STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018017	A. BUILDING: _____ B. WING _____	10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF NEWTON	1088 RADIO STATION ROAD NEWTON, NC 28658

(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 Catawba County Department of Social Services conducted an annual survey and complaint investigation on October 6-8, 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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision of 1 of 3 sampled residents (Resident #2) on a Special Care Unit, in accordance with the resident's assessed needs, care plan and current symptoms related to choking hazards and falls. The findings are: Review of Resident #2's current FL2 dated 7/15/15 revealed: -Diagnoses included Alzheimer's dementia. -Medications included Celexa 10mg daily (an anti-depressant) and morphine sulfate 20mg/ml (pain medication) take 0.25ml (5mg) at 9am and 9pm. -An "FYI" to not give anything by mouth if resident sleepy or sedated. -An "FYI" to hold all medication by mouth while resident is sleepy, sedated or unable to swallow.	D 270		

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-Current level of care was "Domiciliary and a secure unit".
-She was ambulatory, constantly disoriented, incontinent of bowel and bladder, and required personal care assistance with bathing, feeding and dressing.
-She communicated non-verbally and wandering was noted as an inappropriate behavior.

Review of the Resident Register revealed she had been admitted to the facility on 6/18/13.

1. Review of the staff notes in Resident #2's record revealed:
-On 8/17/15 at 7:30am, a Medication Aide (MA) had found a broken light bulb and stated the resident had bit it off and was chewing it. EMS was notified and resident transported to the Emergency room. There was no documentation the family or physician had been notified.
-On 8/17/15 at 11:00am, the resident returned to the facility with an order stating, "Keep all possible foreign bodies that could be ingested out of reach of the patient."
-On 9/9/15 at 2:00pm, the Resident Care Director (RCC) had been called to the secure unit. The resident was chewing up puzzle pieces and the RCC removed chewed pieces from her mouth. There was no documentation the family or physician had been notified.
-On 9/14/15 at 8:30am, the resident continued to pick things up and immediately attempt to put them in her mouth. The bottom of her shirt "was wet and appeared to have been chewed on." There was no documentation the family or physician had been notified.
-On 9/24/15 at 11:40am, the resident's family had requested she be evaluated for Hospice House but the resident was not appropriate for placement at that time.

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D 270	Continued From page 2 On 9/24/15 at 1:00pm, the resident continued to put her hands in her mouth and suck hands and fingers." Confidential interviews with 4 staff on the secure unit regarding Resident #2 and choking hazards revealed: -On 8/17/15, she had "knocked over the lamp in her room, chewed on the lampshade and eaten part of the light bulb". This had been the first time the staff had noticed her putting objects in her mouth. -On 9/9/15, the Resident Care Coordinator had been called to the unit and removed chewed puzzle pieces from Resident #2's mouth. -The resident had been found eating a paper napkin. -One of the staff heard her crunching on "something". Upon inspection, the resident had pulled out one of her teeth and was chewing on it. (Note: The staff had noticed she had "pulled out several teeth" but this was the only tooth she had been found chewing. -She had been found eating a washcloth she had been given to hold. -"One day, at snack time, she had stuffed the plastic bag containing the cookies into her mouth before one of the staff noticed she had something in her mouth and pulled it out." -They were not aware of the physician being notified for any incident other than the light bulb. -They had not received specific instructions to monitor the resident for safety related to choking hazards. Interview on 10/8/15 at 1:30pm with the Regional Director of Operations and the Executive Director revealed: -They were aware of two incidents where Resident #2 had placed foreign objects in her	D 270		

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mouth (the light bulb and puzzle pieces).
-They were not aware of other incidents.
-The RDO stated the staff on the secure unit were doing their jobs by closely monitoring the resident and stopping her from choking on things she put in her mouth.
-The RDO stated everything on the secure unit couldn't be locked up because of the other residents Resident Rights.

Interviews on 10/6/15, 10/7/15 and 10/8/15 with Resident #2's family members revealed:
-The facility had notified them of one incident where the resident had placed a foreign body in her mouth (when she had been found chewing on a light bulb).
-The family was not aware of any other incidents.
-The family had made arrangements to move the resident to another facility.

Telephone call to Resident #2's physician's office on 10/7/15 at 12:45pm was not returned by exit.

