STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	01/27/2016

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WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

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D 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services conducted an annual survey and complaint investigation on January 20, 21, 26, and 27, 2016. The complaint investigation was initiated by the Martin County Department of Social Services on December 21, 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 increased supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 5 sampled residents (#1, #3), one with multiple falls, including falls with injuries requiring Emergency Medical Services (#3), and one eloping from the facility by going out a window, and using a bar to break the glass out of an exit door (#1). The findings are: 1.Review of Resident #3's current FL2 dated 04/14/15 revealed diagnoses of cerebral vascular accident, degenerative disc disorder, and venous insufficiency.	D 270	Responses to the cited Deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared soley as a matter of compliance with State Law.	

See attached Signature page

(see p. 2)

Reviewed & Accepted Edwards 3/7/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathy Capenart TITLE Administrator (X6) DATE 3/2/2016

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D 270	Continued From page 1 Resident register for Resident #3 dated 04/14/15 revealed the resident was admitted on 08/06/09. Observation of Resident #3 on 01/20/16 at 11:17 AM revealed: -The resident was sitting in a power chair in his room. -The resident's power chair was lifted very high and tilted back. -The resident's neck was contracted (an area that is drawn together or condensed) and he had a hard time moving his head around. -The resident has a sign in his room on the wall that says call before you fall. Interview with Resident #3 on 01/20/16 at 11:17 AM revealed: -He has had several falls since he had been living here. -There have been at least 8 falls maybe more, but he was not sure of how many falls all together. -The last fall that he remembered was a couple of weeks ago. -He slipped down on the floor trying to make his coffee. Review of the facility's policy and procedure for falls revealed: -The policy was dated effective on 08/01/15. -A fall risk assessment tool is completed for all residents admitted to determine factors that may contribute to falls. -All staff will receive formal training on fall prevention awareness once a year, and will be reminded of fall prevention techniques during staff meetings. -The staff are responsible for completing an incident report for any fall, and will contact family/responsible party as well as contact	D 270	Fall Risk Assessments completed by an Registered Nurse on 1/24 & 1/25/16. Residents determined to be a fall risk are identified by a "Falling Leaf". A universal sign within the facility. The falling leaf is located on each identified residents name plate. "Who am I" form completed 1/25/16 & posted inside each closet/ward robe as a reference for care staff. Registered Nurse reviewed fall interventions with Care Manager & Administrator to determine effectiveness and adjusted interventions according to resident need & physician recommendations. Completed 2/1/16. Fall Management Program training provided by Registered Nurse on 1/24/16 & reviewed on 2/16/16 with all staff to include but not limited to; -Risk Assessments -Incident Reporting -72 Hour Follow up -Interventions -Fall Team Meetings -Physician notification & Recommendation -Physical Therapy, as ordered -Documentation Falls, Transfer & Hoyer lift refresher conducted by Physical Therapist & Registered Nurse. Training conducted on 2/4 & 2/5/16. Administrator will facilitate compliance in Personal Care & Supervsion. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor compliance in Personal Care & Supervision.	Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 2/26/16

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D 270	Continued From page 2 physicians via phone or fax. -The Executive Director is responsible for reviewing all falls, and determining any immediate interventions that are required based on circumstances. -The staff are required to do a 72 hour follow up on residents that fall to investigate possible circumstances that contribute to the falls, and document observations for that 72 hour period. -The staff will document each shift vital signs, possible risk factors for falls, and if there are any environmental hazards that may result in future falls for 72 hours following the fall. -If the resident has 2 or more falls in a 4 week time period the staff are to contact the primary doctor and request orders for a physical therapy evaluation or other treatments and interventions. -The falls management team will review incident reports on a monthly basis, and asses for any trends for residents having frequent falls. Review of Resident #3's care notes revealed: -The resident had a fall on 11/01/15. -The resident was trying to use the urinal and lost his balance. Review of the incident report dated 11/01/15 revealed the resident was found on the floor of his room. Review of the 72 hour monitoring sheets dated 11/01/15 revealed the resident had been assessed each shift and vital signs were taken. Review of Resident #3 record revealed there was no other documentation related to this fall. Review of Resident #3 Care notes revealed the resident had a second fall on 11/27/15.	D 270	Supervision increased for resident identified as # 3, 30 minutes checks from 1/21/16 until 2/10/16. Compliance monitored by Care Manager & Adminstrator. Physician assessed resident # 3 and recommended a higher level of care. Safe & orderely discharge conducted 2/9/16 to a skilled facility. Supervision checklist developed & implemented to verify & account for the presence of all residents. Training conducted by Registered Nurse. Resident # 3 was evaluated on 1/25/16 and received physical therapy services until 2/9/16 as ordered. Administrator will facilitate compliance in Personal Care & Supervsion. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor compliance in Personal Care & Supervision.	Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 2/26/16

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D 270	Continued From page 3 Review of the incident report dated 11/27/15 revealed: -The resident was found on the floor. -The resident was trying to get around the table in his room. Review of the 72 hour monitoring sheets dated 11/27/15 revealed the resident had been assessed each shift and vital signs were taken. Review of Resident #3 record revealed there was no other documentation related to this fall. Review of Resident #3 care notes revealed: -The resident had a third fall on 12/04/15. -The fall happened around 9:50 PM while the resident was getting ready for bed. Review of the incident report dated 12/04/15 revealed: -The resident was found on the floor next to his coffee maker in his room. -Documentation showed there were no injuries. Review of the 72 hour monitoring sheets dated 12/04/15 for Resident #3 revealed: -The resident had been assessed for each shift and vitals were taken. -There were signs of bruising around the injured areas on all shifts. -The resident had soreness around the injured areas on all shifts. -The resident received Tylenol 3 times per day for complaints of pain. Review of Resident #3's care notes revealed: -On 12/06/15 the resident complained of pain and has bruises noted on his back. -On 12/07/15 the resident complained of pain in	D 270		

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D 270	Continued From page 4 his right shoulder and arm, and has a bruise on his back. -On 12/08/15 the staff encouraged the resident to use his call bell when he wants to get up, and a sign was placed in his room to remind him to use his call bell when he needs assistance. -On 12/08/15 the resident was sent out to the emergency room and was sent back with diagnosis of fractures and received a prescription for Percocet (a narcotic used to treat moderated to severe pain.). -On 12/08/15 on second shift the resident was in severe pain and was given as needed Tylenol to assist with pain. Review of hospital discharge paperwork for Resident #3 dated 12/09/15 revealed: -The resident was seen in the emergency room for three closed rib fractures, humeral head fracture, and non-displaced fracture of lateral end of right clavicle related to fall. -The resident was sent home with a prescription for Percocet (a narcotic used to treat moderated to severe pain.). Review of Resident #3 record revealed there was no other documentation related to this fall. Review of Resident #3 care notes dated 12/29/15 revealed: -The resident was found lying on the floor beside his chair. -The resident said he was trying to sit in his chair but missed it. Review of incident report for Resident #3 dated 12/29/15 revealed: -The resident was found lying on his back beside his power chair. -The resident said he was trying to sit in his chair	D 270		

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D 270	Continued From page 5 and missed the chair. Review of the 72 hour monitoring sheets dated 12/29/15 revealed the resident had been assessed each shift and vital signs were taken. Review of Resident #3's record revealed there was no other documentation related to this fall. Review of Resident #3's care notes dated on 01/03/16 revealed: -The resident was found on his bathroom floor laying on his back yelling help. -The resident said he slipped and fell while trying to make his coffee. Review of incident report dated 01/03/16 revealed: -The resident was found lying on his back underneath his bathroom sink. -The resident stated he slipped and fell trying to make his coffee. Review of the 72 hour monitoring sheets dated 01/03/16 revealed the resident had been assessed each shift and vital signs were taken. Review of hospital discharge paperwork dated 01/03/16 revealed: -The resident was seen for a sacral contusion and a lumbosacral sprain. -No new medication were prescribed at this time. -Resident to return to the emergency room in on week if symptoms return. Review of Resident #3's record revealed there was no other documentation related to this fall. Review of Resident #3's care notes dated 01/21/16 revealed:	D 270		

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D 270	Continued From page 6 -The resident had a fall and refused to go to the emergency room. -The resident said he did not hit his head and was not in any pain. -The responsible party was called and he convinced the resident to go out to the emergency room for evaluation. Review of hospital discharge paperwork revealed: -The resident was seen on 01/21/16 for a fall. -No new medication were prescribed at this time. -The resident is to follow up with primary medical doctor in 5-6 days if symptoms worsen. Interview with Resident #3 on 01/21/16 at 10:27 AM revealed: -He can control his power chair on his own. -He has tried using the call bell but the staff do not respond to assist him so he has to do things on his own. -He has had several falls over the last few months but not sure how many. -He has told the Executive Director (ED) that the staff are not coming to help him. -He said all the ED did was put a sign in his room that says call before you fall. -The staff only come down to his room to assist with feeding and changing him; he is not aware of them checking on or monitoring him. -The resident was not sure how many times a day the staff were coming to check on him. Telephone interview with Resident #3 responsible party on 01/21/16 at 10:36 AM revealed: -The staff called him and reported all the falls that happened to the resident. -Resident #3 refuses to go to the emergency room a lot. -The staff put a sign in his room to encourage him to call for assistance.	D 270		

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D 270	Continued From page 7 -He was not aware of any other things that had been done to assist with fall prevention. -The resident was receiving physical therapy a little over a year ago. -The staff have not mentioned anything about any further physical therapy being ordered. Interview with a Personal Care Aide (PCA) on 01/21/16 at 1:28 PM revealed: -She does checks on the all the residents every hour. -She is not aware of any of the residents who have a lot of falls. -The bed bound residents get checked on every 30 minutes. -There is no documentation done when they check on the residents. Interview with a Medication Aide (MA) on 01/21/16 at 1:35 PM revealed: -Checks on all the residents every 2 hours. -Resident #3 has frequent falls. -Resident #3 does not use his call bell to call out for help. -There were no orders to do special checks on Resident #3 at this time. -No documentation done that the residents are checked on every 2 hours. Interview with a second Medication Aide (MA) on 01/21/16 at 1:40 PM revealed: -All the residents are checked on every 2 hours. -No documentation is done that the residents are being checked on every 2 hours. -If the resident has frequent falls they do checks on that resident every 30 minutes to an hour. -There is documentation that residents with frequent falls are being checked on more frequently. -Resident #3 has had several falls; she thinks	D 270		

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D 270	Continued From page 8 about 5-6 over the last 6 months. -There was a sign placed in Resident #3 room for him to use his call bell when he needs assistance. -They had the family come in and talk to him about using his call bell for assistance. -She does check on Resident #3, but there is no order or protocol to check on this resident. Interview with a second Personal Care Aide (PCA) on 01/21/16 at 2:06 PM revealed: -The residents get checked on every 2 hours. -None of the residents have orders to be checked on every 30 minute. -She checks on some residents more frequently, because she likes to keep a check on them. -There is no policy to do special checks on residents that have falls. -She does not work on the hall with Resident #3 that is the Medication Aides hallway. Interview with a third Personal Care Aide (PCA) on 01/26/16 at 12:11 AM revealed: -She notified the Medication Aide when a fall happened. -She would take the vital signs of the resident that had fallen. -She documents the incident in the care notes as to what happened, when it happened, and where it happened. -She would call the medical doctor and make them aware the resident had fallen. -The Resident Care Manager RCM would be notified. -Check the resident for any injuries or bruises. -She said that Resident #3 has had several falls, but not sure of how many. -She remembered Resident #3 falling a couple of weeks ago but not sure of the exact date. -Resident #3 is on a fall watch, she said this is	D 270		

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D 270	Continued From page 9 where he gets checked on every 30 minutes to assess the resident and their needs. -The staff are to document what the resident is doing and where he is located in the building on these 30 minute checks. -Resident #3 has been on fall watch since 01/25/16. -There is a falls policy at the nursing station. -It is the Medications Aide's responsibility to make sure the falls policy is being followed. Interview with a third Medication Aide (MA) on 01/26/16 at 2:37 PM revealed: -She would assess the residents for injury or bruising if they fall. -She would check there vital signs. -All residents that have head injuries get sent to the emergency room for evaluation. -She would call the responsible party and the medical doctor after a fall. -All residents that have falls get 72 hour checks. -The 72 hour checks allows the resident to be assessed and vitals taken each shift for 72 hours. -Resident #3 has had multiple falls but she was not sure how many. -Resident #3 is on 30 minute checks that were started on 01/22/16. -All of the staff are responsible for doing Resident #3 30 minute checks. -There is no set policy for care of the resident post fall. -The staff just follow what the medical doctor orders when they report the fall to them. Interview with a fourth Medication Aide (MA) on 01/26/16 at 2:53 PM revealed: -She would assess the residents for injuries or bleeding. -All falls that result in a head injury are sent to the emergency room for evaluation.	D 270		

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D 270	Continued From page 10 -She would check the vital signs of the resident that had fell. -The responsible party and medical doctor would be notified of the fall. -The resident that fell would be placed on a 72 hour watch. -The 72 hour watch is where they assess the resident for any injury and pain, as well as taking vital signs each shift for 72 hours. -She is not aware of any written policy that is place for falls precautions. -She said Resident #3 falls frequently, and she remembers about 10 falls over the last 6 months. -She remembered one fall where he has some fractured ribs and some bruising on his right side. -Resident #3 is on 30 minute checks that were started on 01/22/16. -The 30 minutes checks the staff check on him every 30 minutes and document what he is doing and where he is located in the building. -All staff members are responsible for doing 30 minute checks on Resident #3. -She was not aware of any other protocols that have been put into place other than the 30 minute checks with all the falls that Resident #3 had. Telephone interview with a Physicians Assistance (PA) on 01/26/16 at 3:53 PM revealed: -She was the PA that worked with Resident #3 and his primary medical doctor. -She just started seeing Resident #3 in November of 2015. -She had been made aware by the facility of all the falls that Resident #3 had. -The staff have encouraged numerous times for Resident #3 to use his call bell for help. -She put an order in on 01/22/16 for safe strides (this is a physical therapy program) evaluation. -None of the staff have called and recommended any physical therapy until 01/22/16.	D 270		

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D 270	Continued From page 11 -She remembered he had one fall that caused some rib fractures, a clavicle fracture, and some contusions. -She does not feel that the falls are medication related. -She feel the resident does not want to call out and ask for help but is not able take care of himself independently. Interview with the Resident Care Manager (RCM) on 01/27/16 at 10:38 AM revealed: -The facility does have a policy and procedure to follow when a resident has a fall. -When a resident falls the staff let her know and she contacts the medical doctor. -After a fall if there were no injuries the resident will receive monitoring for 72 hours. -If the resident has any injuries or hits their head with a fall they are sent to the emergency room for evaluation. -All resident falls get a 72 hour monitoring after the fall happens. -On the 72 hour checks the staff assess the resident for any injuries or pain and takes vitals, this is done on each shift for 72 hours. -The Medication Aides are responsible for filling out the incident reports. -She was not aware of the section on the falls policy to get a physical therapy evaluation after 2 or more falls in a 4 week time period. -Resident #3 does have frequent falls, but she is not sure how many he had. -The staff have encouraged him to use his call bell to call for assistance. -There was a sign placed in his room to remind him to call before he falls. -Resident #3 was getting checked on every 2 hours. -Since 01/21/16 he has been getting 30 minute checks.	D 270		

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D 270	Continued From page 12 -Resident #3 is also getting an evaluation for safe strides (this is a physical therapy program) evaluation. -The order for the safe strides evaluation was obtained on 01/22/16. -There are also staff meetings where they meet and talk about residents who have multiple falls and try to come up with ideas to help prevent future falls. Interview with the Executive Director (ED) on 01/27/16 at 11:19 AM revealed: -There is a falls protocol policy for residents that have falls. -The Personal Care Aides are to report any falls to the Medication Aides. -The Resident Care Manager or the Medication Aide supervisor on that shift is to assess the resident that fell and check vital signs. -The staff is then responsible for reporting the falls to the medical doctor. -If the medical doctor says to send the resident out then the staff sends the resident to the emergency room for an evaluation. -If the resident has a head injury from the fall they will be sent to the emergency room for an evaluation. -All residents that fall are put on a fall precautions list. -If the resident has more than 1 fall they are then put on a 2 hour toileting/monitoring list. -The 2 hour toileting/monitoring is for the staff to check on the resident and see if he needs to use the bathroom or needs any assistance with anything. -Contacts the doctor to do any evaluation of meds and lab work to see if there is a medical reason causing the falls. -Request orders from the medical doctor for a chair alarm or bed alarm.	D 270		

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D 270	Continued From page 13 -There is a monthly team meeting to discuss intervention to assist with residents who have had frequent falls. -Resident #3 has been told to use his call bell for assistance and a sign was placed in his room to remind him to call before he falls. -She knows Resident #3 has had multiple falls. -She believes he had 4 or 5 falls since October of 2015. -There were signs put up in Resident #3 room that said call before you fall. -Resident #3 has been placed on 30 minute checks since 01/21/16. -It is all the staff's responsibility to do 30 minute checks on Resident #3 2. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 9/18/15. Review of Resident #1's current FL-2 dated 9/18/15 revealed: - Diagnoses included Schizophrenia, paranoid, chronic, and hypertension. - There was no documetation in the categories of orientation and behaviors. Record review for Resident #1 revealed a Physician's order for Ativan 0.5 mg every 8 hours as needed. Review of Resident #1's Care Plan dated 10/15/15 revealed: - The resident had a history of mental illness. - For the question "was the resident receiving medication for mental illness/behavior", the answer was "no". - The resident was ambulatory and had adequate memory and vision. - The resident was "sometimes disoriented".	D 270	Supervision increased on resident identified as # 1 to 30 minutes checks from 1/21/16 to 1/25/16. Resident # 1 had previously initiated a notice of discharge and relocated to a facility of her choice on 1/25/16. Safe & orderly discharged conducted per resident . choice on 1/25/16. Training provided on managing difficult behaviors, documentation, notification of mental health provider and Resident Rights conducted by Trillium Health Services on 2/12 & 2/16/16. Documentation training provided by Registered Nurse on 1/24/16.	1/25/16 Target Date 2/26/16 Target Date 2/26/16

