills or ointments for a rash. - Another resident who stated she had not had any rashes, nor was she aware of anyone who did. - Two residents who denied a rash and did not know if they received medications to prevent scabies. - Another resident who had "heard nothing" about scabies, had no rashes and had no received medication for scabies. - Another resident who denied skin rashes or scabies and did know know if he took any medication. Confidential interview with a family member of a resident revealed: - Before leaving for a trip, she visited her family member and observed a rash on her leg. - Upon her return from her trip (no time interval provided), she visited her family member and observed a rash now "all over" the resident's body. - She had heard "through the grapevine" that other residents in the facility had scabies. - A friend of the family who at one time resided at the facility also had scabies, but had moved to another facility. Confidential interview with an acquaintance of another resident revealed: - She had heard there was an outbreak of	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 11	D 338		

scabies.
- She was very concerned since she and the resident would often go to the common areas and sit on the furniture and she and the resident had frequent contact with the other residents in the facility.
- It was her understanding that the outbreak happened sometime in June, but she was not informed about it until the beginning of August and this bothered her because if she had known about the scabies, she would not have sat on the furniture in the common room nor allowing her friend to do so.
- She found out about the scabies when her friend went to the hospital for a fall.
- At the time of the interview, she still had not been informed about scabies by the facility staff nor had any staff recommended any precautions she or her friend should take as a result of the scabies.
- She stated her friend had been treated more than once for the scabies at the facility, but she did not know how well she was responding to the treatment.

Confidential interview with another family member of another resident revealed the resident had no bites or rashes in the recent past.

A Plan of Protection was obtained from the facility on 09/21/15 and included:
- Additional staff were called in to do a thorough cleaning and laundering all resident clothing and bedding according to CDC guidelines, completed on 09/01/15.
- Mandatory training for all staff on 09/22/15 with the regional Ombudsman to review Residents' Rights.
- Administrator will review with staff guidelines for

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D 338	Continued From page 12 scabies including investigating, treating, controlling and preventing. - A new policy and procedure has been written and implemented for investigating, treating, controlling and preventing scabies. - Any concerns regarding scabies, including signs and symptoms of scabies with residents, will be reported to the Resident Care Coordinator. - Administrator will be informed and will ensure that the new policy and procedure will be followed. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 19, 2015.	D 338		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to assure that medications were administered as ordered for 2 of 6 sampled residents (Resident #1 and #6) and failed to order preventative scabies medication in a timely	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 358}	Continued From page 13 manner for 42 of 42 residents. The findings are: A. Review of Resident #1's current FL2 dated 06/17/15 revealed diagnoses including: - Advanced dementia. - Hypothyroidism. - Edema of the lower extremities. Review of Resident #1's record revealed: - A local hospital's emergency department home care instructions form dated 7/10/15 with diagnoses of an acute urinary tract infection and conjunctivitis. - A hospital's provider order dated 07/10/15 for ciprofloxacin 250mg taken orally every twelve hours for five days (ciprofloxacin is used to treat different types of bacterial infections). - A hospital's provider order dated 07/10/15 for tobramycin 0.3% ophthalmic solution one drop in each eye four times a day for ten days (tobramycin is used to treat different types of bacterial infections). Review of Resident #1's Electronic Medical Record (e-MAR) for the month of July 2015 for ciprofloxacin revealed: - An entry for ciprofloxacin tablet 250mg, one orally every twelve hours for five days with a start date of 07/10/15 and an end date of 07/15/15. - Doses were documented as administered beginning at 8:00PM on 07/12/15 and ending at 8:00PM on 07/15/15. - There were 7 doses documented as administered out of a possible 10 opportunities. - The 3 missed opportunities on 07/11/15 at 8:00AM and 8:00PM and on 07/12/15 at 8:00AM showed no documentation of the reason(s) the medication was not administered.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 358}	Continued From page 14 Further review of the e-MAR for the month of July 2015 for tobramycin revealed: - An entry for tobramycin 0.3% ophthalmic solution instill one drop in each eye four times a day for ten days with a start date of 07/10/15 and a stop date of 07/17/15. - Doses were documented as administered beginning at 8:00PM on 07/12/15 and ending at 12:00PM on 07/17/15. - There were 15 doses documented as administered out of a possible 24 opportunities. - 2 of the missed doses were documented as due to the resident being out of the facility and the remaining 7 missed doses had no documented reason on the e-MAR. Interview with the interim Executive Director (ED) on 09/02/15 at 9:00AM revealed: - He had started working at the facility on 08/13/15. - He had no knowledge as to the reason Resident #1's medications were not administered as ordered. - In the event that a prescription could not be filled by the regular pharmacy and it needed to be filled immediately, the facility had access to a backup pharmacy in the local community. - Filling of an antibiotic medication would be a situation where they would call the backup pharmacy in order to start the medication immediately. - He was unable to say why the former ED had not done so as he was not with the facility at that time. Interview with the interim Memory Care Manager on 09/02/15 at 9:22AM revealed: - She had no information on why the full ordered courses of ciprofloxacin and tobramycin for	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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{D 358}	Continued From page 15	{D 358}		