2. Review of the Resident's record revealed:
-She was totally dependent on the staff for all activities of daily living (eating, dressing, bathing, grooming and toileting).
-Documentation the resident had an unsteady gait.
-Documentation of 14 falls from 1/19/15 through 10/6/15 (1/19/15, 1/30/15, 2/4/15, 3/1/15, 3/17/15, 4/2/15, 4/9/15, 4/18/15, 4/24/15, 5/2/15, 5/17/15, 5/30/15, 8/2/15 and 9/12/15).
-Documentation indicating 5 falls had been witnessed by the staff.

Review of incident and accident reports documenting Resident #2's falls (16) between 1/19/15 and 10/6/15 revealed:
-On 1/19/15 at 9:00am: She had been found on

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the floor of the Media Room, no apparent injury.
-On 1/30/15 at 12:15am: She had been found on floor of her room, no apparent injury.
-On 2/4/15 at 12:45am: She had been found face down on the floor of her room. "Resident busted her nose (nosebleed), scraped her upper nose area and had a red mark on her right forehead". EMS evaluated the resident and but did not transport to the hospital.
-On 3/1/15 at 6:30am: She had been found on the floor in her room with a nose bleed and a skin tear to the bridge of her nose. She did not go to the Emergency Room.
-On 3/1/15 at 11:45pm: A staff member heard the resident hit the floor. She had hit her head, no bleeding was noted, and Hospice did not send her out. A bruise had been noted on the resident's right breast.
-On 3/17/15 at 9:30am: She had been found on the floor of her room with no apparent injury.
-On 4/2/15 at 6:45am: She had fallen in her room, no incident report located.
-On 4/7/10 at 6:30am: She had fallen face first onto the floor in her room. She had one mark on her nose and two on her forehead. EMS was notified but did not transport her to the Emergency Room.
-On 4/9/15 at 3:00pm: She had fallen out of her wheelchair in the dining room, was unresponsive and sent to the hospital. Returned the same day. No incident report located.
-On 4/18/15 at 7:40am: She lost her balance and fallen while ambulating in her room. No injury noted
-On 4/24/15 at 10:30pm: She had lost her footing in the kitchen area on the unit and had fallen onto her side. No injury was noted.
-On 5/2/15 at 7:00am: She had been observed, by a staff member, falling to the floor in her room and hitting her head on the dresser drawers. No

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D 270	Continued From page 5 apparent injury had been noted. EMS had been called but family member declined transport to the Emergency Room. -On 5/17/15 at 7:00am: Staff observed resident falling to the floor with no apparent injury noted. -On 5/30/15 at 10:00pm: She had been found sitting on the floor in another resident room with no apparent injury noted. -On 8/2/15 at 9:45am: Staff heard the resident yelling as she slid down her night stand onto the floor. A long bruise, painful to the touch, had been noted on her upper and lower back and the resident was noted to be holding her right leg and hip. EMS had not been notified and she had not been transported to the Emergency Room for evaluation. -On 9/12/15 at 7:15am: The residents roommate shouted for help stating the resident had fallen. She had been found on the floor by her chest of drawers. She had a 6" long scrape down the center of her back. Continued review of Resident #2's incident and accident reports for 16 falls between 1/19/15 and 9/12/15 revealed: -The primary care physician had been notified of 10 falls. -The family had been notified of 14 falls. -Hospice had been notified of 8 falls -Interventions had been noted for 0 of the falls. -Follow-up (undated) for the fall on 5/17/15 documented, "Ambulatory, no complaints of pain, no signs/symptoms of injury, Hospice aware and evaluated, no changes". -Follow-up dated 6/1/15 for the fall on 5/30/15 documented "Resident able to ambulate, gait unsteady, residents norm. Will continue to monitor". There was no documentation of what the monitoring would include.	D 270		

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D 270	Continued From page 6 Review of the facility policy and procedure regarding falls revealed: -In the event of a head injury, or suspected head injury, the resident was to be sent to the hospital for evaluation. Review of Licensed Health Professional Support (LHPS) forms revealed: -On 4/1/15 documentation "the resident uses a hospital bed with half rails and a chair alarm for precautions". -On 10/2/15 documentation "the resident had last fallen 9/12/15, staff monitor for safety and a hospital bed with half rails and chair alarm for precautions". -There were no recommendations for falls prevention interventions noted on the form. Review of Hospice notes in Resident #2's record dated 7/15/15 revealed: -The resident was being followed for chronic obstructive pulmonary disease (COPD) with dementia. -An additional diagnosis of "instability of gait". -Her activity/ mobility was diminished due to disease progression related to resident's "recent TIA's, dementia and COPD". -"(Resident #2) continues to pose safety concerns, as she has had 2 more falls since last assessment (5/12/15). Falls will continue as long as she is independently ambulatory, unsteady and confused. Facility staff do their best to observe her and keep her safe". Review of Hospice notes in Resident #2's record dated 9/15/15 revealed: -The resident was unable to verbalize. -She was 40% ambulatory-mainly in bed. -She was agitated, restless, confused, anxious and disoriented.	D 270		