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D 270	Continued From page 14 - The resident had Licensed Health Professional Support (LHPS). Review of the LHPS Quarterly Review for Resident #1 dated 12/29/15 revealed: - The resident was up most nights, was anxious and paranoid, refused physicial assessment. - No LHPS tasks as this time. - Recommendations (for facility) to meet the resident's needs were to speak with the resident's primary care physician (PCP) about parancia and abnormal sleep habits. Review of the facility Accident/Injury Report for Resident #1 dated 12/21/15 revealed: - On 12/21/15 at 9:00 am, the "resident was not in her room or building". - The "resident returned to the facility unharmed (no time or date documented)". Review of the facility Accident/Injury Report for Resident #1 dated 1/02/16 at 10:00 am revealed: - "Resident (#1) accidently bumped into another resident who then turned around and hit resident (#1) in the back. Resident's (#1) reaction was to turn around, hit the other resident twice in the arm." - Resident (#1) said she was walking away when the other resident struck her in the back, so she hit her back." - "The resident (#1) wanted to go to ER for evalution." - Resident #1 was transported to a local hospital by EMS at 10:30 am. - "Resident was returned to the facility from ER without being seen for an evaluation." (No documentation as to why resident was not evaluated). Review of the facility Accident/Injury Report for	D 270	Administrator will facilitate compliance in Personal Care & Supervsion. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor compliance in Personal Care & Supervision.	2/26/16

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D 270	Continued From page 15 Resident #1 dated 1/15/16 at 3:00 pm revealed: - "Resident broke the glass out of the side door." - The resident refused to have vital signs (blood pressure, pulse, respirations) taken. - The resident was transported to a local hospital by police at 4:00 pm. Confidential interview with a resident revealed: - Resident #1 had broken a glass window at the facility last week. - The resident stated the resident was afraid of Resident #1 and concerned since Resident #1 had broken the glass window. - Resident #1 had not harmed or threatened the resident but the resident was concerned about Resident #1's behavior. Confidential interview with a second resident revealed: - Resident #1 came in the resident's room and cursed at the resident and slept on the resident's floor (could not give time frame). - The resident cursed back at Resident #1. - Resident #1 broke a glass door last week. - The resident was "scared of" Resident #1. Review of Care Notes/ChartingNotes (electronic notes) for Resident #1 from 9/18/15 to 1/25/16 revealed: - On 9/23 15 the resident called 911 herself and stated she "wanted to go to the ER, she felt she was a danger to herself; she did not know to tell anyone, she wanted to go." - On 11/02 15 (the resident) was smoking cigarettes in her room; she said "she did it on purpose." - On 11/03/15 (the resident) had been a little agitated and antsy tonight; she was in the TV room earlier with a pillow cushion from the seat sleeping in the corner.	D 270	Administrator attended Resident Council meeting on 2/17/16 to communicate avenues for residents to voice concerns. Administrator reviewed the resident sign in/out policy at the Resident Council Meeting conducted on 2/17/16.	Target Date 2/26/16 Target Date 2/26/16

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D 270	Continued From page 16 - On 11/25/15 the resident called 911 to take her to a hospital; she "felt like she needed to be committed in a mental facility", she returned from the hospital, had no new orders, will continue to monitor. - On 11/27/15 the resident called the police again, she "was under the impression someone was planting drugs in her room, she had not seen any, but wanted the officers to do a search of her room." - On 12/21/15 "resident was missing at 8:45 am, the medication aide (MA) went to give am meds, resident was not in room, checked facility and all outside of facility was done, called 911 to report missing resident, another search was done by the police officers, resident was spotted by officer by (a pizza restaurant) in town, was picked up and brought back to the facility; staff needs to continue to monitor resident, keep check of room as well. - On 12/21/15 (electronic charting note at 4:19 pm) staff alerted the Executive Director (ED)Resident #1 had not been seen that morning and staff started looking, but could not find her; the ED checked the sign out book and the resident had signed herself out on 12/20/15, but did not put a time or date; the police found the resident, Resident #1 stated "I have the right to sign myself out and that's what I did." - On 1/02/16 resident got into an altercation with another resident when the other resident accidently bumped into her, as she was walking away, the other resident struck her in the back, the resident reacted by striking the other resident in the arm; (Resident #1) was sent to a local hospital, but returned before being seen. (no reason was documented). - On 1/15/16 (electronic charting note at 5:34pm) at 3:00 pm the resident took a metal bar and broke the glass out of the 300 hall door from the	D 270		

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D 270	Continued From page 17 outside, police and the resident's mental health physician were called; involuntary committment (IVC) papers were filed, and the resident was removed from the facility at 4:00 pm; the resident was taken to the hospital. - On 1/19/16 "the resident returned to the facility; she had been given Ativan and her medications were adjusted." - On 1/22/16 the resident "was doing ok tonight, we are monitoring her every hour." - On 1/25/16 "(Resident #1) has been discharged to the facility of her choice to go to." Interview on 1/27/16 at 12:40 pm with a 1st shift medication aide (MA) revealed: - On 12/21/15 at 7:00 am the MA and the 3rd shift (12/20/15) MA reported to each other and checked the medication cart. - No residents were reported as being out of the facility. - The 1st shift MA was not told Resident #1 was missing and thought the resident was in the facility. -When the MA knocked on Resident #1's room door, the resident did not answer; the MA called to the resident, when no one answered, the MA used keys to enter the locked room, saw no one, checked the bathroom, no one was there and the room did not look any diffrerently than usual. - The MA checked at Resident #1's "hang out spots", hallways, back porch, TV room, back hall, and porches. - The MA checked with other staff to see if anyone had seen the resident and all staff started looking for Resident #1. - The ED was called and the sign-out log was checked. - The resident had signed the log,dated it 12/20/15, but did not put time or destination. - The 3rd shift staff was called to determine the	D 270		

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D 270	Continued From page 18 last time she was seen, if she was present at the beginning of 3rd shift (11:00 pm) or if someone had let her out of the building. - No one on 3rd shift could recall the last time Resident #1 had been seen. - A 2nd Shift staff from 12/20/15 was called and reported the resident was last seen by her at the end of 2nd shift at 11:00 pm and the resident was watching the TV in her room from a chair placed in the middle of the hall outside of the room. - The MA gave the police a description of the resident, heard on the police radio around 9:00 am, that the resident had been found at a local pizza restaurant. - The resident was returned to the facility by the ED. - The resident laughed about leaving and would not tell staff when or how she left the facility. - The MA was later told by another staff that Resident #1 had exited the building through the window in her room. - Resident #1 was not on strict monitoring; she was supposed to be checked on every 2 hours. - The MA did not know when Resident #1 left the facility. - There was no log to make documentations of times when staff did "walk-throughs" of observing and supervising residents, only verbal reports were given between staff at shift change. - The pizza restaurant was about 1-1/2 miles away (in town highway) and the resident liked to walk. - Resident #1 said "who realized I was gone?" when she was returned to the facility. Interview on1/27/16 at 3:32 pm with the 3rd Shift MA revealed: - The MA was working 3rd shift (11pm to 7am) on 12/20/15. - Between 11:00 pm and 11:30 pm staff was	D 270		

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D 270	Continued From page 19 checking on residents and saw Resident #1 seated in the living room. - The last time staff saw the resident was at 1:15am (12/21/15) sitting outside the nurse's station at the window. - At that time, the resident was calm and did not say anything about leaving. - Routinely, Resident #1 slept in places all over the building, pulling the mattress off of her bed and placing it on the floor. - If staff said anything to the resident, she would become agitated; staff let her sleep where ever she wanted to. - The resident could have been anywhere at any time. - The personal care aides (PCA) made rounds every 2 hours for residents who needed toileting; the MA expected the aides to check on everyone at that time. - On 12/21/15 the MA was called at home at 9:30 am by the ED and was notified Resident #1 was missing and the MA returned to the facility. - The ED told the MA Resident #1 signed out at 11:45 pm on 12/20/15. - There were "no special instructions for supervision for Resident #1, she did what she wanted to". - The MA did not see the sign-out sheet, "there was no reason to check it". - The MA no longer worked at the facility. Review of the facility's reisdent sign-out sheets documentation for Resident #1 revealed; - On 10/12/15 at 10:20 am, the resident signed out to go to the "store" with "self"; no time returned documented. - On 11/09/15 at 6:08 (no am or pm) the resident signed out documenting "mother"; no time returned documented. - On 12/19/15 the resident signed out; no time,	D 270		

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D 270	Continued From page 20 with whom, destination, or return time documented. - On 12/20/15 the resident signed out; no time, with whom, destination, or return time documented. Interview on 1/21/16 at 12:45 pm with a 3rd Shift PCA revealed: - The PCA worked 3rd shift (11pm to 7am) on 12/20/15. - The PCA's started making rounds about 12:30 am and saw Resident #1 in the TV room at that time. - The resident did not like anyone to bother her when she was sleeping. - After the PCA left work the next morning, the facility called saying Resident #1 was missing. Attempted interview on 1/21/16 with the second 3rd Shift PCA working 12/20/15 was unsuccessful. Observation on 1/27/16 of the window in the room occupied by Resident #1 on 12/20/15 revealed: - The window was closed and equipped with a blocking device to the base track to prevent window from sliding completely open and window has to slide vertically to the left to be opened. - It was observed that the locking mechanism to this window was partially broken. - With the assistance of housekeeping staff, this window was opened and it was observed that the right side of the window could be jiggled and removed from the sliding tract due to the broken locking mechanisms. Observation on 1/27/16 at 11:20 am of the window in Resident #1's room with a corporate staff revealed: - The Corporate staff was located in and used the	D 270	Maintenance service contacted to ensure window locks are operating properly. Any window locks or blocking device found broken or missing will be repaired by ordering parts and restored to full operating status.	Target Date 2/26/16

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D 270	Continued From page 21 room that Resident #1 had eloped from as office space. - It was observed that there was no locking mechanism to the window in this room and the blocking mechanism was in the sliding tract of this window. - The Corporate staff slid open the right side of the window and it was noted that the window jiggled out of the sliding tract and was able to be removed from the tract by the corporate staff. Interview with the Corporate staff on 01/27/16 at 11:25a.m. revealed: - It took a lot of strength to take the window out of its tract. - Resident #1 had the right to leave the building if resident wanted to and that it did not matter that Resident #1 left out through the window. Interview on 12/21/15 at 10:45 am with Resident #1 revealed: - The resident stated "I proved my point, staff did not keep an eye on me like they should, I know I was wrong, but I did it anyway." - The resident stated she did not like it at the facility because she was being mistreated by other residents. - "I am different from other residents from the facility, I do not get along with other women, I cannot relate to them and sometimes they look at me funny." - She stated she was at a local restaurant and was hoping to get a ride to see her family. - She did sign out even though she did not put a time and "I have the right to do that". - " I am ready to find another place to go, but I am going to do it right, I will not leave the facility like I did any more." - The resident would not state how long she was away from the facility.	D 270	Correction: The corporate staff was misquoted. The corporate staff in question made the following statement; "The resident used an improper exit and it wouldn't matter to this resident cause she stated she had a right to leave the building". We respectfully request to be noted in for the file.	

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D 270	Continued From page 22 Interview on 1/21/16 at 11:29am with a 1st Shift MA revealed: - On 12/21/15 the night shift did not do what was supposed to be done; checking on all residents was supposed to be every 2 hours. - Since the incident, staff monitored Resident #1 every hour. - "Before1/20/16, there was no documentation verifying the monitoring done on each resident, but it is now." - "If there was a system in place, I believe Resident #1 would not have eloped." Interview on 1/21/16 at 10:40 am with Resident #1's primary care physician's (PCP) office assistant revealed: - The resident had been seen in the office on 10/26/15 for the first time to establish care. - The resident told the office staff she did not like doctors and would not be coming back. - There was no documentation in the resident's records about the resident eloping from the facility. - There were no subsequent appointments with Resident #1. Interview on 1/27/15 at 9:30 am with Resident #1's PCP revealed: - Resident #1's appointment was on 10/26/15. - The physician was notified on 12/21/16 that the resident had eloped from the facility. - Resident #1 had mental health concerns and behavioral issues and should be seen by a mental health provider. - The PCP made no medication adjustments and stated the resident would not be coming back. Interview on 1/21/16 at 10:06 am with Resident #1's Mental Health Provider's office manager	D 270	Supervision check list implemented for all residents. Training on supervision check list provided by Registered Nurse. Administrator will facilitate compliance in Personal Care & Supervsion. Clinical Support Team, QA Team & Registered Nurse will monitor compliance in Personal Care & Supervision.	Target Date 2/26/16 2/26/16

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D 270	Continued From page 23 revealed: - Resident #1's Psychiatrist was not available. - Resident #1 was first seen on 11/10/15 for a new patient visit after going to a local hospital ER. - Ativan (Lorazepam, prescribed to treat anxiety disorders) had been ordered by the hospital physician, but the facility did not obtain the medication for the resident. - For routine care, the resident was seen weekly by a therapist at the facility starting on 11/18/15 with the last appointment on 1/19/16. - Therapist notes revealed: 11/18/15 - Resident believed other residents in the facility wished to hurt her, she had been feeling nervous. 11/24/15 - Resident reported symptoms of anxiety and worried alot. 12/03/15 - Staff reported resident called 911 last week and asked to be taken to "the nut house". 12/15/15 - Resident reports she is unhappy at facility and would like to leave. 12/29/15 - Staff reports no current issues or concerns. 1/06/16 - Staff reports resident involved in a physical altercation with another resident, no one hurt. 1/20/16 - Staff reported resident was IVC'd (Involuntary Committment) after breaking out a window last week. - Request to speak with Resident #1's Psychiatrist given to the office manager. - Attempted interview was unsuccessful. Interview on 1/27/16 at 10:47 am with the Mental Health Provider's Owner/Clinical Director (OCD) revealed: - He was usually on call for crisis management and communicated with the facility RCD and ED by phone.	D 270		

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D 270	Continued From page 24 - He was aware of all (not specific) the incidents with (Resident #1) from calls from the RCD and the ED. - The calls were not documented and he did not have a listing of dates and times of the calls. - After she broke the glass in the exit door, he attempted to have the resident admitted to the hospital. - The hospital determined the length of stay and sent her back to the facility; the resident did not have the assessment he had hoped for. - The resident had become increasingly agitated and irritable; staff needed to do bed checks 2-3 times during the evening and night; there should have been a way to have improved the supervision from what was done that night (12/20-21/15). Interview on 1/27/16 at 12:15 pm with the OCD revealed: - It was "fine for (Resident #1) to be signing out until the elopement; but that had been reconsidered since her incidents. Interview on 1/27/16 at 4:10 pm with the Resident Care Manager (RCM) revealed: - Resident #1 "would have her days, paranoia increased". - She had requested to change facilities before she left the facility (12/20/15) and broke the door; she wanted to go to a group home. - "About 2 weeks before the elopement she would get a little more agitated; she was taking Abilify (medication) and her sleeping habits had changed - she would not sleep in her room." - The facility policy for supervision was to see all residents every 2 hours when residents who needed toileting were assisted; Resident #1 would have been checked every 2 hours. - On 12/21/15 the RCM was notified Resident #1	D 270		

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D 270	Continued From page 25 was missing. - After the elopement, if the resident went out, staff needed to be with her; supervision,in general, was to keep her busy with tasks. - The facility did not have check off sheets or a log to document when residents were checked on, verbal reports were done. - The RCM did not know what time Resident #1 left; if staff were doing 2 hour checks, (Resident #1) could have left in between the checks. - Staff did not know when Resident #1 left, she signed the book, but did not give a time. - "We could have supervised her more often to have prevented her from eloping." Interview on 1/27/16 at 5:00 pm with the Executive Director (ED) revealed: - When the ED first met Resident #1 (October, 2015), she was a sweet person who liked to be involved, watered plants, fold clothes, and came in to talk about her family. - The resident was paranoid, she reacted to some residents well, others, not. - The resident had an altercation with another resident and was sent to a local hospital; she was sent back 10 minutes after arrival. - Resident #1 wanted to be near her family. - On 12/21/15 the ED came to work between 7-7:30 am. - After a facility wide search was made for the resident and she was not located, 911 and The County Department of Social Services was called. - The police found the resident at a local pizza restaurant around 9:00 am and was returned to the facility with the ED. - Resident #1 told the ED she left the facility between 11:50 pm to 12 midnight. - The resident stated "staff do not do their checks", and said she got out of her window.	D 270		

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D 270	Continued From page 26 - The resident said she signed out writing in the log book (Resident #1), "out", and "12/20/15". - Routine supervision checks were every 2 hours, staff knew to do toileting every 2 hours. - Staff could check on other residents at that time, also. - For supervision, Resident #1 would have every 2 hour checks, but would not need toilsting assistance. - If staff did their walk through every 2 hours (on 12/20-21/15), they would have known Resident #1 was gone or she could have been "caught in the act". - "Staff did not follow facility policy, staff had been trained to do 2 hour checks." The facility provided a Plan of Protection for all residents dated 1/21/16. Fall risk assessments will be conducted by a nurse on all residents. Care Manager will notify the Physician and request Physical Therapy evaluation and treatment. Current interventions will be reviewed by the Care Manager, Administrator in coordination with the nurse for effectiveness. Residents at risk for falls will be identified by use of a marking outside the door for stafff to identify. Supervision for Resident #3 and Resident #1 will be increased to every 30 minutes and monitored by Care Manger/Administrator. Residents exhibiting behaviors, Care Manager will notify physician and /or mental health provider for evaluation and treatment. additional training will be provided by a nurse on the FAll Management Program to include documentation and effectiveness of interventions at monthly Fall Team Meetings conducted by the Administrator. Mental Health Provider will be contacted by the Administrator to conduct managing difficult behaviors, documentation and resident rights.	D 270		

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D 270	Continued From page 27 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2016	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure referral and follow-up to meet the routine and acute care needs for 3 of 5 sampled residents (#1, #2, #3), one resident who had multiple falls with fractures, abrasion, and laceration injuries (#3), one resident who required swallowing precautions and honey-thickened liquids, hematology lab work, and occupational therapy following a hospitalization (#2), and one resident who eloped from the facility and was having behaviors (#1). The findings are: 1.Review of Resident #3's current FL2 dated 04/14/15 revealed diagnoses of cerebral vascular accident, degenerative disc disorder, and venous insufficiency. Resident register for Resident #3 dated 04/14/15 revealed the resident was admitted on 08/06/09. Observation of Resident #3 on 01/20/16 at 11:17	D 273	Chart audits conducted to ensure Health Care Referal & Follow up to include comparing physician orders, medication administration record, medications on hand and follow through on all orders. Audit was monitored by Registered Nurse. Physicians were notified of any discrepancies and facility followed through with any recommendations and orders. Completed 2/15/16 & ongoing Documentation training conducted by Registered Nurse on 1/24/16. Quality Assurance: Chart audits will be conducted at a rate of 10% per month for 3 months and 5% thereafter. Implemented 10% on 2/26/16, will be reduced to 5% on 5/26/16, ongoing.	Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16