Resident #1 were not administered since she was not employed at the facility at that time.
- Facility policy was that if the regular contracted pharmacy could not fill an antibiotic prescription immediately, the backup pharmacy should have been utilized to fill the prescription.
- Even if the resident received her medications from a pharmacy other than the contract pharmacy, the contract pharmacy would still receive a copy of the medication orders for "profile only" so that the orders would be entered into the e-MAR.
- Medication Aides did not see on their computer screens the whole e-MAR month but only the medications due at that given time.
- After the last dose of antibiotic was given, as set by the dates in the e-MAR, the medication would "drop off" the e-MAR.
- Expected facility practice would have been that the Medication Aide, upon finding that there were remaining doses of antibiotics in the medication cart but having no corresponding prompt in the e-MAR to administer the medication, should have brought the matter to the attention of the facility Memory Care Manager to be investigated and addressed.
- If it was determined that the resident did not receive their full courses of antibiotics, due to the "flag" of remaining doses in the medication cart, the pharmacy would have to be called to move the start date of the medication on the e-MAR so that it would end later and thus be completed.
- She did not think there was a corporate policy for someone in the facility to check.

Interview with the hospital provider on 09/03/15 at 12:30PM revealed:
- She was the one who ordered the ciprofloxacin and tobramycin for Resident #1 on 07/10/15.
- She would have expected the facility to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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{D 358}	Continued From page 16	{D 358}		

administer the medication as ordered.
- She would have expected the facility to have notified Resident #1's attending physician to insure the full course of the medication was administered.
- She considered this a serious error yet could not determine if it was detrimental to Resident #1 without a follow-up examination.

B. Review of Resident #6's current FL2 dated 4/7/15 revealed diagnoses including:
- Alzheimer's dementia with behavioral disturbance.
- Mood disorder, not otherwise specified.
- Hypothyroidism.
- Senile osteoporosis.
- Benign essential hypertension.
- Asthma.
- Atrial fibrillation.

Review of Resident #6's record revealed a physician's order dated 08/10/15 for ranitidine hydrochloride 150mg tablet, 1 tablet twice per day (ranitidine is used to treat gastroesophageal reflux disease).

Review of Resident #6's Electronic Medical Record (e-MAR) for the months of August and September 2015 revealed no entries for ranitidine.

Interview with a Medication Aide (MA) on 09/02/15 at 1:35PM revealed she had no knowledge about an order for ranitidine since the medication was not listed on Resident #6's e-MAR.