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D 270	Continued From page 7 -Notation of "Falls history" and "Safety fall risk due to confusion". Observations of Resident #2 and her room on 10/6/15 at 4:05pm revealed: -The resident was sitting on the edge of the cushion in a chair across the room from her bed. -Her eyes were closed and she was sucking and chewing on her fingers as she rocked back and forth. -A hospital bed, with half rails in the raised position, was along the far wall. -The two chairs in the room did not have a chair alarm attached. -There was not a chair alarm on the resident's wheelchair. Confidential interviews with 5 Special Care Unit staff revealed: -They were each aware the resident was "a fall risk". -They were aware the resident had fallen "multiple times". -They stated they tried to watch her more frequently than the other residents but it was not always possible. -They were not aware of specific falls prevention interventions put in place for the resident. -They had not seen a chair alarm used with Resident #2. -Resident #2 required total care. Interview on 10/8/15 at 1:10pm with the Special Care Unit Coordinator revealed: -Resident #2 was ambulatory, up and down, and a chair alarm would not have been appropriate since it would constantly be "going off". -The staff on the unit were aware Resident #2 was a fall risk and they monitored her closely, "at least every hour".	D 270		

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D 270	Continued From page 8 Interview on 10/8/15 at 11:00am with the Regional Nurse regarding the facility falls protocol, put in place June 2015, revealed: -Level One, was implemented when a resident demonstrated a recent onset of a new fall pattern and involved assessment of the resident and their environment, notifying the resident's physician of the fall dates and requesting recommendations and/or orders in an effort to reduce falls. -Level Two, was implemented when the falls trend continued, despite previous measures, and included a care conference with the staff, the resident and resident's responsible party and a physician's appointment for the resident to be evaluated for medical reasons for the continuing falls. -Level Three, was implemented when the resident demonstrated a continued trend of falls despite previous measures and the physician was once again asked for additional recommendations to decrease the falls. -The Frequent Fall Care Addendum, was added when the resident's frequent fall pattern continues despite the previous measures, the resident and the responsible party state they do not wish to move to a higher level of care and accept the negotiated risk based on that decision. Review of Resident #2's record specific to the Fall Intervention and Request for Level One, Level Two, Level Three and an Addendum forms revealed these documents could not be located in the record. Interview on 10/7/15 at 11:10am with Resident #2's family member revealed: -She was aware the resident had fallen multiple times since the first of the year but had not realized there had been "so many".	D 270		

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D 270	Continued From page 9 -She stated she felt "their (management's) reaction to falls was good but prevention of falls was a different question." -She stated, "There has been too much leniency on the front line. They weren't taking care of strengthening or putting protocols in place." -She had never seen Resident #2 with a chair alarm and she would not have allowed one to be used if they had chosen to use it. Telephone call to Resident #2's physician's office on 10/7/15 at 12:45pm was not returned by exit. _____ A Plan of Protection provided by the facility on October 8, 2015 at 3:15pm revealed: -The facility will review fall risk of all residents. -The facility will implement Falls Protocol to ensure proper interventions are in place to assist in reducing of falls for all residents. -The facility will inservice all staff on Falls Protocol to ensure they are aware of which residents are at risk of falls to ensure proper interventions are being followed. -The facility will inservice staff on ensuring safety needs of residents are being met. -Facility management will ensure these inservices take place and all staff are trained in the above mentioned areas by 10/23/15. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 7, 2015.	D 270		
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,	D 338		

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Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 2 of 3 sampled residents in a secure unit were treated with respect, dignity, and a right to privacy related to the posting on social media of a picture of a resident using the toilet (Resident #2) and the placement of an alert and oriented resident (Resident #1) on a secure unit.