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D 273	Continued From page 28 AM revealed: -The resident was sitting in a power chair in his room. -The resident's power chair was lifted very high and tilted back. -The resident was contracted (an area that is drawn together or condensed) in his neck and had a hard time moving his head around. -The resident has a sign in his room on the wall that says call before you fall. Interview with Resident #3 on 01/20/16 at 11:17 AM revealed: -He has had several falls since he had been living here. -There have been at least 8 falls maybe more, but he was not sure of how many falls all together. -The last fall that he remembered was a couple of weeks ago. Review of the facility's policy and procedure for falls revealed: -The policy was dated effective on 08/01/15. -A fall risk assessment tool is completed for all residents admitted to determine factors that may contribute to falls. -All staff will receive formal training on fall prevention awareness once a year, and will be reminded of fall prevention techniques during staff meetings. -The staff are responsible for completing an incident report for any fall, and will contact family/responsible party as well as contact physicians via phone or fax. -The Executive Director is responsible for reviewing all falls, and determining any immediate interventions that are required based on circumstances. -The staff are requires to do a 72 follow up on residents that fall to investigate possible	D 273		

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D 273	Continued From page 29 circumstances that contribute to the falls, and document observations for that 72 hour period. -The staff will document each shift vital signs, possible risk factors for falls, and if there are any environmental hazards the may result in future falls for 72 hours following the fall. -If the resident has 2 or more falls in a 4 week time period the staff are to contact the primary doctor and request orders for a physical therapy evaluation or other treatments and interventions. -The falls management team will review incident reports on a monthly basis, and asses for any trends for residents having frequent falls. Review of Resident #3 Care Notes revealed: -On 10/28/15 Resident #3 was yelling out for help, he was found on the floor of his room laying on his right arm. -On 11/01/15 Resident #3 had a fall around 10:45 AM, he said he lost his balance trying to use the urinal. -On 11/27/15 Resident #3 fell down in his room, and had some bruises on his left side and lower back. -On 12/04/15 Resident #3 had a fall around 9:50 PM while he was getting ready for bed. -On 12/06/15 the resident complained of pain and has bruises noted on his back. -On 12/07/15 the resident complained of pain in his right shoulder and arm, and has a bruise on his back. -On 12/08/15 the staff encouraged the resident to use his call bell when he wants to get up, and a sign was placed in his room to remind him to use his call bell when he needs assistance. -On 12/08/15 the resident was sent out to the emergency room and was sent back with diagnosis of fractures and received a prescription for Percocet (a narcotic used to treat moderated to severe pain.).	D 273	Fall Risk Assessments completed by an Registered Nurse on 1/24 & 1/25/16. Residents determined to be a fall risk are identified by a "Falling Leaf". A universal sign within the facility. The falling leaf is located on each identified residents name plate. "Who am I" form completed 1/25/16 & posted inside each closet/wardrobe as a reference for care staff. Registered Nurse reviewed fall interventions with Care Manager & Administrator to determine effectiveness and adjusted interventions according to resident need & physician recommendations. Completed 2/1/16. Fall Management Program training provided by Registered Nurse on 1/24/16 & reviewed on 2/16/16 with all staff to include but not limited to; -Risk Assessments -Incident Reporting -72 Hour Follow up -Interventions -Fall Team Meetings -Physician notification & Recommendation -Physical Therapy, as ordered -Documentation Falls, Transfer & Hoyer lift refresher conducted by Physical Therapist & Registered Nurse. Training conducted on 2/4 & 2/5/16.	Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16

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D 273	Continued From page 30 -On 12/08/15 on second shift the resident was in severe pain and was given as needed Tylenol to assist with pain. -On 12/29/15 Resident #3 was found lying on the floor beside his chair, he said he was trying to sit in his chair and missed it when sitting down. -On 01/03/16 Resident #3 was found on the bathroom floor yelling help, he said he slipped and fell trying to make his coffee. -On 01/20/16 Resident #3 had a fall and refused to go to the emergency room, he said he did not hit his head when he fell. Review of the facility ' s incident reports revealed: -On 08/12/15 Resident #3 was found lying near the door of his room, he said he was trying to get some clothes out to wear; There were no injuries noted and the resident refused to go to the emergency room. -On 08/14/15 Resident #3 was found lying on his right side by his toilet, he said he was trying to sit on the toilet: There were no injuries noted and the resident refused to go to the emergency room. -on 08/30/15 Resident #3 was found on his back lying next to his bed, he said he was trying to get something out of the refrigerator; There was an abrasion (an area damaged by scraping or tearing away) noted on the residents mid back, and he was not taken to the emergency room for evaluation. -On 10/28/15 Resident #3 was found on his right side, he had a laceration (a deep cut or tear in the skin) to the right side of his head; He was taken to the emergency room for evaluation. -On 11/01/15 Resident #3 was found on the floor in his room, no injuries were present at this time and resident not taken to the emergency room for evaluation. -On 11/27/15 Resident #3 was found on the floor; he did have some bruising on his left side and he	D 273	Administrator will facilitate compliance in the Falls Management Program. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor compliance in Personal Care & Supervision related to falls management.	2/26/16

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D 273	Continued From page 31 refused to go to the emergency room for an evaluation. -On 12/04/15 Resident #3 was found on the floor, he did not have any injuries at this time and resident refused to go to the emergency room for an evaluation. -On 12/29/15 Resident #3 was found on his back beside his power chair, he did not have any injuries and he refused to go to the emergency room for an evaluation. -On 01/03/16 Resident #3 was found on is back under the bathroom sink, he did not have any injuries and he refused to go to the emergency room for an evaluation. Interview with Resident #3 on 01/21/16 at 10:27 AM revealed: -He has had several falls over the last few months but not sure how many. -He has told the Executive Director (ED) of the facility that the staff are not coming to help him. -He said all the ED did was put a sign in his room that says call before you fall. -The staff only come down to his room to assist with feeding and changing him; he is not aware of them checking on or monitoring him. Telephone interview with Resident #3 responsible party on 01/21/16 at 10:36 AM revealed: -The staff does call him and reports all the falls that happened to the resident. -Resident #3 does refuse to go to the emergency room a lot. -The staff put a sign in his room to encourage him to call for assistance. -He was not aware of any other things that had been done to assist with fall prevention. -The resident was receiving physical therapy a little over a year ago. -The staff have not mentioned anything about any	D 273		

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D 273	Continued From page 32 further physical therapy being ordered. Telephone interview with a Physicians Assistance (PA) on 01/26/16 at 3:53 PM revealed: -She just started seeing Resident #3 in November of 2015. -She had been made aware by the facility of all the falls that Resident #3 had. -The staff have encouraged numerous times for Resident #3 to use his call bell for help. -She put an order in on 01/22/16 for safe strides (this is a physical therapy program) evaluation. -None of the staff have called and recommended any physical therapy until 01/22/16. Interview with the Resident Care Manager (RCM) on 01/27/16 at 10:38 AM revealed: -The facility does have a policy and procedure to follow when a resident has a fall. -When a resident falls the staff let her know and she contacts the medical doctor. -After a fall if there were no injuries the resident will receive monitoring for 72 hours. -If the resident has any injuries or hits their head with a fall they are sent to the emergency room for evaluation. -All resident falls get a 72 hour monitoring after the fall happens. -On the 72 hour checks the staff assess the resident for any injuries or pain and takes vitals, this is done on each shift for 72 hours. -She was not aware of the section on the falls policy to get a physical therapy evaluation after 2 or more falls in a 4 week time period. -Resident #3 does have frequent falls, but she is not sure how many he had. -The staff have encouraged him to use his call bell to call for assistance. -There was a sign placed in his room to remind him to call before he falls.	D 273	Resident # 3 received order for physical therapy evaluation and treatment on 1/22/16. Gentiva Home Health evaluated on 1/25/16 and provided services until 2/9/16. Resident # 3 was evaluated by his primary care physician and level of care was increased to skilled nursing. Resident # 3 received a safe and orderly discharge on 2/9/16.	Target Date 2/26/16

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D 273	Continued From page 33 -Resident #3 was getting checked on every 2 hours. -Since 01/21/16 he has been getting 30 minute checks. -Resident #3 is also getting an evaluation for safe strides (this is a physical therapy program) evaluation. -The order for the safe strides evaluation was obtained on 01/22/16. -There are also staff meetings where they meet and talk about residents who have multiple falls and try to come up with ideas to help prevent future falls. Interview with the Executive Director (ED) on 01/27/16 at 11:19 AM revealed: -There is a falls protocol policy for residents that have falls. -The Personal Care Aides are to report any falls to the Medication Aides. -The Resident Care Manager or the Medication Aide supervisor on that shift is to assess the resident that fell and check vital signs. -The staff is then responsible for reporting the falls to the medical doctor. -If the medical doctor says to send the resident out then the staff sends the resident to the emergency room for an evaluation. -If the resident has a head injury from the fall they will be sent to the emergency room for an evaluation. -All residents that fall are put on a fall precautions list. -If the resident has more than 1 fall they are then put on a 2 hour toileting/monitoring list. -The 2 hour toileting/monitoring is for the staff to check on the resident and see if he needs to use the bathroom or needs any assistance with anything. -Contacts the doctor to do any evaluation of meds	D 273		

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D 273	Continued From page 34 and lab work to see if there is a medical reason causing the falls. -Request orders from the medical doctor for a chair alarm or bed alarm. -There is a monthly team meeting to discuss intervention to assist with residents who have had frequent falls. -She knows Resident #3 has had multiple falls. -She believes he had 4 or 5 falls since October of 2015. -There were signs put up in Resident #3 room that said call before you fall. -Resident #3 has been placed on 30 minute checks since 01/21/16. -It is all the staff 's responsibility to do 30 minute checks on Resident #3. 2. Review of Resident #2's current FL-2 dated 01/20/16 revealed: - The resident's diagnoses included atrial fibrillation, ruptured abdominal aortic aneurysm, and history of prostatic malignancy. - Resident is non-ambulatory. Review of Resident #2's current care plan dated 02/06/15 revealed: - Resident was fully dependent for bathing, dressing, mobility, toileting, eating, and required the assistance of 2 people with all transfers. - Resident had limited strength of his upper extremities. - Resident was fully dependent and required the assistance of staff to feed him. A. Review of Hospital Discharge Summary for Resident #2 dated 11/05/15 revealed: - Resident #2 was hospitalized from 11/01/15 to 11/05/15 with diagnoses of aspiration pneumonia, anemia, Coumadin toxicity, hypertension, and acute renal failure.	D 273		

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D 273	Continued From page 35 - The hospital discharge summary acknowledged Resident #2 had a swallow evaluation that showed aspiration with thin liquid and Resident #2 needed honey thickened liquids and pureed diet to prevent aspiration. - There were recommendations for aspiration precautions to be practiced with Resident #2 based of the swallowing evaluation done on 11/03/15. Review of Resident #2's record revealed there was no documentation that the facility notified the primary physician to clarify recommended aspiration precautions for Resident #2 after this hospital discharge. Review of Swallowing Evaluation for Resident #2 dated 11/03/15 revealed: - Swallowing evaluation recommended reflux precautions which included for Resident #2 to have pureed diet, honey thickened liquids, medications to be given in puree (pudding, applesauce), resident needs to be upright at 90 degrees for the intake of food and liquids, and to remain upright for 30 minutes after each meal. Review of Discharge Care Note for Speech Therapy for Resident #2 dated 12/04/15 revealed: - The speech therapist recommended for Resident #2 to remain on honey-thickened liquids with pureed diets. - It was documented to continue aspiration precautions with Resident #2 and these instructions were discussed with the facility nursing care staff by the speech therapist. Review of an Order from the Nurse Practitioner dated 01/20/16 revealed that Resident #2 was to have a No Added Table Salt, Pureed Diet with Honey Thickened Liquids.	D 273	Training provided to the nursing staff and dietary department on thickened liquids, mixing, use of pre-thicken liquids and positioning on 1/21 and 1/22/16. Training conducted by Physical Therapist, Nurse Practitioner and Register Nurse. Facility will use pre-thickened liquids for any resident who has thicken liquid orders as of 1/27/16. Should a resident request a beverage that isn't supplied in a pre-thicken form, a validated staff will thicken the beverage of choice as of 1/27/16. Administrator & Care Manager will facilitate compliance with physician ordered thicken liquids to include use and proper mixture. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor compliance with thicken liquids.	Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 2/22/16

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	HAL058011	A. BUILDING: _____ B. WING _____	01/27/2016

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D 273	Continued From page 36 Observation of Resident #2 on 01/20/16 at 12:05 p.m. - Resident was lying on bed fully clothed. - Resident had just returned back to the facility from a doctor's appointment. - Resident's voice was weak when he talked. - Resident had a container of Thick-It on the book shelf in his room (Thick-It is used to thicken thin liquids for residents with swallowing difficulties). Interview with Resident #2 on 01/20/16 at 12:05 p.m. - He was waiting for lunch and that staff had to feed him. - His food is pureed and his liquids thickened so that he does not choke. Interview with Family Member of Resident #2 on 01/20/16 at 12:05 p.m. revealed: - Resident #2 had been hospitalized for pneumonia in 11/2015 and required thickened liquids after he was discharged. - She knows that the facility does have Thick-It in their kitchen for the resident but that she also buys and keeps Thick-It in the resident's room in case they run out. Observation of medication aide (MA) on 01/21/16 at 8:35 a.m. during medication administration for Resident #2 revealed: - Resident #2 was lying in bed with head of the bed raised at approximately a 30 degree angle. - MA did not elevate the head of the bed for Resident #2 during his medication administration. - MA administered whole medications in pill form mixed with pudding. - MA administered a liquid medication to Resident #2 unthickened. - Resident #2 grimaced but did not appear to	D 273	Resident # 2 was evaluated by primary care physician and ordered a higher level of care. Safe and orderly discharged to skilled nursing conducted on 2/9/16. Medication administration refresher conducted by Registerd Nurse on 1/24/16. Medication Aide revalidation conducted on 1/24 & 1/25/16 by Registered Nurse. T Medication pass observations conducted by Registered Nurse 1/25, 2/3, 2/11 & ongoing.	Target Date 2/26/16 Target Date 2 /26/16 Target Date 2/26/16 Target Date 2/26/16

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D 273	Continued From page 37 have any problems with swallowing his medications. - MA did not offer any liquids to Resident #2 during this observation. - MA did not demonstrate any other swallowing precautions with the medication administration. Observation of Medication Aide (MA) on 01/21/16 at 10:40 a.m. during medication administration for Resident #2 revealed: - MA did not elevate the head of the bed for Resident #2 prior to medication administration. - Head of the bed for Resident #2 was elevated at approximately a 30 angle during the medication administration. Interview with the Medication Aide (MA) on 01/21/16 at 10:40 a.m. during medication administration for Resident #2 revealed: - She did not normally elevated the head of bed for Resident #2 during his medication administration. - She had never used Thick-it with medication administration for Resident #2 but used prepackaged thickened water. - MA did not offer any liquids to Resident #2. Observation of Resident #2 on 01/21/16 at 12:40 p.m. revealed: - The Resident Assistant (RA) was observed feeding Resident #2 his pureed diet for his lunch and his thickened liquids using a spoon. - The head of the bed was elevated at approximately a 45 degree angle during this feeding session. - The RA did not elevate the head of the bed to 90 degrees for the resident. - RA did not demonstrate any other swallowing precautions with during this observation.	D 273	Diet list and care plan updated to identify residents with thickened liquid orders. List is available to nursing and dietary departments for quick review. Care Manager to maintain and update diet list and care plans, as applicable. Administrator will monitor compliance. Completed: 1/28/16 Training on positioning/elevation of bed/chair when feeding,administering medications or consuming liquids provided by Nurse Practioner, 2 Registered Nurses on 1/21 & 1/22/16. Administrator & Care Manager will monitor proper postioning to ensure compliance.	Target Date 2/26/16 Target Date 2/26/16 2/26/16

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D 273	Continued From page 38 Interview with the Executive Director (ED) on 01/21/16 at 1:00 p.m. revealed: - The Executive Director was aware that Resident #2 needed thickened liquids and pureed diet. - The ED was unaware that facility staff were using Thick-It from Resident #2's room to thicken his liquids. - Staff were supposed to use prepackaged honey-thickened liquids with Resident #2. - She was unaware that the head of Resident #2's bed was not being elevated to 90 degrees. - She would work with RCC to educate their staff to implement swallowing precautions for Resident #2. - It was the responsibility of the RCC to review all discharge instructions and care notes received for the residents from other medical providers and ensure that the instructions are carried out. - It was the responsibility of RCC to communicate to other facility staff the care needs of the residents in the facility. Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 1:00 p.m. revealed: - The Resident Care Coordinator was aware that Resident #2 needed thickened liquids and pureed diet. - The RCC was aware that facility staff were using Thick-It from Resident #2's room to thicken his liquids. - She was unaware that the head of Resident #2's bed was supposed to be elevated to 90 degrees. - She was unaware of the other swallowing precautions that were recommended from the Swallowing evaluation done on Resident #2 on 11/03/15. - She had not contacted the medical provider to clarify the specific swallowing precautions needed for Resident #2.	D 273		

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D 273	Continued From page 39 Observation of Resident #2 on 01/21/16 at 1:15 p.m. revealed: - Resident #2 was lying in bed with his head elevated at a 45 degree after being feed his lunch. - No respiratory distress was observed for Resident #2. Interview with RCC on 01/21/16 at 1:20 p.m. revealed: - She and the Executive Director had already elevated the head of the bed for Resident #2 at approximately 1:10pm. and the resident had just finished eating his lunch. - The head of the bed had not been previously elevated to a 90 degree angle because Resident #2 did not like to be elevated. - She had not contacted the medical provider regarding Resident #2 not liking to be elevated for his meals or drinking liquids. - RCC elevated the head of the bed for Resident #2 to approximately 90 degrees at 1:25pm. Interview with Resident Assistant (RA) on 01/21/16 at 1:45 p.m. revealed: - She had never been instructed that Resident #2 needed any special swallowing precautions. - She did elevated the head of Resident #2's bed when she fed him about 30 - 45 degrees because she did not want him to choke but she had never been instructed to elevated the head of the bed to any specified degree of elevation. Interview with Resident #2 on 01/21/16 at 2:00 p.m. revealed: - He did not know that his head should be elevated at 90 degrees when eating or drink and that resident needed to stay upright for at least 30 minutes after eating or drinking due to prevent aspiration.	D 273		

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D 273	Continued From page 40 - He does not like to sit upright because it caused him back pain. - He was unaware that he needed any other special swallowing precautions besides using honey-thickened liquids. Interview with family of Resident #2 on 01/21/16 at 2:00 p.m. revealed: - She did not know that resident should have his head elevated at 90 degrees when eating or drink and that resident needed to stay upright for at least 30 minutes after eating or drinking due to prevent aspiration. - She was unaware that the resident needed any other special swallowing precautions besides using honey-thickened liquids. - The facility staff did raise the head of bed when feeding Resident #2 at about a 45 degree angle but the resident was never raised up to a 90 degree angle. Review of Care Note for Resident #2 dated for 01/21/16 revealed: - The home health nurse wanted Resident #2 sent out to emergency room for evaluation for possible aspiration and the medical provider was notified. Review of Hospital Discharge Instruction Sheet dated for 01/21/06 revealed: - Resident #2 went to the emergency room on 01/21/16 and had a modified barium swallow test. There were no results for this test. Interview with Resident #2 on 01/21/16 at 6:50 p.m. revealed: - Resident #2 was just returning back to the facility from the hospital. - He went to the hospital to get checked out and he took an x-ray after he was given some thick	D 273		