Interview with the interim Executive Director (ED) on 09/02/15 at 9:00AM revealed:
- He had started working at the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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{D 358}	Continued From page 17 08/13/15. - He had no knowledge as to the reason Resident #6's medications were not administered as ordered. - In the event that a prescription could not be filled by the regular pharmacy and it needed to be filled immediately, the facility had access to a backup pharmacy in the local community. Interview with Resident #6's primary care physician (PCP) on 09/03/15 at 1:20PM revealed: - The order for ranitidine was to address complaints of chest pains the PCP diagnosed as gastro-intestinal problems, for which she had a past history. - The ranitidine order was given to staff from the facility, whose name he did not know, who had accompanied Resident #6 to the appointment with the physician at his office on 08/10/15. - He expected the facility to follow his orders as written. - Not filling and dispensing the ranitidine would have resulted in discomfort to Resident #6, but the omission was not life threatening. - Earlier on the same day of the interview (09/03/15) he had received a telephone call from the facility to inquire if the order for ranitidine was still valid and if they should proceed with administering it and he instructed the facility to administer the medication as ordered. C. Review of a summary of notes provided by the county Health Department revealed: - A note dated 06/10/15 (Wednesday) that the Health Department received a complaint that multiple residents were sent to the local hospital for unrelated concerns and all were noted to have scabies. - The Health Department visited the facility and met with the former ED on 06/10/15.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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{D 358}	Continued From page 18 - The Health Department recommended the whole facility be treated for scabies and not just those residents who presented to the hospital. - The Health Department provided information from the Centers for Disease Control and Prevention (CDC) for reference, discussed environmental cleaning, monitoring resident's skin and treatment modalities for both residents and staff. - The facility was encouraged to contact the Health Department for any needs or concerns. Review of CDC information on control of scabies, obtained from their web site and with a review date of 11/02/10, revealed: - "A scabies outbreak suggests that transmission has been occurring within the institution for several weeks or months- thus increasing the likelihood that some infected staff or patients may have had time to spread scabies elsewhere in the community." - Control measures for multiple cases of non-crusted scabies included "confirmation of the diagnosis of scabies, early and complete treatment and follow-up of cases, and prophylactic treatment of staff, other patients, and household members who had prolonged skin-to-skin contact with suspected and confirmed cases." Review of a summary of notes provided by the county Health Department revealed: - A note dated 06/15/15 documenting a call from the Health Department to the former ED regarding treatment of all residents and environmental cleaning. - The Health Department documented the former ED as "awaiting the go-ahead from her boss." Review of notes provided by the county Health	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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{D 358}	Continued From page 19 Department revealed: - A note documenting the former ED sending an e-mail reply on 06/24/15 to a Health Department message that the facility was "planning a full building precautionary, beginning with obtaining prescriptions by in-house doctor on 6-25 [2015]." Review of notes provided by the county Health Department revealed: - A note dated 06/29/15 that the former ED informed the Health Department that the in-house physician had provided treatment orders for scabies for all of their residents and other physicians were notified about their residents. - The former ED was documented as stating "all would be in place no later than 06/30/15" and orders for medications were being faxed to the pharmacy. Review of 8 of 12 sampled resident's orders provided by the contract pharmacy, handwritten by the former Memory Care Manager (MCM) and dated 06/30/15, revealed: - "As a precaution we are treating all residents for scabies. Below is the order for the oral pill medication. Please sign and return ASAP [as soon as possible]. The pharmacy will calculate dose off resident's weight." - The medication ivermectin (an antiparasitic agent), "[oral] to treat scabies." - Resident's current weight, specific to each resident. - The orders were signed by the attending family nurse practitioner (FNP) on 07/01/15. - These orders were corroborated with a separate report also provided by the pharmacy. Interview on 09/02/15 at 2:10PM with the Pharmacy Technician representative from the contracted pharmacy revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 358}	Continued From page 20 - Her review of pharmacy computer records revealed numerous doses of oral ivermectin were filled for the