The findings are:

A. Review of Resident #2's current FL2 dated 7/15/15 revealed:
-Diagnoses included Alzheimers dementia.
-Current level of care was "Domiciliary and a secure unit".
-She was ambulatory, constantly disoriented, incontinent of bowel and bladder, and required personal care assistance with bathing, feeding and dressing.
-She communicated non-verbally and wandering was noted as an inappropriate behavior.

Review of the Resident Register revealed an admission date to the facility on 6/18/13.

Review of the Resident's record revealed she was totally dependent on the staff for all activities of daily living (eating, dressing, bathing, grooming and toileting).

Review of Hospice notes in Resident #2's record dated 9/15/15 revealed:
-The resident was unable to verbalize.
-She was 40% ambulatory-mainly in bed.

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D 338	Continued From page 11 -She was agitated, restless, confused, anxious and disoriented. Review of documents provided by the facility on 10/6/15 revealed: -An anonymous call had been received by the Executive Director (ED) of the facility on 9/25/15 alleging an employee had taken a picture of one of the residents on the secure unit sitting on the toilet and posted it on social media. -The ED was aware of the incident within an hour of its occurrence. -The anonymous caller sent the ED a copy of the posted picture showing an elderly resident (Resident #2) sitting on the toilet with her pants down around her ankles and 2 staff members also in the picture. -Staff G, a Personal Care Aide (PCA) was standing on the left side of the picture between the resident and the cell phone camera. She was smiling at Staff H, also a PCA, who was standing across from her and laughing. -The picture had been taken by Staff I, a Medication Aide (MA), and once posted on her social media, the incident was reported by the local television station, which showed the picture, obscuring the faces of the resident and 2 staff and not naming the resident or the staff involved. -The ED immediately suspended the three employees (they were escorted off the property) and filed the required 24-hour report with the Health Care Personnel Registry (HCPR). -Resident #2's family had been immediately notified of the incident as were the police and Social Services. -The 5 Day Investigation Report was completed on 10/2/15 by the Regional Director of Operations (RDO) and sent to the HCPR as required. -On 10/5/15, the investigator from the HCPR acknowledged receipt of the two required reports.	D 338		

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-Staff I provided a statement which stated she had taken a video of them "horsing around" and had nothing to do with the resident in the picture."
-All three employees, Staff G, Staff H and Staff I, had received a Facility Team Member Handbook (Revised 2/12), upon hire, which provided information on company policies and procedures including: always treating residents with respect and dignity and the expectation every team member would maintain high standards of performance and conduct.

Continued review of the Facility Team Member Handbook revealed:
-If the facility did not supply the team member with a cell phone, they were not to carry them while on duty.
-Cell phones were to be kept in their car, purse or locker and used only while on break.
-Violation of the cell phone policy could result in disciplinary action, up to and including, termination.
-Team members were to keep personal use of communications systems separate and not to transmit any information related to the facility via social media outlets in order to protect the residents and their interests.

Review of the Personnel records for Staff G, Staff H and Staff I revealed each had attended a facility orientation and a facilitated presentation on Resident Rights.

Interview on 10/7/15 at 11:10am with Resident #2's family member revealed:
-On Wednesday 9/29/15, the ED and the RDO had informed the family of the investigation into the posting of a picture taken by a staff member and posted on social media.
-They discussed the employees, as much as they

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CARILLON ASSISTED LIVING OF NEWTON	1088 RADIO STATION ROAD NEWTON, NC 28658

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were able, and what had been discovered about the incident through their investigation.
-She believed the facility "was as transparent as possible".
-She had been shown the picture by the ED and as a result stated, "I can't sleep. I live out of state and have been dealing with flooding and now this. It has been horrible."
-She realized Resident #2 was not aware of what had occurred but it was devastating for the family to realize how "insignificant" she was to the staff involved.
-The investigator from the police department informed her there were no criminal statutes for this type of incident and he complemented the facility on their transparency.
-That same day, 9/29/15, the family asked the television station to not show the photograph. The station had stated it was their responsibility to keep the public informed but they would continue to protect the privacy of those in the picture.
- On 10/2/15, there was a second story on the news stating the three employees had been fired.
-It was the police investigator who informed the family, not the facility, that abuse had been substantiated per facility policy for one of the staff and neglect for the other two. His information had come from the ED.
-She stated she was happy HCPR was involved.
-Staff G had been particularly fond of the resident and had always provided her with the best of care.
-The police investigator had told the family Staff G had shown "great remorse" but they were extremely saddened and disappointed Staff G had not prevented or reported the incident.
-As a result of the incident, the family had decided to move the Resident to another facility.