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D 273	Continued From page 41 liquid to drink. Review of Resident #2's Licensed Health Professional Support Quarterly Review dated 01/22/16 revealed: - Resident #2 had swallowing difficulties. - He was fully dependent on staff for feeding assistance due to his swallowing difficulties. Observation of Resident #2 on 01/26/16 at 12:45 p.m. revealed: - Resident #2 sitting upright at a 90 degree angle while being fed by the resident assistant (RA). - RA used prepackaged honey-thickened liquids for Resident #2 to drink. - The swallowing intervention precautions dated 11/03/15 were posted over the head of Resident #2's bed. Interview with Resident Care Coordinator on 01/26/16 at 3:30 p.m. revealed: - The facility had implemented at the end of the previous week for Resident #2 to follow the swallowing precautions from the swallowing evaluation done on 11/03/15. - Some teaching was done with staff on 01/21/16 and 01/22/16 regarding practicing these swallowing precautions for Resident #2. - Swallowing precaution sheet was posted over the head of Resident #2's bed. Interview with second Resident Assistant (RA) on 01/27/16 at 9:55 a.m. revealed: - She received instructions on the end of last week that Resident #2's head of bed should be elevated at 90 degrees when feeding or giving him liquids. - She also makes sure that the resident stays up for at least 30 minutes after he eats or drinks. - She gave prepackaged tea, cranberry juice, and	D 273		

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D 273	Continued From page 42 lemon drink at honey consistency to Resident #2. Interview with Speech Therapy for Resident #2 on 01/27/16 at 1:18 p.m. revealed: - The speech therapist gave discharge instructions for speech therapy with RCC on 12/04/15. - The discharge instructions included for Resident #2 to remain on a pureed diet with honey thickened liquids, resident to be elevated upright as close to 90 degree as possible during meals and to remain upright for at least 30 minutes after eating, and resident should swallow 2 times with every bite of food or sip of liquid. Interview with Resident #2's primary nurse practitioner (NP) on 01/27/16 at 2:15 p.m. revealed: - She was aware Resident #2 needed swallowing precautions to prevent aspiration. - Resident #2 needed all his liquids to be honey-thickened consistency and a pureed diet. - The facility could use either prepackaged honey-thickened liquids or Thick-It to thicken liquids. - Resident #2's head of bed should be elevated 90 degrees when he is eating or drinking and the resident should be remain in the elevated position for at least 30 minutes after he eats or drinks. - She was not aware that the swallowing precautions recommended were not being practiced by the facility staff. Interview with a third Resident Assistant (RA) on 01/27/16 at 4:5 p.m. revealed: - She did not know that Resident #2 needed any swallowing precautions until the end of last week. - A nurse from the facility had instructed the resident assistants to make sure the head of the bed for Resident #2 be elevated at least 90	D 273		

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D 273	Continued From page 43 degrees when the resident is eating or drinking on either the previous Thursday or Friday. Interview with second Medication Aide (MA) on 01/27/16 at 5:20 p.m. revealed: - She received instructions on swallowing precautions for Resident #2 on 01/21/16. - The RCC posted the swallowing intervention precautions sheet over Resident #2 bed on 01/21/16. B. Review of Lab Report for Resident #2 dated 11/01/15 revealed: - Blood levels for Resident #2 were: Red blood cell - 2.1 (Normal range is 4.63 - 6.08), Hemoglobin - 6.9 (Normal range is 13.7 - 17.5), Hematocrit - 22.9 (Normal range is 40.1 - 51.0), and Mean Corpuscular volume (MCV) - 109.0 (Normal range is 79.0 - 92.2). Review of Lab Report for Resident #2 dated 11/02/15 revealed: - Blood levels for Resident #2 were: Red blood cell - 2.54 (Normal range is 4.63 - 6.08), Hemoglobin - 8.0 (Normal range is 13.7 - 17.5), Hematocrit - 26.2 (Normal range is 40.1 - 51.0), and Mean Corpuscular volume (MCV) - 103.0 (Normal range is 79.0 - 92.2). Review of Lab Report for Resident #2 dated 11/03/15 revealed: - Blood levels for Resident #2 were: Red blood cell - 2.61 (Normal range is 4.63 - 6.08), Hemoglobin - 8.4 (Normal range is 13.7 - 17.5), Hematocrit - 26.8 (Normal range is 40.1 - 51.0), and Mean Corpuscular volume (MCV) - 102.7 (Normal range is 79.0 - 92.2). Review of Lab Report for Resident #2 dated 11/04/15 revealed:	D 273		

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D 273	Continued From page 44 - Blood levels for Resident #2 were: Red blood cell - 2.69 (Normal range is 4.63 - 6.08), Hemoglobin - 8.5 (Normal range is 13.7 - 17.5), Hematocrit - 27.8 (Normal range is 40.1 - 51.0), and Mean Corpuscular volume (MCV) - 103.3 (Normal range is 79.0 - 92.2). Review of Lab Report for Resident #2 dated 11/05/15 revealed: - Blood levels for Resident #2 were: Red blood cell - 2.59 (Normal range is 4.63 - 6.08), Hemoglobin - 8.3 (Normal range is 13.7 - 17.5), Hematocrit - 27.2 (Normal range is 40.1 - 51.0), and Mean Corpuscular volume (MCV) - 105.0 (Normal range is 79.0 - 92.2). Review of Hospital Discharge Summary for Resident #2 dated 11/05/15 revealed: - Resident #2 was hospitalized from 11/01/15 to 11/05/15 with diagnoses of aspiration pneumonia, anemia, Coumadin toxicity, hypertension, and acute renal failure. - Resident #2 was found to be anemic on his admission and received a transfusion of 2 units of packed red blood cells on his admission on 11/01/15. - Resident #2 would benefit from a follow-up with Hematology after his hospital discharge due to his diagnosis of anemia and his test results indicated possible bone marrow etiology. - Resident #2 was ordered to have a Hematology post-hospital discharge due to anemia diagnosis. - It was to be considered for Resident #2 to have a follow-up basic metabolic panel one week after hospital discharge. - Resident #2 would be discharged on 11/05/15 and would need to follow-up with his primary care provider in the outpatient setting. - The hospital discharge summary dated for 11/05/15 was electronically signed by a physician.	D 273		

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D 273	Continued From page 45 Review of records for Resident #2 revealed that there was no documentation the resident had been referred or received a Hematology follow-up after he was discharged from the hospital on 11/05/15. Review of Lab Report for Resident #2 dated 11/23/15 revealed: - A basic metabolic panel was performed on Resident #2 by his primary medical provider. Interview with the Executive Director (ED) on 01/21/16 at 1:00 p.m. revealed: - It was the responsibility of the RCC to review all discharge instructions and care notes received for the residents from other medical providers and ensure that the instructions are carried out. Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 1:10 p.m. revealed: - It was her responsibility to review all care notes received from other providers. - It was her responsibility to review all hospital discharge instructions and referrals received for residents. - It was is her responsibility to make sure that referrals are made for residents who need any type of therapy or needed follow-ups. - She overlooked the referral for Hematology follow-up on the discharge summary for Resident #2. - Resident #2 has not received the Hematology follow-up since his hospital discharge in 11/2015. Interview with Resident Care Coordinator (RCC) on 01/26/16 at 3:30 p.m. revealed: - Resident #2 did have a basic metabolic panel done after he was discharged from the hospital in November 2015.	D 273		

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D 273	Continued From page 46 - She overlooked the referral for Hematology follow-up on the discharge summary for Resident #2 and she has not contacted the medical provider yet regarding the Hematology referral. Interview with Resident #2's primary nurse practitioner (NP) on 01/27/16 at 2:15 p.m. revealed: - She was unaware of the recommendation for Resident #2 to have a Hematology follow-up from the 11/05/15 hospital discharge summary. - She usually gets the order and referrals from the RCC if a resident needed or is ordered for therapy. - She will make a referral for Resident #2 to be seen by a hematologist on her next medical visit. C. Review of Hospital Discharge Summary for Resident #2 dated 11/05/15 revealed: - Hospital discharge summary dated 11/05/15 showed that Resident #2 was hospitalized from 11/01/15 to 11/05/15 with diagnoses of aspiration pneumonia, anemia, Coumadin toxicity, hypertension, and acute renal failure. Review of Hospital Discharge Summary Report dated 11/05/15 revealed: - It was ordered for Resident #2 to be referred for speech therapy, occupational therapy, and physical therapy. Review of Home Care Referral Documentation dated 11/05/15 revealed: - Resident #2 was referred for physical therapy and speech therapy. - There was no documentation that Resident #2 was referred for occupational therapy. Review of Physical Therapy Care Notes for	D 273		

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D 273	Continued From page 47 Resident #2 revealed: - Resident #2 received physical therapy services after the 11/05/15 hospital stay and was discharged from physical therapy on 12/21/15. Review of Speech Therapy Care Notes for Resident #2 revealed: - Resident #2 received speech therapy services starting 11/09/15 and was discharged from speech therapy on 12/04/15. Interview with the Executive Director (ED) on 01/21/16 at 1:00 p.m. revealed: - It was the responsibility of the RCC to review all discharge instructions and care notes received for the residents from other medical providers and ensure that the instructions are carried out. Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 1:10 pm, revealed: - It was her responsibility to review all care notes received from other providers. - It was her responsibility to review all hospital discharge instructions and referrals received for residents. - It was her responsibility to make sure that referrals are made for residents who need any type of therapy or needed follow-ups. - She overlooked the referral for occupational therapy on the discharge summary report for Resident #2. - Resident #2 has not received any occupational services since his hospital discharge in 11/2015. Interview with Resident Care Coordinator (RCC) on 01/26/16 at 3:30 p.m. revealed: - She knew that Resident #2 had received physical therapy and speech therapy after he was discharged from the hospital in November 2015. - She did not understand how she overlooked the	D 273		

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D 273	Continued From page 48 order for occupational therapy dated for 11/05/15 and the medical provider had not been contacted in regards to the missed order. - There was no documentation of occupational therapy services provided in the chart for Resident #2. - She said it was sometimes hard to keep up with all the orders and discharge instructions coming in for all the residents. - She said that it was hard to keep up with therapy service care notes for all of the residents. - The facility had started a new protocol to make sure that the RCC reviewed all new orders and referrals for the residents. - She would start to make sure to follow-up with therapy care services to make sure that residents are receiving their therapies are ordered and these care notes are in the residents' charts. Interview with Resident #2's primary nurse practitioner (NP) on 01/27/16 at 2:15 p.m. revealed: - She was aware that it was recommended for Resident #2 to be referred for physical therapy and speech therapy and that Resident #2 did get those services. - She was not was aware of the order for Resident #2 to have occupational therapy. - She usually got the orders and referrals from the RCC if a resident needs or is ordered for therapy. - She was aware the facility asked for clarification on 01/27/16 if Resident #2 to receive occupational therapy as ordered but NP had not made a decision if occupational services were currently needed. 3. Review of Resident #1's Resident Register revealed: - The resident was admitted to the facility on 9/18/15. - The resident was her own responsible person.	D 273		

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D 273	Continued From page 49 Review of Resident #1's current FL-2 dated 9/18/15 revealed: - Diagnoses included Schizophrenia, paranoid, chronic, and hypertension. - There was no documetation in the categories of orientation and behaviors. - The medication prescribed for the resident was Abilify (aripiprazole, used to treat Schizophrenia) 5 mg 1-1/2 tab by mouth daily. Review of Resident #1's Care Plan dated 10/15/15 revealed: - The resident had a history of mental illness. - For the question "was the resident receiving medication for mental illness/behavior", the answer was "no". - The resident was ambulatory and had adequate memory and vision. - The resident was "sometimes disoriented". - The resident had Licensed Health Professional Support (LHPS). Review of the LHPS Quarterly Review for Resident #1 dated 12/29/15 revealed: - The resident was up most nights, was anxious and paranoid, refused physicial assessment. - No LHPS tasks as this time. - Recommendations (for facility) to meet the resident's needs were to speak with the resident's primary care physician (PCP) about paranoia and abnormal sleep habits. Confidential interview with a resident revealed: - Resident #1 had broken a glass window at the facility last week. - The resident stated the resident was afraid of Resident #1 and concerned since Resident #1 had broken the glass window. - Resident #1 had not harmed or threatened the	D 273	Supervision increased on resident identified as # 1 to 30 minutes checks from 1/21/16 to 1/25/16. Resident # 1 had previously initiated a notice of discharge and relocated to a facility of her choice on 1/25/16. Safe & orderly discharged conducted per resident . choice on 1/25/16. Training provided on managing difficult behaviors, documentation, notification of mental health provider and Resident Rights conducted by Trillium Health Services on 2/12 & 2/16/16. Documentation training provided by Registered Nurse on 1/24/16. Administrator attended Resident Council meeting on 2/17/16 to communicate avenues for residents to voice concerns. Administrator reviewed the resident sign in/out policy at the Resident Council Meeting conducted on 2/17/16. Supervision checklist developed & implemented to verify & account for the presence of all residents. Training conducted by Registered Nurse. Supervision check list will be monitored by Care Manager & Administrator.	1/25/16 Target Date 2/26/16 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16

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D 273	Continued From page 50 resident by the resident was concerned about Resident #1's behavior. - Resident #1 left the facility about a month ago and nobody knew where she was gone. - Staff checked Resident #1's room and she was gone. Confidential interview with a second resident revealed: - Resident #1 came in the resident's room and cursed at the resident and slept on the resident's floor (could not give time frame). - The resident cursed back at Resident #1. - Resident #1 broke a glass door last week. - The resident was "scared of" Resident #1. Review of the facility Accident/Injury Report for Resident #1 dated 12/21/15 revealed: - On 12/21/15 at 9:00 am, the "resident was not in her room or building". - The "resident returned to the facility unharmed (no time or date documented)". Review of Care Notes/ChartingNotes for Resident #1 from 9/18/15 to 1/25/16 revealed: - On 1/02/16 resident got into an altercation with another resident when the other resident accidently bumped into her, as she was walking away, the other resident struck her in the back, the resident reacted by striking the other resident in the arm; (Resident #1) was sent to a local hospital, but returned before being seen. - On 1/15/16 (electronic charting note at 5:34pm) at 3:00 pm the resident took a metal bar and broke the glass out of the 300 hall door from the outside, police and the resident's mental health physician were called; involuntary committment (IVC) papers were filed, and the resident was removed from the facility at 4:00 pm; the resident was taken to the hospital.	D 273	Administrator will facilitate compliance in Personal Care & Supervision. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor compliance in Personal Care & Supervision by reviewing systems during site visits.	2/26/16

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D 273	Continued From page 51 - On 1/19/16 "the resident returned to the facility; she had been given Ativan and her medications were adjusted." Observation on 1/27/16 of the window in the room occupied by Resident #1 on 12/20/15 revealed: - The window was closed and equipped with a blocking device to the base track to prevent window from sliding completely open and window has to slide vertically to the left to be opened. - It was observed that the locking mechanism to this window was partially broken. - With the assistance of housekeeping staff, this window was opened and it was observed that the right side of the window could be jiggled and removed from the sliding tract due to the broken locking mechanisms. Observation on 1/27/16 at 11:20 am of the window in Resident #1's room with a corporate staff revealed: - The Corporate staff was located in and used the room that Resident #1 had eloped from as office space. - It was observed that there was no locking mechanism to the window in this room and the blocking mechanism was in the sliding tract of this window. - The Corporate staff slid open the right side of the window and it was noted that the window jiggled out of the sliding tract and was able to be removed from the tract by the corporate staff. Interview with the Corporate staff on 01/27/16 at 11:25a.m. revealed: - It took a lot of strength to take the window out of its tract. - Resident #1 had the right to leave the building if resident wanted to and that it did not matter that	D 273	Maintenance service contacted to ensure window locks are operating properly. Any window locks or blocking device found broken or missing will be repaired by ordering parts and restored to full operating status.	Target Date 2/26/16

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D 273	Continued From page 52 Resident #1 left out through the window. Review of the facility Accident/Injury Report for Resident #1 dated 1/02/16 at 10:00 am revealed: - "Resident (#1) accidently bumped into another resident who then turned around and hit resident (#1) in the back. Resident's (#1) reaction was to turn around, hit the other resident twice in the arm." - Resident (#1) said she was walking away when the other resident struck her in the back, so she hit her back." - "The resident (#1) wanted to go to ER for evalution." - Resident #1 was transported to a local hospital by EMS at 10:30 am. - "Resident returned from ER without being seen for an evaluation." Review of Care Notes/ChartingNotes for Resident #1 from 9/18/15 to 1/25/16 revealed: - On 1/02/16 resident got into an altercation with another resident when the other resident accidently bumped into her, as she was walking away, the other resident struck her in the back, the resident reacted by striking the other resident in the arm; (Resident #1) was sent to a local hospital, but returned before being seen. Review of the facility Accident/Injury Report for Resident #1 dated 1/15/16 at 3:00 pm revealed: - "Resident broke the glass out of the side door." - The resident refused to have vital signs (blood pressure, pulse, respirations) taken. - The resident was transported to a local hospital by police at 4:00 pm. Review of Care Notes/ChartingNotes for Resident #1 from 9/18/15 to 1/25/16 revealed: - On 1/15/16 (electronic charting note at 5:34pm)	D 273	Correction: The corporate staff was misquoted. The corporate staff in question made the following statement; "The resident used an improper exit and it wouldn't matter to this resident cause she stated she had a right to leave the building". We respectfully request to be noted in for the file. Training provided on managing difficult behaviors, documentation, notification of mental health provider and Resident Rights conducted by Trillium Health Services on 2/12 & 2/16/16.	Target Date 2/26/16

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D 273	Continued From page 53 at 3:00 pm the resident took a metal bar and broke the glass out of the 300 hall door from the outside, police and the resident's mental health physician were called; involuntary committment (IVC) papers were filed, and the resident was removed from the facility at 4:00 pm; the resident was taken to the hospital. - On 1/19/16 "the resident returned to the facility; she had been given Ativan and her medications were adjusted." Observation on 01/27/16 at 11:00a.m.of the 300 hall exit door revealed: - The upper door panel showed the remains of broken glass in the edges of the exit door and the door was covered with plastic over the opened areas. - It had been reported by the staff facility that Resident #1 had broken the glass to this exit door. Review of hospital records for Resident #1 dated 9/23/15 reveled: - The resident was admitted to a local hospital at 6:50 pm for Medical Clearance. - The patient presented to the emergency department with anxiety, parancia. - History of Schizophrenia, hypertension. - Home meds: Abilify 5 mg oral tab once daily. - Psych: Positive for anxiety, Schizophrenia - The resident was treated with Ativan and released at 8:06 pm with instructions to follow-up with Private Physician in 2-3 days to recheck today's complaints and provide continuance of care. Problem is new. Rx. for Ativan. Record review for Resident #1 revealed: - A Physician's order dated 9/23/15 for Ativan 0.5 mg (1) oral tablet to be taken every 8 hours as needed.	D 273		