facility on 07/01/15, which would have been delivered to the facility later that same day or early morning on 07/02/15. - The ivermectin would have been packaged and labeled individually for each resident and placed on the electronic medication administration record (E-MAR). Review of 1 of 12 sampled resident orders provided by the contract pharmacy, as documented on a pharmacy report, revealed: - On 07/06/15 an order for Ivermectin 3 milligram tablet was filled. - This resident's attending physician was different from the in-house FNP. Review of 3 of 12 sampled resident orders provided by the contract pharmacy, as documented on a pharmacy report, revealed: - On 07/07/15 orders for Ivermectin 3 milligram tablet were filled. - These residents' attending physicians were different from the in-house FNP. Interview on 09/02/15 at 3:45PM with the attending FNP revealed: - A named resident (no longer at the facility) was mentioned as possibly having scabies in February 2015. - As the spring season progressed "others" developed a rash, with two named residents mentioned. - The entire resident population was treated (no date was given), at first some specific residents with lidane or permethrin cream, then all residents with oral medication. - One named resident had recently gone to a dermatologist and was diagnosed with scabies.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 358}	Continued From page 21 - Another named resident was mentioned as the latest person with a discreet popular rash that might not be scabies as she was not "100 percent certain." - A "sister facility" had a similar outbreak and in both cases the facility response was "appropriate." Interview on 09/03/15 at 1:15PM with an attending provider for a sampled resident revealed: - His review of his electronic notes revealed this resident was seen 3 weeks prior for a rash, at first it was cleared up and then it reappeared and was spreading. - He had heard scabies "was going around the facility" and he ordered permethrin cream to be applied for 12 hours then washed off. - He would not say the scabies was a serious issue, but that the resident could be made uncomfortable by it. - Scabies was hard to diagnose but required a "very benign" treatment. - His review of a note by a palliative nurse also documented a rash suspected to be scabies. Interview with the corporate Regional Director of Operations on 09/03/15 at 2:15PM revealed: - There was no policy regarding scabies, just the CDC guidelines. - He had first become aware of scabies around June and believed it was reported by the former Executive Director at that time. - He knew diagnosis required a skin scrape and residents could be treated prophylactically for it. - He gave the former Executive Director a "handout" and would have sent it by e-mail. - The "handout" would have addressed prophylactic medications, housekeeping, and drying clothes at a high temperature.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 358}	Continued From page 22 - He would have expected the former Executive Director to follow the "handout" he provided. - At various times (no frequency provided) he followed up with the facility concerning the situation. - He was told there was no positive confirmation of scabies and the rashes could have possibly been due to a reaction with laundry detergent. - At some point the rashes may have or may not have been scabies, but at some point with a resident being treated, the facility now had to "nip it." - The former Executive Director left employment on 08/13/15 and left no documentation regarding the management of the scabies in the facility. Phone interview on 09/04/15 at 8:35AM with the Program Specialist of the county Department of Health, Environmental Health Division revealed: - The former Executive Director did initially contact the Health Department and received advice on treatment options and environmental controls. - The Health Department had received reports from the local hospital of residents who presented for care and had scabies treatment ordered there. - "Part of the problem was they [facility] did not think it [scabies] was house-wide."	{D 358}		
D 448	10A NCAC 13F .1211 Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following:	D 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 448	Continued From page 23 (1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications; (2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse; (3) accident, fire safety and emergency procedures; (4) infection control; (5) refunds; (6) missing resident; (7) identification and supervision of wandering residents; (8) management of physical aggression or assault by a resident; (9) handling of resident grievances; (10) visitation in the facility by guests; and (11) smoking and alcohol use. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a policy in place to treat and further prevent the spread of scabies. The findings are: Review of an e-mail dated 06/05/15 from the corporate Regional Director of Operations to the former Executive Director (ED) and with the contracted Corporate Consultant copied revealed: - A subject line of "FW" [Forwarded]. - An attachment listed and titled "SCABIES	D 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 448	Continued From page 24	D 448		