Confidential interviews with 3 secure unit staff

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revealed:
-They were aware a photo had been taken of Resident #2 and placed on social media.
-They could not believe someone would do that to a resident and their family.
-One stated she had seen the 3 staff members go in the bathroom that day and thought it didn't take all 3 to toilet the resident. She stated she wished she had gone in to find out what they were doing.
-They stated the incident had made them all look "bad" and the facility was the "hot topic in town".
-They felt the residents got good care but the publicity had really been hard.
-Some of the staff were embarrassed to say they worked there.
-Since the incident, they had received training on Resident Rights, abuse and the cell phone policy.

Confidential interviews on 9/6/15 through 9/8/15 with 11 residents, 6 family members and 8 staff revealed one resident had observed a caregiver texting, it had not prevented the resident from getting the help she needed and she had not decided if she was going to report it to management.

B. Review of Resident #1's current FL2 dated 6/25/15 revealed:
-Diagnoses included TIA's (transischemic attacks) and Alzheimer's dementia.
-Medications included Exelon patch 9.5mg, apply a new patch to skin every 24 hours (used to treat all stages of Alzheimer's disease), Remeron 15mg at bedtime (anti-depressant), Namenda XR 28mg daily (used to treat moderate to severe Alzheimer's dementia) and Seroquel 25mg (1/2 tablet) every day at 5:00pm (used to treat manic depression).
-The resident was ambulatory, continent of bowel and bladder and oriented with no inappropriate

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behaviors.
-The level of care indicated was domiciliary.

Review of the Resident Register revealed an admission date of 7/5/13.

Review of Resident #1's most recent Care Plan revealed:
-A completion date of 7/7/15 and signed by the RCC and the physician on 7/16/15.
-The resident resided in the Assisted Living, was alert and oriented, cooperative, participated in activities of choice, took meals in the dining room and socialized with residents and staff.
-It did not indicate the Resident received Mental Health services.
-Activities of Daily Living were listed as independent with toileting, ambulation, dressing and transfers, needing supervision with grooming/personal hygiene and eating and limited assistance with bathing.
-The resident's memory was noted as adequate.

Review of physician's orders in Resident #1's record revealed:
-The Exelon patch had been discontinued on 9/16/15 as a cost savings measure by the resident's family.
-On 9/16/15, Exelon pills twice a day had been started.
-A fax to the resident's physician on 9/17/15 informing him of the change from the Exelon patch to pills and of the resident's resulting behavior changes including not leaving her room, stating she felt "bad" (nothing in particular) and not eating.
-The physician responded, "The Exelon (pills) can cause nausea and may be the reason for those changes" and he was "faxing order to discontinue the Exelon 6mg twice a day and resume Exelon

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D 338	Continued From page 16 patches 9.5mg provide 1 patch to skin every day after removing the old patch." Review of staff documentation revealed: -A staff note from 9/19/15 at 12:45am documenting, "Resident was found outside on D Hall. She stated she was looking for the lady who stole her 25 rolls of pennies. She was re-directed back to her room and slept the rest of the night." -There was no documentation of wandering or exit seeking behavior prior to or after 9/19/15 at 12:45am. -The next staff entry, dated 9/21/15 at 10:00am, documented completion of a BCRS (Brief Cognitive Rating Scale - see below) with no score listed, the resident did not recall the incident on 9/19/15 and with recent medication change, the resident had been noted to be staying in her room and not wanting to eat. Medication (patches) put back in place and the resident was feeling better. -Staff note entry for 9/21/15 at 11:00am documented the resident's family was notified of resident's change and family "will call the MD (physician) and get the patch back." The order had been received on 9/18/15 to discontinue the pills and start the Exelon patch which was applied 9/19/15 at 8:00am. -On 9/21/15 at 12:15pm, a staff note documenting the family was called and notified of incident (9/19/15 at 12:45am) and "became upset." -On 9/28/15 at 5:00pm, a staff note documenting the family was coming in for a Care Conference regarding the resident going out the door on D Hall, not remembering the incident and for her safety would be placed on their secure unit. A verbal order to move the resident had been received from the after hours on-call physician and faxed to the attending physician by the facility.	D 338		

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-On 9/28/15 at 7:30pm, staff notes documented the family assisted with the transition to the secure unit.
-On 9/29/15 at 5:00pm, documentation in the staff notes by the Regional Nurse a BCRS (see below) had been conducted at 4:00pm (Score 3.0) and the resident was "pleasant and cooperative and struggled momentarily to concentrate at times."
-On 9/29/15 at 6:30pm, the resident was noted to be adjusting to the new unit but voiced concern about residents entering her room.