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D 273	Continued From page 54 - On 1/24/16 a communication form sent from the facility to the resident's primary care physician stated on 9/23/15 resident received order for Ativan 0.5 mg (1) by mouth 8 hours as needed, order was never put in Quikmar or administered, do you wish to continue or discontinue; the word "continue" was hand written above the physician's signature and dated 1/25/16. Review of hospital records for Resident #1 dated 11/25/15 revealed: - The resident was admitted to a local hospital at 2:53 pm for Altered Mental Status, Unspecified. - The patient presented with agitation, trouble concentrating, manic speech pressure, possible causes: INADEQUATE MEDS. - Home meds: Abilify 5 mg oral tab once daily. - History of Schizophrenia, hypertension. - The resident was treated and released at 4:35 pm with instructions for follow-up in 2-3 days. Unknown Primary Care. Review of hospital records for Resident #1 dated 1/15/16 revealed: - The resident was admitted to a local hospital at 4:26 pm with complaints of IVC (involuntary commitment) by local police department, Medical Clearance, disgnoses of Schizophrenia and episodes of agressive behavior, hypertension. - Onset: began/occurred suddenly, 2 days ago, the patient presents with depression, manic behavior, paranoia, psychosis. - Home (facility) medications: Abilify 5 mg oral tab once daily for Schizophrenia. - The resident had a history of cocaine/alcohol abuse. - Psych: Behavioral/mood is anxious, manic, animated, not oriented to time, judgement/insight impaired. - Patient threatened violence, will attenpt	D 273		

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D 273	Continued From page 55 consultation with institutional psych. - Patient responded to medication and symptoms have markedly improved after treatment. - Discharged 1/19/16 at 9:04 am with the following instructions: Follow-up private physician today to recheck complaints, problem of acute exacerbation.Unknown Primary Care. Interview on 1/21/16 at 10:40 am with Resident #1's primary care physician's (PCP) office assistant revealed: - The resident had been seen in the office on 10/26/15 for the first time to establish care. - The resident told the office staff she did not like doctors and would not be coming back. - There was no documentation in the resident's records about the resident eloping from the facility. - There were no subsequent appointments for Resident #1. Interview on 1/27/15 at 9:30 am with Resident #1's PCP revealed: - Resident #1's first and last appointment was on 10/26/15. - The physician was notified on 12/21/16 that the resident had eloped from the facility. - Resident #1 had mental health concerns and behavioral issues and should be seen by a mental health provider. - The PCP made no medication adjustments and stated the resident would not be coming back. Record review for Resident #1 revealed there were no referrals or visits to another primary care provider after 10/26/15. Interview on 1/21/16 at 10:06 am with Resident #1's Mental Health Provider's office manager	D 273		

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D 273	Continued From page 56 revealed: - Resident #1 was first seen on 11/10/15 for a new patient visit after going to a local hospital ER for treatment. - Ativan (Lorazepam, prescribed to treat anxiety disorders) had been ordered by the hospital physician, but the facility did not start the medication for the resident. - For routine care, the resident was seen weekly by a therapist at the facility starting on 11/18/15 with the last appointment on 1/19/16. - Resident #1's Psychiatrist was not available for interview. Interview on 1/27/16 at 10:47 am with the Mental Health Provider's Owner/Clinical Director (OCD) revealed: - He was usually on call for crisis management and communicated with the facility RCM and ED by phone. - He was aware of all (not specific) the incidents with (Resident #1) from calls from the RCM and the ED. - The calls were not documented and he did not have a listing of dates and times of the calls. - After Resident #1 broke the glass in the exit door, he attempted to have the resident admitted to the hospital. - The hospital determined the length of stay and sent her back to the facility; the resident did not have the assessment he had hoped for. - The resident had become increasingly agitated and irritable; staff needed to do bed checks 2-3 times during the evening and night; there should have been a way to have improved the supervision from what was done that night (12/20-21/15). Interview on 1/27/16 at 12:15 pm with the OCD revealed:	D 273		

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D 273	Continued From page 57 - It was "fine for (Resident #1) to be signing out until the elopement; but that had been reconsidered since her incidents. - The Nurse Practitioner who had evaluated and treated Resident #1 was not available for interview. - He was familiar with Resident #1 and the resident had always had typical behavior problems. - Resident #1 was increasingly agitated. - Resident #1 had been to the hospital recently and the hospital providers said nothing was wrong with the resident. - He was not aware of Resident #1 having any physical altercations with other residents. - He did not know anything about an Ativan order. - He thought the RCM had contacted them about the resident missing some doses of Abilify but he did not know the dates. Interview on 1/27/16 at 5:20 pm with the Executive Director (ED) revealed: - The last appointment Resident #1 had with her Primary Care Physician was on 10/26/15. - The resident did not like doctors and did not want to go back. - She saw the therapist from the mental health provider. The facility provided a Plan of Protection for all residents dated 1/21/16. Resident #2 (was) sent out for medical evaluation. Home Health provided training on positioning Resident #2 while feeding and medication administration on 1/21/16. Resident chart audits will be conducted to ensure health care referral and follow-up by Care Manager, Administrator and Clinical Support Team. Physician will be notified of any discrepancies and follow through with any	D 273		

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D 273	Continued From page 58 additional orders. Compliance to be monitored by Care Manager in coordination with Administrator. Communication log will be established by Care Manager to report appointments, follow-up, and referrals. Documentation training will be provided to Care Manager, Administrator and Med Aides (and) be conducted by a nurse. Resident Care Manager in coordination with Administrator will audit 10% of the charts each month for 3 months and 5% thereafter. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2016.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walk-in cooler, food storage area, ice machine, reach-in cooler, kitchen walls, and the dining room floors, ceilings, and walls were clean and protected from contamination. The findings are: Observation of the entry doorways of the dining room on 01/20/16 at10:47 revealed: -The doorways had black stains and peeled paint all around them. -They black smudges and dried up orange stains	D 282	Realignment of dietary staff to include a new dietary manager. Area Dietary Manager provided training and support to new dietary manager and klitchen staff as of 2/1/16 and ongoing. Kitchen/dining area deep cleaned on 2/1/16. Corporate Dietary Director making routine visits to monitor compliance as of 2/1/16 and ongoing.	3/12/16 3/12/16 3/12/16

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D 282	Continued From page 59 of the doorways. Observation of the dining room chairs on 01/20/16 at 10:51 AM revealed that thirty out of thirty six chairs had dried up white stains and chipped wood on the back and legs of the chairs. Observation of the dining room tables on 01/20/16 at 10:52 AM revealed: -Fourteen of fourteen dining room tables had white table clothes and smaller vinyl table clothes on top of them. -Fourteen out of fourteen of the dining room tables had dried up white food particles all around the legs of the tables. -Fourteen out of fourteen tables had orange rust all over the bottom of them. -There were ten out of fourteen tables that had dried up yellow and white stains on the vinyl table cloths. -There was dried up brown stains on ten out of fourteen white table clothes. Observation of the ceilings in the dining room on 01/20/16 at 10:56 AM revealed that two out of eight vents in the ceiling had caked up brown and black dirt particles covering the entire vents. Observation of the dining room floor on 01/20/16 at 10:58 AM revealed there was dried up white and brown food particles all over the floor of the dining room. Observation of the walls of the dining room on 01/20/16 at 11:00 revealed: -Four out of four walls had peeled paint and dried up black stains on them. -Two out of two wall shelves were covered in brown dust and dirt. -One of the two shelves had a nail laying on top	D 282	Kitchen/dining cleaning checklist implemented to include; floors, tables, walls, chairs, doors, vents and kitchen equipment on 1/28/16 and being monitored by area dietary manager and administrator. New stove purchased and installed on 1/18/16.	3/12/16 1/18/16

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D 282	Continued From page 60 of it with the point of the nail sticking up. -The baseboard had chipped pieces of wood and peeled paint in sections of the baseboard. Observation of the emergency exit door of the dining room on 01/20/16 at 11:04 AM revealed: -All around the door frames there was dried up black stains. -There was also a dried and caked up orange stains spotted on the door frame. Observation of window seals in the dining room on 01/20/16 at 11:10 AM revealed: -Two out of two window seals had black and brown dirt all over the window seals. -Two out of two window seals had nails laying on top of them that the point of the nails were sticking up. Observation of a preparation table in the kitchen on 01/20/16 at 2:57 PM revealed: -There were white and brown food particles all over the bottom of the table. -Four out of four table legs had orange and black rust stains all over them. Observation of the ice machine on 01/20/16 at 2:53 PM revealed: -There were dried up brown and white food particles all over the inside of the ice machine lid. -There were dried up white stains all over the outside of the ice machine. -There were brown dust particles all over the ventilation system of the ice machine. Observation of the reach in freezer on 01/20/16 at 2:55 PM revealed: -Dried up brown and white stains all over the bottom outside of the reach in freezer. -There were dried up white stains on the outside	D 282		

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D 282	Continued From page 61 of two out of three doors to the reach in freezer. -There was dried up orange food particles on the bottom inside of the reach in freezer. -There were a pack of hotdog buns and a package of frozen pizza's that were opened and did not have a date on them. Observation of the dried food storage area on 01/20/16 at 3:00 PM revealed: -There were sixteen out of twenty-three containers that had white, black, and brown food particles all over the top of them. -Six out of twenty-three containers had dried up brown stains on top of them. -There were dried up white, brown, and orange food particles all over the floor. -There were five out of ninety-six cans of food that had dents in the side of them. -There were two bags of flour that were opened and not in a sealed container; they were sitting in a bin with a piece of plastic lying on top of them. -There were two bags of flour that were opened and did not have a date on them. -There was one out of four boxes labeled scalloped potatoes that were opened and did not have a date on them. -There were two out of four bags of rice that had been opened and were not labeled or in a sealed container. -Four out of four walls had dried up yellow and brown stains all over them. Observation of the vent hood to the dish washer on 01/20/16 at 3:10 PM revealed caked up black and brown stains on it. Observation of reach in cooler on 01/20/16 at 3:12 PM revealed: -There was dried up black and orange stains all of the side and frame of the cooler.	D 282		

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D 282	Continued From page 62 -There was one pack of cheese that had been opened and not dated. -There was one pack of butter that had been opened and not dated or put in a sealed container. -There were two gallons of milk that were half full and had an expiration date of 01/18/16. -There were dried up white stains all over the front doors and bottom sides of the cooler. Observation of the stove in the kitchen on 01/20/16 at 3:15 PM revealed: -There was caked up black and brown grease all over the top of the stove. -There were dried up brown and white food particles all over the back wall behind the stove. -Dried up white and yellow grease stains all over the back wall behind the stove. Observation of the kitchen floors on 01/20/16 at 3:17 PM revealed there were white and brown food particles all over the floor in the kitchen area. Interview with the dietary manager on 01/20/16 at 3:49 PM revealed: -The dietary aides are responsible for cleaning the dining room every day after each meal. -The dietary aides are to wipe up off all the tables after each meal. -The dietary aides are to sweep and mop the floors after each meal. -The dietary staff are to wipe the chairs out after each meal. -None of the staff ever clean the bottom of the tables. -The staff are only required to clean the walls when there is a spill or they need to be cleaned. -The window seals and shelves on the wall only get cleaned when they need to be cleaned. -The maintenance staff are responsible for any	D 282		

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D 282	Continued From page 63 painting and repair work. -The maintenance man only works at the facility on Mondays, and if an emergency repair needs to be done. -She said it was her responsibility to tell the maintenance man when there is something that needs to be painted or repaired. -All the dietary staff are responsible for cleaning up the kitchen area. -The staff sweep and mop after each meal. -The freezer, cooler, and ice machine only gets cleaned when it needs to be cleaned, and does not have a set schedule for cleaning. -The staff tries to clean the freezer, cooler, and ice machine one a week. -The facility does not have any logs showing these areas are cleaned. -She said it was her responsibility to make sure these areas were cleaned. Interview with a cook on 01/21/16 at 9:10 AM revealed: -The dietary aides are responsible for cleaning the dining room. -The dietary aides are to clean the dining room after each meal. -They are to sweep and mop the dining room floor. -The dietary aides clean the tables and wipe down the chairs. -The table clothes are new and she was not sure how they were to be cleaned. -The table clothes were usually only used for holidays. -The tables use to have vinyl table clothes on them. -The walls of the dining room get cleaned but not on a regular basis. -The window seals and shelves on the wall are cleaned but not every day.	D 282		

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D 282	Continued From page 64 -The maintenance staff are responsible for cleaning the vents in the ceiling, but she was not sure how often. -Housekeeping are responsible for cleaning the windows and doors. -The dietary aides and housekeeping are responsible for cleaning the walls and baseboards. -The kitchen is cleaned after each meal and as areas of the kitchen are utilized for preparing meals. -There is no set schedule or log for cleaning the cooler, freezer, ice machine, or the dry food storage area. -The ice machine is wiped down daily but not sure how often it gets a thorough cleaning. -The dry food storage area is swept and mopped at the end of each shift. -The cooler and freezer is cleaned when the delivery truck comes each week. -She feels that the stove needs a thorough cleaning and she has reported that to the Dietary Manager and Executive Director. Interview with a Dietary Aide on 01/21/16 at 9:24 AM revealed: -The Dietary Aides are responsible for cleaning the dining room after each meal. -The facility use to have vinyl table clothes and they would just wipe those down. -There were new white table cloths put on the tables on 01/21/16. -She wipes out the chairs and sweeps the floor after each meal. -The floor gets spot mopped after each meal and at the end of the shift, but if the floor is real dirty the staff will mop the whole floor. -She has cleaned the baseboards with a mop, but only when there was a spill or stain that needed to be cleaned.	D 282		

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D 282	Continued From page 65 -She was never told to wipe the walls down or that it had to be done. -It is the maintenance staff's responsibility to clean the vents in the ceiling. -The housekeeping staff are responsible for cleaning the windows and door frames. -The dry food storage area is cleaned at the end of each shift. -The cooks are responsible for cleaning the cooler and freezer. -The cook is responsible for cleaning the stove area. -She wipes down the ice machine every day at the end of each shift. -The preparation tables are cleaned after each meal is prepared. -She thinks the maintenance staff are responsible for all repairs and painting. -There are not logs or schedules used for cleaning any of the areas in the dining room or kitchen. Attempted interview with housekeeping staff member on 01/27/16 at 1:00 PM revealed the housekeeper had been sent home due to her being sick and there was no other housekeeper at this time for interview. Interview with Resident Care Manager on 01/21/16 at 9:38 AM revealed: -The dietary staff are responsible for cleaning the dining room. -The dining room is to be cleaned after every meal. -The dietary staff are responsible for cleaning the table, floors, and chairs. -The dietary staff also clean the windows when the housekeeping staff can't get to them. -The housekeeping staff should clean the walls, baseboards, and windows each day.	D 282		

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D 282	Continued From page 66 -The dietary staff are responsible for cleaning the kitchen area. -The cooler and freezer should be cleaned once a week. -The stove, ice machine, floors, and dry food storage area should be cleaned on a daily basis. -She is not aware of any logs or cleaning schedules the staff uses for cleaning the dining room or kitchen. -The Dietary Manager is responsible for making sure these areas are cleaned each day. Interview with the Executive Director on 01/21/16 at 9:45 AM revealed: -The dietary staff are responsible for cleaning the dining room. -The dining room should be cleaned after each meal. -The tables, chairs, table cloths, windows and window seals should be cleaned after each meal. -The legs to the dining room tables should be cleaned after each meal. -The floor should be swept and mopped after each meal. -The vents in the ceiling should be cleaned daily with a duster by the dietary staff. -The kitchen should be cleaned between meals. -The dry food storage area gets cleaned daily including sweeping and mopping. -The cooler and freezer should be wiped down and cleaned every day by the dietary staff. -The ice machine should be wiped down daily by the dietary staff. -Not sure how often the stove and behind the stove were being cleaned. -There are no logs or documentation showing these areas have been cleaned and when. -The Dietary Manager is responsible for all the cleaning being done unless she is off, then it ' s the responsibility of the head cook on that shift.	D 282		

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D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Type B Violation Based on observation, interview and record review, the facility failed to assure thickened liquids were prepared and served as ordered by the physician for 1 of 1 sampled residents (#2) with orders for thickened liquids and history of aspiration pneumonia. The findings are: Review of Resident #2's current FL2 dated 01/20/16 revealed: -Diagnoses of Atrial Fibilation, history of Prostatic Malignancy, and a ruptured Abdominal Aortic Aneurysm. -There was no diet order on the current FL2. Resident register for Resident #2 dated 01/30/16 revealed the resident was admitted on 01/30/15. Review of Hospital Discharge Summary for Resident #2 dated 11/05/15 revealed: - Resident #2 was hospitalized from 11/01/15 to 11/05/15 with diagnoses of aspiration pneumonia, anemia, Coumadin toxicity, hypertension, and acute renal failure. - The hospital discharge summary acknowledged	D 310	Training provided to the nursing staff and dietary department on thickened liquids, mixing, use of pre-thicken liquids and positioning on 1/21 and 1/22/16. Training conducted by Physical Therapist, Nurse Practitioner and Register Nurse. Facility will use pre-thickened liquids for any resident who has thicken liquid orders as of 1/27/16.	Target Date 2/26/16 Target Date 2/26/16

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D 310	Continued From page 68 Resident #2 had a swallow evaluation that showed aspiration with thin liquid and Resident #2 needed honey thickened liquids and pureed diet to prevent aspiration. - There were recommendation for aspiration precautions to be practiced with Resident #2. - The hospital discharge summary was electronically signed by the physician. Review of a discharge order from the hospital signed by a Speech and Language Therapist dated for 11/23/15 revealed: -Resident #2 required supervision and total feeding assistance on each meal. -The diet was ordered to be pureed food and honey thickened liquids diet. Review of a Physician ' s order dated 01/20/16 revealed: -The medical doctor signed this order on 01/25/16. -Resident #2 was to be on a pureed food, no added table salts, and honey thickened liquids diet. Observation of the spoon used to dip out the thickener on 01/21/16 at 12:34 AM revealed: -The spoon had two sizes. -One side of the spoon said table spoon, and the other said teaspoon. Review of the manufacturer's instructions for preparing thickened liquids on 01/21/16 at 12:35 PM revealed: -To prepare water add 4-5 teaspoons of thickener per 4oz of fluid. -To prepare other beverages add 5-5 ½ teaspoons of thickener per 4oz of fluid.	D 310	Should a resident request a beverage that isn't supplied in a pre-thicken form, a validated staff will thicken the beverage of choice as of 1/27/16. Diet list and care plan updated to identify residents with thickened liquid orders. List is available to nursing and dietary departments for quick review. Completed: 1/28/16 Care Manager will maintain and update diet list and care plans. Administrator will monitor compliance. Training on positioning/elevation of bed when feeding,administering medications or consuming liquids provided by Nurse Practioner, two Registered Nurses on 1/21 & 1/22/16. Resident # 2 was evaluated by primary care physician and ordered a higher level of care. Safe and orderly discharged to skilled nursing conducted on 2/9/16. Administrator will facilitate compliance in Nutrition & Food Service. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor compliance in Nutrition & Food Service.	Target Date 3/12/16 Target Date 3/12/16 Target Date 3/12/16 Target Date 3/12/16 2/26/16