INFO-081811.pdf" (a copy of the attachment was not provided).
- The text "Here are the recommendations for dealing with possible cases of scabies."
- "Health Department is coming next Wednesday" [no specific date mentioned].

Review of a summary of notes provided by the county Health Department revealed:
- A note dated 06/10/15 (Wednesday) that the Health Department received a complaint that multiple residents were sent to the local hospital for unrelated concerns and all were noted to have scabies.
- The Health Department visited the facility and met with the former ED on 06/10/15.
- The Health Department recommended the whole facility be treated for scabies and not just those residents who presented to the hospital.
- The Health Department provided information from the Centers for Disease Control and Prevention (CDC) for reference, discussed environmental cleaning, monitoring resident's skin and treatment modalities for both residents and staff.
- The facility was encouraged to contact the Health Department for any needs or concerns.

Review of CDC information on control of scabies, obtained from their web site and with a review date of 11/02/10, revealed:
- "A scabies outbreak suggests that transmission has been occurring within the institution for several weeks or months- thus increasing the likelihood that some infected staff or patients may have had time to spread scabies elsewhere in the community."
- Control measures for multiple cases of non-crusted scabies included "confirmation of the diagnosis of scabies, early and complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 448	Continued From page 25	D 448		

treatment and follow-up of cases, and prophylactic treatment of staff, other patients, and household members who had prolonged skin-to-skin contact with suspected and confirmed cases."
- "In addition, an institution-side information program should be implemented to instruct all management, medical, nursing, and support staff about scabies ..."
- Long-term surveillance for scabies is imperative to eradicate scabies from an institution."

Interview on 09/03/15 at 11:45AM with the Regional Director of Operations and contracted Corporate Consultant revealed:
- They were not aware of any corporate policy that addressed scabies, nor were they certain if an infection control policy addressed it.
- They expected facility leadership to follow Centers for Disease Control and Prevention (CDC) guidelines on treatment and control of scabies.

Interview with the corporate Regional Director of Operations on 09/03/15 at 2:15PM revealed:
- There was no policy regarding scabies, just the CDC guidelines.
- He had first become aware of scabies around June and believed it was reported by the former Executive Director at that time.
- He knew diagnosis required a skin scrape and residents could be treated prophylactically for it.
- He gave the former Executive Director a "handout" and would have sent it by e-mail.
- The "handout" would have addressed prophylactic medications, housekeeping, and drying clothes at a high temperature.
- "Not to my knowledge were linens changed for all residents, just a few."
- He would have expected the former Executive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 448	Continued From page 26	D 448		

Director to follow the "handout" he provided.
- At various times he followed up with the facility concerning the situation.
- He was told there was no positive confirmation of scabies and the rashes could have possibly been due to a reaction with laundry detergent.
- At some point the rashes may have or may not have been scabies, but at some point with a resident being treated, the facility now had to "nip it."
- The former Executive Director left employment on 08/13/15 and left no documentation regarding the management of the scabies in the facility.
- He did not know if staff received communication regarding scabies.

Phone interview on 09/04/15 at 8:35AM with the Program Specialist of the county Department of Health, Environmental Health Division revealed:
- The former Executive Director did initially contact the Health Department and received advice on treatment options and environmental controls.
- The Health Department had received reports from the local hospital of residents who presented for care and had scabies treatment ordered there.
- "Part of the problem was they [facility] did not think it [scabies] was house-wide."
- The Health Department's communicable disease nurse had made periodic calls to the facility.
- The Health Department had received some inquiries from individuals in the community regarding scabies at the facility, but as it is not a reportable disease they were instructed to call the facility directly for information.
- The facility was instructed to bag linens and wash them for all residents.
- She expressed concern about chairs and sofas with cloth coverings by the front door of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 448	Continued From page 27 facility, where many residents would sit.	D 448		
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, interview and record review, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to the management of scabies. Based on observation, interview and record review, the facility failed to follow expert recommendations in a complete and timely manner for scabies [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B violation)].	D912		