Review of Resident #1's Brief Cognitive Rating Scale (BCRS) assessments revealed:
-The scale provides an overview of the stages of cognitive function (the Global Deterioration Scale) for those with Alzheimer's Disease
-Assessments were completed on 7/7/15, 9/29/15 and 10/6/15 and documented consistent scores indicating "Mild cognitive decline or Mild Cognitive Impairment".
-An assessment was completed by the Resident Care Coordinator on 9/21/15 at 4:00pm with no documentation of the score located in the resident's record

An Incident and Accident Report had not been completed when Resident #1 was found outside on the screened porch at the end of D Hall on 9/19/15 at 12:45am.

Review of Resident #1's September 2015 electronic Medication Administration Record (eMAR) revealed the Exelon patch had been discontinued on 9/16/15 at 12:04pm and re-applied on 9/19/15 at 8:00am.

Review of Care Conference notes dated 9/21/15 revealed:
-The form had been completed by the Resident

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D 338	Continued From page 18 Care Coordinator. -Resident #1 was oriented to place, time, caregivers, current living location, how long at the facility, identified the current President and knew the correct month and year. -Comments discussed with family/resident: "Resident went out the D Hall door and doesn't recall doing so. Review of a "Heath Services to Residents Form" dated 10/2/15 for Resident #1 revealed: -The purpose of the visit had been listed as "Follow-up for diagnosis of D, AT (Dementia, Alzheimer's Type). -A note from her Psychiatrist stating, "Please move the patient to previous room. It is my opinion she is not appropriate for a locked unit", -A note from her physician stating, "I agree with (Psychiatrist)-that I feel her cognitive functions have not deteriorated to the point of needing "locked" level of care". -An order for Cipro 500mg twice a day for 5 days. Interview on 10/6/15 at 1:30pm with Resident #1 on the secure unit revealed: -She was alert and oriented. -She knew the month and year, the name of the facility, the current President, the time of day (afternoon) and what she had for lunch. -She stated she hated the room, "It smells", and she didn't like the other people "just walking in on me. I don't have any privacy." -She repeatedly stated she was being punished but didn't know why and asked to please be moved back to her other room. Interview on 10/7/15 at 12:19am with Resident #1's family member revealed: -The resident had lived at the facility since July 2013.	D 338		

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D 338	Continued From page 19 -She was quiet, mobile, alert, oriented, helpful and loved activities. -She had no behaviors. -She had been wearing an Exelon patch, discontinued on 9/17/15 and changed to pill form as a cost savings measure by the family. -The pills made the resident sick to her stomach, she vomited all food and medication and became very weak. The resident "was not herself." -The family member called the physician and asked for the pills to be changed back to a patch. -The resident improved once the patch was in place, had gone out to eat with family and to homecoming at church. -On 9/25/15, the Resident Care Coordinator called to inform her the resident had gone out to the D Hall porch on 9/19/15 at 12:45am. -She stated this was the one and only time something like this had happened. -In speaking to the staff and management, she had been told differing stories about what had occurred (The resident did/didn't exit the building, she was looking for a little boy who taken her shoes or she was looking for a women who stole her coins). -On 9/28/15, the Resident Care Coordinator called to inform her the resident was being moved to the secure unit as a result of the incident on 9/19/15 at 12:45am for "safety reasons." -The family requested a meeting with the Regional Director of Operations (RDO). -At the meeting on 9/28/15, attended by the resident's family, the RDO, the Executive Director and the RCC, the RDO told them the Regional Nurse had seen the staff note documenting the resident going out the D Hall door and the facility policy stated if a resident walked out of the building they were placed on the secure unit, held back there for safety, and BCRS assessments were done over about a two week period of time,	D 338		