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D 310	Continued From page 69 Observation of Resident #2 on 01/21/16 at 12:30 during the lunch meal revealed: -There was a large container of the thickener on his bedside table. -The resident received 10oz of water that was very thin in consistency, and did not appear to be honey thickened. -The resident received 8oz of soda that was very thin in consistency, and did not appear to be honey thickened. -There were no pre-thickened beverages in Resident #2 ' s room at this time. Interview with a Personal Care Aide (PCA) on 01/21/16 at 12:44 PM revealed: -She used the large end of the measuring stick that came with the thickener. -She had put 2 tablespoons in each one of the beverages. -She said if she put the 4-5 in the water it would be too thick. -She was trained by the dietary staff to do the thickened liquids. Interview with a second Personal Care Aide (PCA) on 01/26/16 at 12:21 PM revealed: -She has worked with and fed Resident #2. -She has never used the thickener in Resident #2 ' s drinks or beverages. -She has always used pre-thickened liquids when she fed Resident #2. -She was taught that the thickener was used for the food only. -The dietary staff are the ones who put the thickener in the food. -No one has every trained her on how to use the thickener and that's why she does not use it. Interview with a third Personal Care Aide (PCA) on 01/26/16 at 9:50 AM	D 310		

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D 310	Continued From page 70 -Resident #2's liquids have to be honey thickened. -Most of the time the staff use liquids already pre thickened. -The dietary staff are responsible for pre-thickening liquids before the meal trays are sent out. -She picked up his tray early for breakfast this morning and had to thicken his beverages. -The dietary staff trained all the PCA's on how to thicken liquids. -She said when she prepared each beverage she would just add thickener to the beverage until it was honey thickened. -She had been using the thickener to mix his beverages, but the pre thickened liquids have always been available. Interview with a Dietary Aide on 01/26/16 at 10:00 AM revealed: -The thickener was in the kitchen and was only used on the food. -The facility had pre-thickened liquids such as tea, lemon water, and juices. -She said a sign was put up by corporate on 01/24/16 that said only pre-thickened liquids are to be used for resident ' s that get thickened liquids. -She was not aware of any dietary staff training the Personal Care Aides or the Medication Aides on how to use thickener to thicken beverages and liquids. Interview with a Medication Aide (MA) on 01/26/16 at 2:37 PM revealed: -The facility has pre-thickened lemon water, cranberry juice, tea, and milk that is being used for Resident #2. -The dietary staff are the only ones who have a container of the thickener.	D 310		

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D 310	Continued From page 71 -The dietary staff trained all the Personal Care Aides and MA on how to use the thickener. -She has only used the thickener in his soda, but does not remember how to prepare the beverage now. Interview with a second Medication Aide (MA) on 01/26/16 at 2:53 PM revealed: -She has never prepared the thickener with any beverages for Resident #2. -She uses pre-thickened liquids to administer his medications. -There was a Registered Nurse who came and did an in-service on how to prepare thickened liquids. -This in-service training was done on 01/24/16, she had not ever been trained prior to that day. Interview with a fourth Personal Care Aide (PCA) on 01/27/16 at 10:03 AM revealed: -She had never used the thickener to prepare Resident #2's beverages. -She has always used the pre thickened liquids when she fed Resident #2. -She did get training by another PCA on how to use the thickener to prepare thickened liquids. Interview with the Resident Care Manager (RCM) on 01/27/16 at 10:38 AM revealed: -The Personal Care Aides (PCA) are responsible for feeding Resident #2. -The dietary staff are responsible for mixing all thickened liquids before the meal trays are passed out. -Resident #2's family member would come in and prepare his beverages sometimes. -She was not aware of anyone training the family member on how to prepare thickened liquids. -The PCA's should not be preparing beverages with the thickener.	D 310		

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D 310	Continued From page 72 -An LHPS nurse did training on how to mix and prepare thickened liquids. Interview with the Executive Director (ED) on 01/27/16 at 11:19 AM revealed: -The Personal Care Aides are responsible for feeding Resident #2. -The Personal Care Aides should not be preparing thickened liquids. -The dietary staff are responsible for preparing any thickened liquids before the trays are sent out. -The dietary staff were trained by an LHPS nurse on how to prepare thickened liquids. -Resident #2 family member comes in sometimes and prepares his thickened liquids. -The family member had not had any formal training on how to prepare thickened liquids that she was aware of. -The Medication Aides have been trained to prepare thickened liquids for passing medications. The facility provided a plan of correction for all residents on 1/27/16.The Administrator immediately removed any thickening agents and facility will only use pre-thickened liquids. All staff will be trained on thicken liquid diets and use of pre-thickened products by a nurse. Residents with thickened liquid orders will be identified on the diet list, which will be available in the nursing and dietary departments and identified on the care plan. The Resident Care Manager will be responsible for amintaining and ensuring list is available and order is identified on care plan. Administrator will monitor compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2016.	D 310		

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	HAL068011	A. BUILDING: _____ B. WING _____	01/27/2016

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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 interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to the tone and manner in which staff members spoke to residents, including a staff member (Staff B) who washad previously been reported for being disrespectful to residents. The findings are: Confidential interview with a resident revealed: -Several of the staff have been hollering at her. -Staff B (personal care aide) hollered at the resident when she wanted to go outside, and she told the resident to sit down that the resident was not allowed outside. -The resident had informed the Executive Director of the situation, and nothing had been done. -The resident had also informed the Business Office Manager and the Resident Care Manager, but no one has followed up with the resident as to what had been done. Confidential interview with a second resident revealed: -Staff B hollered at the resident's roommate several times. -The resident said the roommate wanted to leave the facility, because of the way the staff had been	D 338	Resident Rights reviewed with all staff by Administrator , Senior Executive Director & Registered Nurse on 1/22/16. Area Ombudsman conducted formal Resident Rights training on 2/12/16. Administrator attended Resident Council meeting to provide information on voicing concerns on 2/17/16. Complaint/suggestion box established on 12/31/15 with 3 avenues to voice any concerns with options for anonymity. Health Care Personnel Registry reporting requirements reviewed with all staff by Registered Nurse on 1/24 & 1/26/16. Staff B suspened and reported to Health Care Personnel Registry, 24 hr completed 1/21/16, 5 day report completed and submitted on 1/25/16.	Target Date 3/12/16 Target Date 3/12/16 Target Date 3 /12/16 Target Date 3/12/16 Target Date 3/12/16 1/25/16

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D 338	Continued From page 74 towards the roommate. -Staff B hollered at the roommate and told him the resident's roommate not to leave the facility. Confidential interview with a third resident revealed: -The resident said one of the staff members were going to move the resident's belongings into storage without permission. -The resident said this staff member has been verbally loud and yelled several times on several different occasions at the resident. Confidential Interview with a fourth resident revealed: -A staff member has yelled at the resident several different times, but the resident was unable to identify the resident by name. -The resident said the staff member was a new Medication Aide on second shift. -When the resident used the call bell to call for help this staff member came to the room, and yelled at the resident " what do you want now ". -The resident said the staff member also yells when administering the resident's meds; telling the resident to hurry up and take the meds. Confidential interview with a staff member revealed: -She has never heard any of the staff directly be disrespectful or yell at the resident's. -There was one resident who complained to her that Staff B was verbally ugly and used foul language towards that resident. -Another resident had complained that Staff B would make the resident stand up in the common bathroom to change clothes and diapers, and the resident was not to be weight bearing on the lower extremities.	D 338	Resident Rights will be reviewed with all staff on a quarterly basis. Administrator will facilitate protection of Resident Rights and monitor compliance throughout the facility. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor protection of Resident Rights during site visits	3/12/16 3/12/16 3/12/16

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D 338	Continued From page 75 Confidential interview with a fifth resident revealed: - The resident had not been at the facility very long and was still getting used to the residents and staff. -The resident stated that as a general rule the resident was treated with respect and staff were friendly, but it was not true of all staff. - The 1st shift was nice and helpful, but the staff in the evenings were a little different, not so friendly. - There was one staff that was very "short" with the resident when the resident asked for some assistance for personal needs and the resident often had to wait for a long time (over 15 minutes) to be assisted. - The resident could not remember the staff's name, but said that some people were just not as friendly as others, but the resident would get used to it. Confidential interview with a sixth resident revealed: - The resident did not like living at the facility. - The "nurses" call the resident a "b - - - -". - Staff B cursed and called the resident a "b - - - -". - The resident could not give a date of when this occurred. - The resident indicated it had occurred on more than one occasion. Confidential interview with a seventh resident revealed: - Staff B made the resident stand in the shower "not too long ago". - The resident was not supposed to stand and bear weight. - The resident was afraid of falling. - Staff B told the resident that the resident had a	D 338		

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D 338	Continued From page 76 "nasty attitude". - Staff B "hollers and fusses" at the resident. - This hurts the resident's feelings and makes the resident cry. - The resident had reported it to one of the medication aides but the resident could not recall which one. - The resident told the medication aide to tell the Resident Care Coordinator (RCC). - The resident did not know if the RCC was told. Confidential interview with a second staff person revealed: - The staff person had not observed any concerns about staff treatment of residents. - The staff person had a concern in the past about the way the previous Administrator talked to staff and residents in a rude manner. - The concern had been taken care of as the previous Administrator no longer worked at the facility. Confidential interview with a third staff person revealed: - No one had reported any concerns about staff treatment of residents to her. - She had not observed any concerns with the way staff treat residents. Interview with the Administrator on 01/21/16 at 2:48 p.m. revealed: - She had worked at the facility for about 3 months, since October 2015. - About 2 to 3 weeks ago, a resident complained about the way staff talked to the resident. - The Administrator did an investigation regarding two different incidents with two different staff people. - As a result of the investigation, both staff were terminated.	D 338		

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D 338	Continued From page 77 - Residents would usually come and tell the Administrator if they had any concerns. - No other complaints about staff had been reported to the Administrator. Interview with a Senior Executive Director (SED) from a sister facility on 01/21/15 at 2:50 p.m. revealed: - She worked at a sister facility for the corporation and was at the facility to assist and provide support to this facility's Administrator / ED. - The SED was at this facility in September 2015 investigating the previous Administrator regarding allegations of the previous Administrator being rude and disrespectful to staff and residents. - While the SED was at the facility in September 2015, the previous Administrator brought Staff B into the previous Administrator's office. - The previous Administrator reported she had received a complaint that Staff B was talking loud and speaking rude to the residents. - The previous Administrator issued a written warning to Staff B in September 2015. - Consequences depend on the severity of the complaint and the Administrator determines the action to take. - The SED stated if it had been at her facility, the SED would have terminated Staff B. - The process would have been to follow up on Staff B in 30 days after the written warning. - Since there was a change of Administrator in October 2015, the written warning was probably not followed up. Interview with the current Administrator on 01/21/16 at 2:55 p.m. revealed she was unaware of any written warnings against Staff B so she had not followed up.	D 338		

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D 338	Continued From page 78 Review of Staff B's personnel file revealed she had signed a copy of the Declaration of Residents' Rights on 05/01/12 and 10/22/14. Attempts to contact Staff B during the survey were unsuccessful. Review of the facility's plan of protection dated 01/21/16 revealed: - Health Care Personnel Registry (HCPR) 24 hour report will be completed today on identified staff who allegedly verbally violated residents' rights. - Staff B was suspended on 01/21/16. - Administrator will conduct internal investigation and complete 5 day HCPR report. - Complaint / Suggestion box established 12/31/15 with 3 avenues for residents to voice their concerns with options for anonymity. - Resident Rights will be reviewed with all staff by the Senior Executive Director and Administrator. - Administrator will contact Ombudsman to conduct Resident Rights training at the earliest date available. - Administrator will review Resident Rights upon hire and quarterly with all staff. - Administrator will attend a Resident Council Meeting and remind them how to voice their concerns. - HCPR training will be conducted by a nurse. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2016.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 79 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: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 1 of 4 residents (#2) observed during the medication passes, including errors with medications for high blood pressure, depression, gout, anemia, vitamin D deficiency, and topical pain relief and 2 of 5 residents (#1, #4) sampled for record review related to errors with medications for anxiety/agitation, psychosis, and low potassium and Vitamin D levels. The findings are: 1. The medication error rate was 21% as evidenced by the observation of 6 errors out of 28 opportunities during the 8:00 a.m. and 12:00 noon medication passes on 01/21/16. Review of Resident #2's current FL-2 dated 01/20/16 revealed diagnoses included atrial fibrillation, history of prostatic malignancy, and ruptured abdominal aortic aneurysm. Review of a hospital discharge summary for Resident #2 dated 11/05/15 revealed: - The resident was hospitalized from 11/01/15 to	D 358	Medication Aide removed from medication cart on 1/21/16. Realignment of Care Manager position facilitated on 2/8/16. Registered Nurse onsite and training New Care Manager.	Target Date 2/26/16 Target Date 2/26/16

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D 358	Continued From page 80 11/05/15 with diagnoses of aspiration pneumonia, anemia, Coumadin toxicity, hypertension, and acute renal failure. - The resident had a swallow evaluation that showed aspiration with thin liquids. - The resident needed honey thickened liquids and pureed diet to prevent aspiration. - There was recommendations for aspiration precautions. - The form was electronically signed by the physician. Review of swallowing evaluation form for Resident #2 dated 11/03/15 revealed: - Reflux precautions were recommended which included pureed diet, honey thickened liquids, and medications to be given in puree. - The resident needs to be upright at 90 degrees for the intake of food and liquids, and to remain upright for 30 minutes after each meal. Observation during the morning medication pass on 01/21/16 at 8:35 a.m. revealed: - Resident #2 was lying in bed with head of the bed raised at approximately a 30 degree angle when the medication aide (MA) entered the room. - The MA did not elevate the head of the bed for Resident #2 before, during, or after medication administration. - The MA administered 10 whole tablets/capsules mixed with pudding to the resident. - The MA administered a liquid medication to the resident without thickening the liquid. - The resident grimaced but did not appear to have any problems with swallowing his medications. - The MA did not offer any liquids to Resident #2 during this observation. Interview with the medication aide on 01/21/16 at	D 358	Physican contacted to clarify any medication orders in question on 1/21/16. Medication error reports completed and physician notified on 1/21/16. Medication refresher course conducted by Registered Nurse on 1/24 & 1/25/16. Medication Aides Revalidated by Registered Nurse 1/24 & 1/25/16. Registered Nurse evaluated medication administration systems and re-established use, provided training and onsite monitoring to Care Manager and Administrator. Medication pass observations conducted by Registered Nurse on 1/25, 2/3, & 2/11/16, ongoing weekly conducted by Care Manager or qualified desginee for three months and reviewed with the Medication Aide and Administrator. Consultant pharmacist contacted to conduct onsite review, completed 1/31/16. Communication log established 1/25/16 to faciltate follow up on pending physician orders, clarifications and medications. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor medication adminstration procedures and practices during site visits.	Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16

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D 358	Continued From page 81 11:25 a.m. revealed: - The resident was usually sitting up when took his morning medications to him. - She did not usually offer any liquids with the resident's medications because he usually just took it with applesauce. - She thought there was some thickener in the resident's room if needed. - She did not usually thicken the liquid medication. A. Review of Resident #2's current FL-2 dated 01/20/16 revealed an order for Allopurinol 100mg take 2 tablets once daily. (Allopurinol is used to treat gout.) Review of the January 2016 medication administration record (MAR) revealed: - There was an entry for Allopurinol 100mg take 2 tablets once daily. - Allopurinol was scheduled to be administered at 8:00 a.m. Observation during the 8:00 a.m. medication pass on 01/21/16 revealed: - The medication aide administered one Allopurinol 100mg tablet to Resident #2 at 8:35 a.m. instead of two tablets as ordered. Review of medications on hand for Resident #2 revealed: - A vial of Allopurinol 100mg tablets dispensed on 12/29/15. - Instructions on the label to take 2 tablets once daily. Interview with the medication aide on 01/21/16 at 11:25 a.m. revealed: - She was aware Resident #2 was supposed to get 2 Allopurinol 100mg tablets.	D 358	Chart audits conducted to ensure accurate medication administration orders to include comparing physician orders, medication administration record, medications on hand and follow through on all orders. Audit was monitored by Registered Nurse. Physicians were notified of any discrepancies and facility followed through with any recommendations and orders. Completed 2/15/16 & ongoing Quality Assurance: Chart audits will be conducted at a rate of 10% per month for 3 months and 5% thereafter. Implemented 10% on 2/26/16, will be reduced to 5% on 5/26/16, ongoing. Clinical Support Team, QA Team, RDO & Registered Nurse will monitor chart audits, medication adminstration procedures and practices during site visits	Target Date 2/26/16 Target Date 2/26/16 Target Date 2/26/16

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D 358	Continued From page 82 - She usually gave the resident two Allopurinol tablets. - She overlooked the instructions to give two tablets that morning and mistakenly gave one tablet instead. Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 12:55 p.m. revealed: - The medication aides have been trained to read the labels and the MARs. - They should administer the medication according to the orders. B. Review of Resident #2's current FL-2 dated 01/20/16 revealed an order for Isosorbide Dinitrate 20mg 1 tablet 3 times a day. (Isosorbide Dinitrate is used to prevent chest pains and/or treat congestive heart failure. Isosorbide Dinitrate is typically administered 3 - 4 times daily. Isosorbide Mononitrate is used for the management of chronic stable chest pain. Isosorbide Mononitrate is sustained-released and typically administered once daily. Both medications lower blood pressure.) Review of signed physician's order for Resident #2 dated 11/17/15 also included an order for Isosorbide Dinitrate 20mg 3 times daily. Observation during the 8:00 a.m. medication pass on 01/21/16 revealed the medication aide administered Isosorbide Mononitrate 20mg tablet instead of Isosorbide Dinitrate as ordered. Review of the electronic January 2016 medication administration record (MAR) revealed: - There was an entry for Isosorbide Dinitrate 20mg take 1 tablet 3 times daily. - Isosorbide was scheduled to be administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m.	D 358		

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D 358	Continued From page 83 Review of medication on hand for Resident #2 revealed: - There was a supply of Isosorbide Mononitrate 20mg with instructions to take 1 tablet 3 times daily. - It was dispensed from a veteran's hospital on 09/24/16. - There was no supply of Isosorbide Dinitrate on hand. Review of Resident #2's record revealed no order for Isosorbide Mononitrate. Interview with the medication aide on 01/21/16 at 11:25 a.m. revealed: - She had not noticed the medication label and the MAR did not match. - If something does not match, they are supposed to check with the Resident Care Coordinator (RCC). Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 12:55 p.m. revealed: - The medication aides have been trained to read the labels and the MARs. - If something does not match, they should notify her to clarify any discrepancies. Review of Resident #2's monthly vital sign logs revealed: - The resident's monthly blood pressure reading ranged from 96/68 - 98/96 from 10/2015 - 12/2015. - The resident's monthly pulse reading ranged from 60 - 73 from 10/2015 - 12/2015. - There was no recording for January 2016. Attempts to contact the veteran's hospital provider during the survey were unsuccessful.	D 358		

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D 358	Continued From page 84 Telephone interview with the Physician's Assistant (PA) for Resident #2 on 01/27/16 revealed: - She was concerned about the resident's low blood pressure while he was receiving the once daily Isosorbide Mononitrate 3 times a day. - If the resident had been ambulatory, she felt like his blood pressure would have dropped even lower. C. Review of Resident #2's current FL-2 dated 01/20/16 revealed an order for Zoloft 100mg take ½ tablet daily. (Zoloft is an antidepressant.) Review of the January 2016 medication administration record (MAR) revealed: - There was an entry for Zoloft 100mg take 0.5 (half) tablet (50mg) by mouth daily. - Zoloft was scheduled to be administered at 8:00 a.m. Observation during the 8:00 a.m. medication pass on 01/21/16 revealed the medication aide administered one whole Zoloft 100mg tablet to Resident #2 at 8:35 a.m. instead of ½ tablet as ordered. Review of medications on hand for Resident #2 revealed: - A supply of Zoloft 100mg tablets dispensed on 12/29/15. - Instructions on the label was to take ½ tablet once daily. - Most of the tablets in the bottle were whole but there was a few ½ tablets mixed in with the whole tablets. Interview with the medication aide on 01/21/16 at 11:25 a.m. revealed: - There was both whole tablets and ½ tablets in	D 358		

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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 358	Continued From page 85 the bottle. - This confused her so she usually just gave 1 whole tablet. - She had not asked anyone to help clarify her confusion. Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 12:55 p.m. revealed: - The medication aides have been trained to read the labels and the MARs. - If something does not match, they should notify her to clarify any discrepancies. - If they have questions about a medication, they are supposed to ask the RCC. - No one had asked her any questions about Resident #2's Zoloft. D. Review of Resident #2's current FL-2 dated 01/20/16 revealed an order for Ferrous Sulfate liquid 300mg/5ml, take 5ml once daily. [Ferrous Sulfate is used to treat iron deficiency anemia (a lack of red blood cells caused by having too little iron in the body.)] Review of a physician's order dated 11/24/15 for Resident #2 also included an order for Ferrous Sulfate 300mg/5ml take 5ml (300mg) daily. Observation during the 8:00 a.m. medication pass on 01/21/16 revealed: - The medication aide administered Ferrous Sulfate 220mg/5ml and gave 5ml (220mg) to the resident instead of 300mg as ordered. - The medication aide did not thicken the liquid medication. - The resident did not appear to have any problems with swallowing the liquid medication. Review of the electronic January 2016 medication administration record (MAR) revealed:	D 358		

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D 358	Continued From page 86 - There was an entry for Ferrous Sulfate 300mg/5ml liquid, take 5ml (300mg) once daily. - Ferrous Sulfate liquid was scheduled to be administered at 8:00 a.m. Review of medication on hand for Resident #2 revealed: - There was a supply of Ferrous Sulfate 220mg/5ml with instructions to take 6.8ml once daily. - It was dispensed from a local community pharmacy on 11/24/15. - There was no supply of Ferrous Sulfate 300mg/5ml on hand. Interview with the medication aide on 01/21/16 at 11:25 a.m. revealed: - She had not noticed the medication label and the MAR did not match. - If something does not match, they are supposed to check with the Resident Care Coordinator (RCC). - She usually gave 5ml of the Ferrous Sulfate as noted on the MAR. - She had not noticed the label instructions to give 6.8ml. - They do not have any measuring devices at the facility that would accurately measure 6.8ml. Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 12:56 p.m. revealed: - The medication aides have been trained to read the labels and the MARs. - If something does not match, they should notify her to clarify any discrepancies. - She was not aware of a discrepancy with the Ferrous Sulfate liquid. - Resident #2 got some of his medications from a veteran's hospital pharmacy and some from a local independent pharmacy.	D 358		

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D 358	Continued From page 87 - The facility staff was supposed to fax his orders to the new primary pharmacy because they provide the electronic MARs for all residents. - This may have contributed to the MARs and medication label not matching. Telephone interview with a pharmacist from a local independent pharmacy on 01/27/16 at 12:40 p.m. revealed: - She thought they dispensed Ferrous Sulfate 220mg/5ml on 11/24/15 because they did not have any 300mg/5ml in stock. - They adjusted the instructions to take 6.8ml to accommodate for the difference in the strength of the medication so the resident would get 300mg as indicated on the prescription. - They have oral droppers with 0.2ml increments available at the pharmacy. - She did not recall anyone from the facility contacting them about the strength or dosage of Ferrous Sulfate. Telephone interview with the current primary pharmacy provider on 01/27/16 at 12:55 p.m. revealed: - They had just started servicing the facility on 12/01/15. - When the facility changed over to them, the pharmacy received output from the previous pharmacy's electronic MARs. - They used this information to generate the MARs. - The Ferrous Sulfate order transferred as 300mg/5ml take 5ml daily. - On 01/23/16, the facility sent information to change it to 220mg/5ml and take 6.8ml daily. Review of a lab report dated 01/07/16 for Resident #2 revealed: - The red blood cell count was 2.79 (reference	D 358		

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D 358	Continued From page 88 range 4.2 - 5.4). - The hemoglobin was 10.4 (reference range 12 - 18). - The hematocrit was 30.5 (reference range 42 - 52) Telephone interview with the Physician's Assistant (PA) for Resident #2 on 01/27/16 revealed: - The resident has a history of anemia related to cancer and cancer treatments. - The resident recently had a blood transfusion. - She was concerned that the resident was not receiving the fully prescribed dose of Ferrous Sulfate due to his chronic anemia. E. Review of Resident #2's current FL-2 dated 01/20/16 revealed an order for Lidocaine 0.5% gel apply to penis, testicles, and scrotum 4 times a day. (Lidocaine is a topical numbing medication for pain.) Review of physician's visit for Resident #2 dated 10/06/15 revealed: - The resident had a diagnoses of anogenital (venereal) warts. - There was an order for Lidocaine 0.5% topical gel apply to penis, testicles, and scrotal area 4 times a day after gently cleansing the area for pain. Review of the January 2016 medication administration record (MAR) revealed: - There was an entry for Lidocaine 0.5% topical gel apply to penis, testicles, and scrotal area 4 times a day after gently cleansing the area for pain. - Lidocaine was scheduled to be administered at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. Observation during the 8:00 a.m. medication	D 358		

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D 358	Continued From page 89 pass on 01/21/16 revealed: - The medication aide did not administered Lidocaine gel when the resident's other morning medications were administered at 8:35 a.m. - The medication aide clicked on the box of the electronic MAR indicating the Lidocaine was administered when she clicked the boxes for the other morning medications. Interview and observation with the medication aide on 01/21/16 at 11:25 a.m. revealed: - The medication aide was unable to locate any Lidocaine 0.5% gel in the cart. - She found a box with 1 tube of Lidocaine 2% gel and stated she thought that was the gel they were using for Resident #2. - She stated there was another box taped to it at one time that had the prescription label on it. - She forgot to apply the Lidocaine during the 8:00 a.m. medication pass that morning. - She usually applied the gel every day. Interview with Resident #2 on 01/21/16 at 2:00 p.m. revealed: - The medication aide had only applied Lidocaine gel to his scrotal area one time on this date (could not recall the time). - He complained of burning sensation to his penis and scrotum. - The application of Lidocaine gel did not help to relieve the burning sensation. - He was not sure of how often Lidocaine gel was applied to his scrotum. Observation of Resident #2 on 01/21/16 at 2:10 p.m. revealed: - There was no redness, open areas, or bumps on resident's penis, scrotal area, or buttocks. - There was no drainage or discharge coming from Resident #2's penis.	D 358		

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D 358	Continued From page 90 Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 12:55 p.m. revealed: - The medication aides have been trained to read the labels and the MARs. - They are supposed to give medications as ordered. - She was unsure about the resident's Lidocaine gel but she would check with the pharmacy. Telephone interview with a local independent pharmacy provider on 01/27/16 at 10:40 a.m. revealed: - They received the order for Lidocaine 0.5% gel on 10/06/15. - One of the pharmacist's got a verbal order from the prescriber to change it to 2% because they did not have 0.5% gel. - They don't usually send a copy of verbal orders taken at the pharmacy to the facility unless the facility calls and requests it. - No one had contacted the pharmacy regarding the Lidocaine change to her knowledge. Telephone interview with the current primary pharmacy provider on 01/27/16 at 12:55 p.m. revealed: - They had just started servicing the facility on 12/01/15. - When the facility changed over to them, the pharmacy received output from the previous pharmacy's electronic MARs. - They used this information to generate the MARs. - The Lidocaine 0.5% gel was transferred from the previous MARs. - They did not receive an order change for the Lidocaine to 2% until 01/21/16. F. Review of Resident #2's current FL-2 dated	D 358		

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D 358	Continued From page 91 01/20/16 revealed an order for Vitamin D 400 IU take 1 daily. (Vitamin D is a supplement used to treat low Vitamin D levels.) Review of the January 2016 medication administration record (MAR) revealed: - There was an entry for Vitamin D 400 IU take 1 daily. - Vitamin D was scheduled to be administered at 8:00 a.m. Observation during the 8:00 a.m. medication pass on 01/21/16 revealed: - The medication aide did not administered Vitamin D tablet when the resident ' s other morning medications were administered at 8:35 a.m. - The medication aide clicked on the box of the electronic MAR indicating the Vitamin D was administered when she clicked the boxes for the other morning medications. Review of medications on hand on 01/21/16 revealed there was a bottle of over-the-counter Vitamin D 400 IU with the resident's name written on it. Interview with the medication aide on 01/21/16 at 11:25 a.m. revealed: - She usually administered Vitamin D to the resident with the other 8:00 a.m. medications. - She thought she overlooked it this morning because it was on the bottom of the computer screen on the electronic MAR. Interview with the Resident Care Coordinator (RCC) on 01/21/16 at 12:55 p.m. revealed: - The medication aides have been trained to read the labels and the MARs. - They are supposed to give medications as	D 358		

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D 358	Continued From page 92 ordered. 2. Review of Resident #1's current FL-2 dated 09/18/15 revealed the diagnoses included chronic paranoid schizophrenia and hypertension. Review of the Resident Register revealed Resident #1 was admitted to the facility on 09/18/15. A. Review of Resident #1's current FL-2 dated 09/18/15 revealed: - There was an order for Abilify 5mg take 1 and ½ tablets daily. (Abilify is an antipsychotic.) - There was no other medication orders listed. Review of a physician's order dated 09/22/15 for Abilify 5mg once daily. Review of Resident Care Notes for Resident #1 revealed: - 09/23/15: Resident called 911 herself and stated she wanted to go to the emergency room (ER). She felt she was a danger to herself. Staff noted they would follow and fax a note to the physician. Review of Resident #1's hospital discharge forms dated 09/23/15 revealed: - The resident's diagnoses included schizophrenia and anxiety reaction. - The resident was to follow up with physician in 2 to 3 days for worsening of condition. Review of a prescription order from the hospital dated 09/23/15 revealed: - The prescription order was for Ativan 0.5mg take 1 tablet every 8 hours as needed. - There was no indication listed on the prescription.	D 358		

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D 358	Continued From page 93 Review of the September 2015 medication administration record (MAR) revealed: - The order for Ativan was not included on the MAR. - No Ativan was documented as administered to Resident #1 in September 2015. Review of Resident Care Notes for Resident #1 revealed: - 10/06/15: Resident refused to go to bed and sat up in the private dining room all night. - 10/07/15: Resident did not sleep in her room again tonight because she did not want to and the resident stated she was not supposed to be here. - 10/18/15: Resident did not sleep any last night and walked most of the night. - 10/19/15 (6am): Resident was seen smoking in her room by staff. Staff reported to Administrator. Review of the October 2015 MAR revealed: - The order for Ativan was not included on the MAR. - No Ativan was documented as administered to Resident #1 in October 2015. Review of Resident Care Notes for Resident #1 revealed: - 11/02/15 (1am): Staff went down hall and when they passed the resident's room, the smell of smoke was very strong. Staff opened door and the resident was smoking cigarettes in the room. Staff asked the resident not to be smoking in the building. The resident said everybody else does it and the resident said she did it on purpose. - 11/03/15 (8pm): Resident has been "a little agitated and antsy" tonight. She was in TV room earlier sleeping on pillow cushions in the corner. Review of a mental health visit progress note	D 358		

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D 358	Continued From page 94 dated 11/10/15 revealed: - This was the resident's initial visit with the mental health Nurse Practitioner (NP). - Staff reported the resident as compliant with medication. - NP noted the resident was in labile mood. - NP noted the resident was seen in the ER last month for increased agitation, "prn (as needed) Ativan written for, however was not started". - NP noted resident initially agreed to be seen by NP but the resident slammed the door in the NP's face. - NP increased the Abilify to 10mg daily in the morning and noted for the resident to start psychiatric therapy and follow up in 4 weeks. Review of a mental health therapy visit dated 11/24/15 revealed: - Resident reported symptoms of anxiety and says she "worries a lot". - The provider reviewed calming strategies with the resident and encouraged her to practice them at least twice a day to aide in managing her symptoms of anxiety. - Provider noted the resident's psychiatric condition was generally unchanged. Review of Resident Care Notes for Resident #1 revealed: - 11/25/15 (2:30pm): Resident called 911 to come take her to the hospital because she felt like she needed to be committed in a mental facility. - 11/25/15 (2nd shift): Resident returned from the hospital with no new orders. - 11/27/15 (1st shift): Resident called the police again. She is under the impression that someone is planting drugs in her room. She has not seen any but wants the officers to search her room.	D 358		

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D 358	Continued From page 95 Review of the November 2015 MAR revealed: - The order for Ativan was not included on the MAR. - No Ativan was documented as administered to Resident #1 in November 2015. Review of Resident Care Notes for Resident #1 revealed: - 12/21/15 (1st shift): Resident was missing at 8:45 a.m. Medication aide went to give morning medications and resident was not in her room. Checked facility and outside of building. Notified Administrator. Full search of facility and outside of building was done. Called 911 to report missing resident. Another search was done by police. Resident was spotted by officer by a local pizza restaurant in town. Resident was picked up and brought back to the facility. Review of the December 2015 MAR revealed: - The order for Ativan was not included on the MAR. - No Ativan was documented as administered to Resident #1 in December 2015. Review of Resident Care Notes for Resident #1 revealed: - 01/02/16 (1st shift): Resident #1 got in a physical altercation with another resident. Resident #1 was coming out of activity room when the other resident accidentally bumped into Resident #1. As Resident #1 was walking away, the other resident struck Resident #1 in the back. Resident #1 reacted by striking the other resident twice in the arm. Resident #1 was sent to ER for an evaluation but returned before being seen. Staff will monitor and keep residents apart. - 01/15/16: At 3:00pm, resident took a metal bar and broke the glass out of the 300 hall door from the outside. Police were called along with the	D 358		

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D 358	Continued From page 96 physician and the mental health provider's office. Police stayed with the resident until Involuntary Commitment papers were filed. The resident was removed from the facility at 4:00pm. - 01/15/16: Resident is out of the facility tonight. She is staying the night in the hospital. - 01/19/16: The resident returned from the hospital where she was given Ativan. She was seen by mental health provider who adjusted her medications. She seems to be calmer since she returned to the facility. Review of Resident Care Notes for Resident #1 revealed: - 01/21/16 (3rd shift): Resident remained awake throughout the night packing her clothes. - 01/23/16 (10:30pm): Resident went outside to smoke a cigarette and she said she was going to walk around front. Staff found her by the trash can. - 01/25/16: Resident has been discharged to the facility she chose to go to. Review of the January 2016 MAR revealed: - The order for Ativan was not included on the MAR. - No Ativan was documented as administered to Resident #1 in January 2016. Review of pharmacy dispensing records from the previous primary pharmacy provider revealed no Ativan was dispensed to Resident #1 from admission on 09/18/15 - 11/30/15 (end of pharmacy service date). Interview with the current primary pharmacy provider on 01/27/16 at 12:55 p.m. revealed they have never received any orders for Ativan or dispensed any Ativan for Resident #1.	D 358		

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D 358	Continued From page 97 Interview with a Senior Executive Director (SED) from a sister facility on 01/26/16 at 12:13 p.m. revealed: - There was a fax confirmation sheet that indicated a copy of the Ativan order was faxed on 09/23/15. - The fax number did not match the fax number to the pharmacy. - They had been unable to identify who the fax number belonged to on the confirmation sheet. - She did not know why the Ativan order was never implemented. Interview with the Senior Director of Operations of Clinical Services on 01/26/16 at 4:05 p.m. revealed: - They had no explanation for why the prn Ativan order dated 09/23/15 was not implemented. - She had been unable to determine who the order was faxed to because the fax number on the confirmation sheet did not match the fax number for the previous or current pharmacy. Interview with the Resident Care Coordinator (RCC) on 01/27/16 at 1:30 p.m. revealed: - The facility started using a new pharmacy on 12/01/15. - The medications do not come on a cycle fill and have to be ordered on demand. - Staff are supposed to reorder medications when there is a 5 day supply left on hand. - If a medication was not received or was unavailable, the medication aides were supposed to notify the RCC. - She was not aware Resident #1's Abilify had been unavailable. - She would have notified the physician if she had been aware. Interview with a first shift medication aide on	D 358		