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to determine if the resident could return safely to the Assisted Living.
-The family had been told, "Besides the secure unit the only other option was a 24/7 sitter which we could not afford."
-The RDO told her, "They had used the resident for an excellent learning experience for the staff of what they did wrong." and apologized the incident had not been handled correctly.
-The Resident and family arrived on the secure unit after dinner on 9/28/15 and the room was not ready.
-There were no sheets on the bed, the carpet was dirty, the room smelled strongly of urine and the air conditioner didn't work most of which was corrected in the days that followed. The urine odor continued.
-The resident kept saying, "No. No. I have to stay here? What did I do?"
-"In her mental state, the move was inhumane. It was mental torture for her and we pleaded for her to be taken out of there".
-On 10/2/15, the family took the resident to see her psychiatrist, who had cared for her for 2 years, and were told the resident did not need to be in a secure unit.
-On 10/2/15, the family then took the resident to see her physician, who had cared for her over 15 years, and were told the resident was not appropriate for a locked unit.
-The resident had a urinalysis done at the physician's office and he ordered antibiotic for a probable urinary tract infection.
-The family was told by the facility, the resident would be moved out of the secure unit if it was determined she would be safe in the Assisted Living.
-The resident returned to the Assisted Living the evening of 10/6/15 after the family met with facility staff.

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D 338	Continued From page 21 -Before the Resident was moved back to the Assisted Living on 10/6/15, she had to sign a paper stating she was aware the Resident would be moved "immediately and permanently" to the secure unit should another incident occur. Interview on 10/7/15 at 3:20pm with the RDO revealed: -Residents with dementia were always on the "Watch List" and were routinely monitored for changes in their cognition. -The Regional Nurse was the only one who performed the BCRS assessments which were done sporadically and at different times of the day. -The length of time a resident spent in the secure unit dependeded on when/if theBCRS assessment returned to baseline, input from their physician after an office evaluation had been completed and speaking with the Resident and/or Responsible Party -He stated there had been a delay on the facility's part to follow their policy and procedure regarding wandering stating, "I think when the Resident Care Coordinator (RCC) read the staff notes in Resident #1's record, she blamed the incident on medication changes." -The RCC had not received training on the policy/procedure for Emergency Placement: Dementia and Wandering -"When the Regional Nurse saw the note, she spoke with Corporate and the decision was made to move the resident to the secure unit". -The decision was based on the resident's not remembering the event, she had been looking for someone who was not there, in the past she had been observed walking through the building (Assisted Living section) asking, "Where do I go? What do I do next?" -The order to move the resident into the secure	D 338		

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unit was received from an after hours on call physician who did not know the resident.
-The Resident's room on the secure unit smelled strongly of urine and the the family felt the air conditioning unit wasn't cooling properly.
-The unit was adjusted and then replaced and the carpet cleaned. The urine odor is still present and the carpet will need to be replaced.
-The resident's physician and psychiatrist were not contacted by the facility prior to her being moved or during her stay on the secure unit.
-He was aware the Resident's assessment scores had been the same prior to, during, and after the incident on 9/19/15 at 12:45am.
-He was aware it was the family, not the facility, who had made appointments for the Resident to be evaluated by her Psychiatrist and physician for her appropriateness for the secure unit.
-He stated the Resident had not been moved out of the secure until all criteria pertaining to their policy and procedure related to dementia and wandering had been reviewed and met.
-She had been moved out of the secure unit last evening (10/6/15).

Review of the facility's Resident Agreement, Section VII. Emergency Placement: Dementia and Wandering, dated 1/13 revealed:
-An emergency, temporary placement in the secure unit can be made if in the facility's judgement a resident is or will become a danger or safety risk to self or others.
-The placement is not permanent until, and if, the resident is re-assessed by a physician as appropriate for secure care, the facility re-assesses the resident and determines it is able to meet the resident's needs and an addendum to the Resident Agreement is signed by the Resident and/or the Responsible Party in which they agree to the new rate for both the room and

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D 338	Continued From page 23 any additional level of care required. -Should any of the above conditions not be met, the Resident and the Responsible Party will accept immediate discharge from the facility or until suitable to provide secure care appropriate for the Resident's safety and condition. Telephone call to Resident #1's physician's office on 10/7/15 at 11:10am was not returned by exit.	D 338		
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 observations, interviews and record reviews, the facility failed to provide care and services which are adequate, appropriate and in compliance with relevent federal and state laws and rules and regulations. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision of 1 of 3 sampled residents (Resident #2) on a Special Care Unit, in accordance with the resident's assessed needs, care plan and current symptoms related to falls and choking hazards. [Refer to Tag 270, 10A NCAC 13F .0901(b) (Type A2 Violation)].	D912		