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D 358	Continued From page 98 01/27/16 at 2:05 p.m. revealed: - Resident #1 wanted to leave the facility. - Resident #1 had an altercation with another resident. - Resident #1 broke out a window at the facility. - Resident #1 called 911 on more than one occasion. - Most of the time when she worked, Resident #1's behavior was okay. - She was not aware of the resident ever having an order for Ativan. - The resident did not have a "prn" (as needed) medication for behaviors. - Resident #1 only had scheduled medications. - Most of the time, she was able to redirect Resident #1 if she became agitated. Interview with a second shift medication aide on 01/27/16 at 5:00 p.m. revealed: - Resident #1 would pace and curse and fuss with other residents when she was agitated. - Resident #1 would have episodes of agitation at least twice a week when she was working. - The resident only had scheduled medications. - There was no "prn" (as needed) medication to give Resident #1 when she was agitated. - Resident #1 was sometimes hard to redirect and it would have helped to have a "prn" medication to give the resident when she was agitated. - She was not aware of anyone contacting Resident #1's physician to get an order for a "prn" medication. - She had no explanation for not contacting the physician. - She was not aware of a "prn" order for Ativan for Resident #1. Telephone interview with the Owner/Director of the psychiatric provider's office for Resident #1 on	D 358		

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 358	Continued From page 99 01/27/16 at 12:15 p.m. revealed: - The Nurse Practitioner who had evaluated and treated Resident #1 was not available for interview. - The Owner was familiar with Resident #1 and the resident had always had typical behavior problems. - Resident #1 was increasingly agitated. - Resident #1 had been to the hospital recently and the hospital providers said nothing was wrong with the resident. - He was not aware of Resident #1 having any physical altercations with other residents. - He did not know anything about an Ativan order. - He thought the RCC had contacted them about the resident missing some doses of Abilify but he did not know the dates. Review of a note faxed to the physician on 01/24/16 revealed: - On 09/23/15, Resident #1 received an order for Ativan 0.5mg every 8 hours as needed but the order was never put on the MAR or administered. - Facility asked if the physician wanted to continue or discontinue the order for Ativan. - Physician noted on 01/25/16 to continue the Ativan order. B. Review of Resident #1's current FL-2 dated 09/18/15 revealed there was an order for Abilify 5mg take 1 and ½ tablets daily. (Abilify is an antipsychotic.) Review of the Resident Register revealed Resident #1 was admitted to the facility on 09/18/15. Review of a medication release form dated 09/18/15 from Resident #1's former facility	D 358		

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D 358	Continued From page 100 revealed: - The resident was admitted on 09/18/15 with 4 and ½ Abilify 5mg tablets. - The instructions on the form was to take 1 and ½ tablets daily. - The 4 and ½ tablets would have provided a 3 day supply at that dosage. Review of a physician's order dated 09/22/15 revealed an order for Abilify 5mg once daily. Review of the September 2015 medication administration records (MARs) revealed: - There was an entry for Abilify 5mg take 1 and ½ tablet daily at 9:00 a.m. - Staff had documented 1 and ½ tablets were administered from 09/19/15 - 09/22/15 for a total of 4 days. - There was an entry for Abilify 5mg take 1 tablet daily at 9:00 a.m. - Abilify 5mg was documented to start on 09/23/15. - Abilify was not administered on 09/23/15 and 09/24/15 due to the medication being unavailable. Review of pharmacy dispensing records revealed there was 30 Abilify 5mg tablets dispensed on 09/24/15. Review of Resident Care Notes for Resident #1 revealed: - 09/23/15: Resident called 911 herself and stated she wanted to go to the emergency room (ER). She felt she was a danger to herself. Staff noted they would follow and fax a note to the physician. Review of Resident #1's hospital discharge forms dated 09/23/15 revealed: - The resident's diagnoses included	D 358		

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D 358	Continued From page 101 schizophrenia and anxiety reaction. - The resident was to follow up with physician in 2 to 3 days for worsening of condition. Review of Resident Care Notes for Resident #1 revealed: - 10/06/15: Resident refused to go to bed and sat up in the private dining room all night. - 10/07/15: Resident did not sleep in her room again tonight because she did not want to and the resident stated she was not supposed to be here. - 10/18/15: Resident did not sleep any last night and walked most of the night. - 10/19/15 (6am): Resident was seen smoking in her room by staff. Staff reported to Administrator. Review of the October 2015 MARs revealed: - There was an entry for Abilify 5mg take 1 tablet daily at 9:00 a.m. - Abilify was not administered on 10/21/15 and 10/22/15 due to the medication being unavailable. Review of pharmacy dispensing records revealed there was 30 Abilify 5mg tablets dispensed on 10/20/15. Telephone interview with the Owner/Director of the psychiatric provider's office for Resident #1 on 01/27/16 at 12:15 p.m. revealed: - The Nurse Practitioner who had evaluated and treated Resident #1 was not available for interview. - The Owner was familiar with Resident #1 and the resident had always had typical behavior problems. - Resident #1 was increasingly agitated. - Resident #1 had been to the hospital recently and the hospital providers said nothing was wrong with the resident. - He thought the RCC had contacted them about	D 358		

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D 358	Continued From page 102 the resident missing some doses of Abilify but he did not know the dates. Interview with the Resident Care Coordinator (RCC) on 01/27/16 at 1:30 p.m. revealed: - The facility started using a new pharmacy on 12/01/15. - The medications do not come on a cycle fill and have to be ordered on demand. - Staff are supposed to reorder medications when there is a 5 day supply left on hand. - If a medication was not received or was unavailable, the medication aides were supposed to notify the RCC. - She was no aware Resident #1's Abilify had been unavailable. - She would have notified the physician if she had been aware. 3. Review of Resident #4's current FL-2 dated 02/04/15 revealed diagnoses included atrial fibrillation, hypertension, and chronic obstructive pulmonary disease. A. Review of Resident #4's current FL-2 dated 02/04/15 revealed there was an order for Potassium Chloride 20mEq take 1 tablet daily. (Potassium Chloride is a potassium supplement used to treat low potassium levels.) Review of the December 2015 medication administration record (MAR) revealed: - There was an entry for Potassium Chloride 20mEq take 1 tablet daily with a meal and it was scheduled to be administered at 4:00 p.m. - It was documented as "withheld per doctor orders" on 12/10/15, 12/11/15, 12/14/15, and 12/15/15. Interview with the medication aide on 01/17/16 at	D 358		

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D 358	Continued From page 103 10:20 a.m. revealed: - If staff documented the Potassium was withheld, it was not given. - She did not recall anything about orders to withhold the Potassium. Review of pharmacy dispensing records from the former primary pharmacy revealed: - They dispensed 30 Potassium Chloride 20mEq tablets on 09/02/15. - They dispensed 30 Potassium Chloride 20mEq tablets on 10/01/15. - They dispensed 30 Potassium Chloride 20mEq tablets on 11/01/15. - They did not dispense anymore Potassium Chloride after this date. Review of pharmacy dispensing records from the current primary pharmacy revealed: - No Potassium Chloride tablets were dispensed until 12/15/15. - Fourteen Potassium Chloride 20mEq tablets were dispensed on 12/15/15. Interview with the Resident Care Coordinator (RCC) on 01/27/16 at 11:58 a.m. revealed: - She was not aware of any orders to hold Resident #4's Potassium. - She would check on it. Interview with a Senior Executive Director (SED) from a sister facility on 01/27/16 at 11:50 a.m. revealed: - They checked and there was never any orders to hold the Potassium. - The Potassium was dispensed on 11/01/15 and not again until 12/15/15. - The resident would have run out of Potassium around 12/01/15. - Staff chose the wrong reason on the drop down	D 358		

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D 358	Continued From page 104 menu on the electronic MARs. - They should have documented the medication as unavailable. - She thought the Potassium did not get reordered timely when they changed to a new pharmacy on 12/01/15. B. Review of Resident #4's current FL-2 dated 02/04/15 revealed there was an order for Vitamin D 50,000 units once a week. (Vitamin D is a vitamin supplement used to treat low Vitamin D levels.) Review of the September 2015 medication administration record (MAR) revealed: - There was an entry for Vitamin D 50,000 units take 1 capsule every week with a meal and it was scheduled to be administered at 8:00 a.m. - There was only one dose documented on 09/02/15. - No reasons for the omissions for the other weekly doses were documented. Review of the October 2015 MAR revealed: - There was an entry for Vitamin D 50,000 units take 1 capsule every week with a meal and it was scheduled to be administered at 8:00 a.m. - There was only one dose documented on 10/28/15. - No reasons for the omissions for the other weekly doses were documented. Review of the November 2015 MAR revealed: - There was an entry for Vitamin D 50,000 units take 1 capsule every week with a meal and it was scheduled to be administered at 8:00 a.m. - There was only one dose documented on 11/25/15. - No reasons for the omissions for the other weekly doses were documented.	D 358		

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D 358	Continued From page 105 Review of the December 2015 and January 2016 MARs revealed: - There was no entry for Vitamin D on either MAR. - No Vitamin D was documented as administered in December or January. Review of Resident #4's record revealed no order to discontinue the Vitamin D. Review of medications on hand on 01/27/16 at 10:10 a.m. revealed: - There was one supply of Vitamin D 50,000 units in the medication cart with the resident's other actively used medications. - Four Vitamin D 50,000 units capsules were dispensed on 10/28/15 and 2 of the 4 capsules remained in the bubble card. Interview with the medication aide on 01/17/16 at 10:20 a.m. revealed: - The Vitamin D was not listed on the MAR so she did not administer the Vitamin D. - She did not see Vitamin D listed in the active medications or discontinued medications on the electronic MAR. - She did not remember administering any Vitamin D to the resident. - She did not know why there was a supply in the medication cart. Interview with Resident #4 on 01/26/16 at 3:50 p.m. revealed: - She used to take Vitamin D once a month but she does not get it anymore. - She did not know why she stopped receiving Vitamin D. Review of pharmacy dispensing records from the	D 358		

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D 358	Continued From page 106 former primary pharmacy revealed: - Four Vitamin D 50,000 unit capsules were dispensed on 07/03/15. - Four Vitamin D 50,000 unit capsules were dispensed on 09/02/15. - Four Vitamin D 50,000 unit capsules were dispensed on 10/28/15. Interview with the Resident Care Coordinator (RCC) on 01/27/16 at 11:58 a.m. revealed: - If a medication order is discontinued, the medication aide on duty was supposed to fax the order to the pharmacy. - The pharmacy would remove the order from the electronic MARs. - The medication aide on duty was supposed to remove the discontinued medication from the medication cart and return it to the pharmacy. Interview with a Senior Executive Director (SED) from a sister facility on 01/27/16 revealed: - When medication orders are entered into the electronic MARs, a code is entered for how often the medication should be set up on the MAR to be administered. - It appeared the Vitamin D was set up to pop up on the screen monthly instead of weekly as ordered. - Facility staff was responsible for checking this information before accepting and approving order on the MARs. - It looks like no one caught the error. - They would contact the physician regarding the Vitamin D. Review of an order written by the physician's assistant on 01/27/16 revealed to "d/c (discontinue) Vitamin D 50000 as of 12/1/15". Interview with the physician's assistant (PA) on	D 358		

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D 358	Continued From page 107 01/27/16 at 2:09 p.m. revealed: - Staff notified her today that Resident #4 had not received the Vitamin D since November 2015. - She wrote a retroactive order to discontinue the Vitamin D as of 12/01/15 because she assumed the previous provider had only ordered it for a certain number of weeks. - She had been the resident's provider since 10/27/15. - She usually ordered Vitamin D once a week for 12 weeks. - She did not know how long the resident had been taking Vitamin D. - Her records showed the last Vitamin D level was 8.4 (reference range 30 -100) on 02/13/15. - She planned to check the resident's Vitamin D level when her next labs for her blood thinning medication were drawn. _____ Review of the facility's plan of protection dated 01/21/16 revealed: - The identified medication aide was removed from the medication cart. - Physician was contacted to clarify medication orders in question. - Medication error reports were completed on 01/21/16 and the physician was notified. - A refresher course on medication administration will be provided and all medication aides will be revalidated. - The Resident Care Coordinator (RCC) and Administrator will immediately conduct a physician order / medication administration record (MAR) to cart audit. - Random medication pass audits will be conducted weekly by the RCC for 3 months and reviewed with medication aide and Administrator. - RCC in coordination with Administrator will audit 10% of the charts each month for 3 months and	D 358		

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D 358	Continued From page 108 5% thereafter. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2016.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure action was taken in response to medication reviews and documented for 1 of 5 residents (#1) sampled for review related to clarifying an order for an anxiety medication for a resident with symptoms of agitation and anxiety. The findings are: Review of Resident #1's current FL-2 dated 09/18/15 revealed the resident's diagnoses included chronic paranoid schizophrenia and hypertension. Review of the Resident Register revealed Resident #1 was admitted to the facility on 09/18/15. Review of Resident #1's most recent medication review dated 11/23/15 revealed: - Pharmacist noted the resident was given an order for Ativan 0.5mg every 8 hours as needed on 09/23/15 but it was not on the current	D 406	Consultant pharmacist contacted to conduct pharmacy review. Completed on 1/31/16. Care Manager and Administrator will follow through with pharmacy review within 1 week of receipt and document action taken. Registered Nurse will monitor for compliance. Target Date 3/12/16 Clinical Support Team, QA Team, RDO & Registered Nurse will monitor to ensure pharmacy reviews are reviewed and follow through timely during site vists. Target Date 3/12/16	

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D 406	Continued From page 109 medication administration record (MAR). - There was no order in the record to discontinue the Ativan. - Please clarify. Review of Resident #1's record revealed no documentation the medication review recommendations had been followed up. Review of Resident Care Notes for Resident #1 revealed: - 09/23/15: Resident called 911 herself and stated she wanted to go to the emergency room (ER). She felt she was a danger to herself. Staff noted they would follow and fax a note to the physician. Review of Resident #1's hospital discharge forms dated 09/23/15 revealed: - The resident's diagnoses included schizophrenia and anxiety reaction. - The resident was to follow up with physician in 2 to 3 days for worsening of condition. Review of a prescription order from the hospital dated 09/23/15 revealed: - The prescription order was for Ativan 0.5mg take 1 tablet every 8 hours as needed. - There was no indication listed on the prescription. Review of the September 2015 - January 2016 MARs revealed: - The order for Ativan was not included on the MARs. - No Ativan was documented as administered to Resident #1. Review of Resident Care Notes from 10/06/15 - 01/15/16 for Resident #1 revealed:	D 406		

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D 406	Continued From page 110 - The resident refused to go to bed and would stay up all night and walk around the facility on at least 3 occasions (10/06/15, 10/07/15, 10/18/15). - The resident was seen smoking in her room by staff on at least two occasions (10/19/15, 11/02/15). - The resident was "a little agitated and antsy" on 11/03/15. - The resident called 911 and / or the police on at least two occasions (11/25/15, 11/27/15). - The resident was missing from the facility on 12/21/15 at 8:45 a.m. and found later by a police officer near a local pizza restaurant. - The resident got into a physical altercation with another resident on 01/02/16. - The resident took a metal bar and broke the glass out of the 300 hall door from the outside on 01/15/16. Telephone interview with the Consultant Pharmacist (CP) on 01/27/16 at 9:55 a.m. revealed: - She completed the medication regimen reviews on 11/23/15. - She emailed the medication review recommendations / summary to the facility to the shared file which goes to the Administrator. - If the file is unopened for 30 days, the software system would not allow the file to be opened. - She was unaware the facility was not able to open the file until last week on 01/20/16 when the Administrator called her. - The Administrator said she could not open the file and asked the CP to resend the medication review recommendations on 01/20/16. - She emailed the medication review recommendations from 11/23/15 again to the Administrator on 01/20/16. - No one had contacted her prior to 01/20/16 about the recommendations.	D 406		

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D 406	Continued From page 111 - She had not had any problems in the past with the facility being unable to open the email file with the recommendations. Interview with the Administrator on 01/26/16 at 3:12 p.m. revealed: - She received the medication review recommendations via email from the CP on the same day the reviews were completed, 11/23/15. - She could not open the file and the message displayed was "access denied". - She did not recall contacting the CP to resend the recommendations until the survey team requested the summary on 01/20/16. Review of a note faxed to the physician on 01/24/16 revealed: - On 09/23/15, Resident #1 received an order for Ativan 0.5mg every 8 hours as needed but the order was never put on the MAR or administered. - Facility asked if the physician wanted to continue or discontinue the order for Ativan. - Physician noted on 01/25/16 to continue the Ativan order.	D 406		
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 interview, the facility failed to assure the right for each resident to be treated with respect, consideration, dignity, and full recognition of his or her individuality as related to	D911	Resident Rights reviewed with all staff on 1/22/16. Ombudsman conducted Resdient Rights training on 2/12/16.	Target Date 3/12/16 Target Date 3/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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
D911	Continued From page 112 staff's treatment of residents. The findings are: Based on interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to the tone and manner in which staff members spoke to residents, including a staff member (Staff B) who washad previously been reported for being disrespectful to residents. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation).]	D911	Administrator attended Resident Council to provide avenues for voicing concerns to include the compliant./suggestion box established 12/31/15 with options for anonymity. Healthcare Personnel Registry reporting requiremetns reviewed by Registered Nurse on 1/26/16. Resident Rights will be reviewed on a quarterly basis with all staff. (Refer to D338, Type B Violation)	Target Date 3/12/16 Target Date 3/12/16 Target Date 3/12/16
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 every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to personal care and supervision, health care, nutrition and food service, and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide increased supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 5 sampled residents (#1, #3), one with multiple falls, including falls with injuries	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	01/27/2016

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D912	Continued From page 113 requiring Emergency Medical Services (#3), and one eloping from the facility by going out a window, and using a bar to break the glass out of an exit door (#1). [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 2. Based on observation, interview, and record review, the facility failed to assure referral and follow-up to meet the routine and acute care needs for 3 of 5 sampled residents (#1, #2, #3), one resident who had multiple falls with fractures, abrasion, and laceration injuries (#3), one resident who required swallowing precautions and honey-thickened liquids, hematology lab work, and occupational therapy following a hospitalization (#2), and one resident who eloped from the facility and was having behaviors (#1). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 3. Based on observation, interview and record review, the facility failed to assure thickened liquids were prepared and served as ordered by the physician for 1 of 1 sampled residents (#2) with orders for thickened liquids and history of aspiration pneumonia. [Refer to Tag D310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation).] 4. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 1 of 4 residents (#2) observed during the medication passes, including errors with medications for high blood pressure, depression, gout, anemia, vitamin D deficiency, and topical pain relief and 2 of 5 residents (#1, #4) sampled for record review	D912	Refer to Plan of Correction D270 Type A2 Violation Personal Care and Supervision Refer to Plan of Correction D273 Type A 2 Violation Health Care Refer to Plan of Correction D310 Type B Nutrition and Food Service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	01/27/2016

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D912	Continued From page 114 related to errors with medications for anxiety/agitation, psychosis, and low potassium and Vitamin D levels. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]	D912	Refer to Plan of Correction D 358 Type A 2 Medication Administration	