Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL046004	A. BUILDING: _____ B. WING _____	C 02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHOSKIE HOUSE	407 LOFTIN LANE AHOSKIE, NC 27910

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 2/11/2016 - 2/12/2016.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure the water temperatures at the facility ranged from 100-116 degrees for 7 water fixtures in the resident's rooms on the 200 hall and the 400 hall. The findings are: Observation in resident room 400 on 02/11/2016 at 12:15 PM revealed a shower with a hot water temperature of 96 degrees. Observation in resident room 405 on 02/11/2016 at 12:10 PM revealed: -A sink with a hot water temperature of 96 degrees. -A shower with a hot water temperature of 96 degrees.	D 113	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 solely as a matter of compliance with State law. Building Maintenance Service (BMS) technician will record water temperatures when onsite to assure Resident accessible water temperature are within the required range of 100-116 F. If adjustment is required, the technician will document water temperatures to ensure stabilization to required range. BMS will inform Executive Director of status during adjustment.	2/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra J. Planty, ED — TITLE — (X6) DATE: 03/16/16

Renewed & Accepted SM 3/17/16

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D 113	Continued From page 1 Observation in resident room 215 on 02/11/2016 at 12:10 PM revealed a shower with a hot water temperature of 76 degrees Observation of a sink in resident room 401 on 02/12/2016 revealed: -At 8:20 AM a hot water temperature of 76 degrees. -At 9:05 AM a hot water temperature of 86 degrees. -At 9:05 AM a hot water temperature of 86 degrees was also obtained by Maintenance using his digital thermometer. Observation of a sink in resident room 403 on 2/12/2016 at 9:20 AM revealed a hot water temperature of 92 degrees. Observation of a sink in resident room 405 on 2/12/2016 at 8:25 AM revealed a hot water temperature of 90 degrees. Observation of a sink in resident room 208 on 02/12/2016 at 8:35 AM revealed a hot water temperature of 88 degrees. Observation of a sink in resident room 213 on 02/12/2016 at 8:38 AM revealed a hot water temperature of 88 degrees. Observation of the shower in resident room 215 on 02/12/2016 revealed: -At 9:40 AM a hot water temperature of 78 degrees. -At 10:35 AM a hot water temperature of 76 degrees. Interview with a resident with a room on 200 hall on 2/11/2016 at 9:10 AM revealed: -The water temperature in the shower never got	D 113	Executive Director will ensure water temperatures are obtained at least twice weekly in addition to the weekly BMS monitoring. Executive Director will report any water temperatures outside of the required range of 100-116F to the BMS Technician to make any necessary adjustments. The Executive Director provided training to the staff on conducting the "wrist test" prior to providing resident personal care. Maintenance contractor approved for installation of new hot water heater.	3/18/16 3/18/16 3/28/16

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D 113	Continued From page 2 hot. -She told the Administrator about the temperature of the water in the shower a couple months ago. -The Administrator wrote it down and said she would tell Maintenance. -She did not know if they came and checked the water temperature. -The water temperature of the sink was hot enough but took a while to warm up. Interview with a Personal Care Aide (PCA) on 2/12/2016 at 10:00 AM revealed the water would become cooler in the mornings after all the showers were given. Interview with a second PCA on 2/12/2016 at 9:20 AM revealed: -The water on the 400 hall was always cooler than the other halls. -There were certain rooms on the 200 hall that the water temperature does not get hot. -She did not think that the water temperature in some of the resident ' s room was hot enough to use. Interview with Maintenance staff on 2/12/2016 at 9:00 AM revealed: -He checked the water temperatures in the facility every week to ensure the temperature was between 100 degrees and 116 degrees. -He recorded the water temperatures in a binder kept in the medication room. -He used a digital thermometer. -He would choose random rooms each week to check the water temperature. -He had noticed this morning (2/12/2016) when he went to check the water temperatures that they were running low. -If he checked the water temperature and it was low, he would not record that number in the log	D 113		

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D 113	Continued From page 3 book and would recheck the temperature in 1 hour. -He did not know he should record both temperature readings. -If the water temperature was not within range upon the recheck he would adjust the boiler. -He had not had any problems since the summer season when the water was running to hot and he adjusted the boiler. Observation of the Maintenance staff on 2/12/2016 at 9:00 AM revealed the digital thermometer used by the facility and the thermometer used by surveyor, obtained the same temperature readings. Interview with the Administrator on 2/12/2016 at 10:30 AM revealed: -She was just informed by Maintenance that the water temperatures were low. -Maintenance was contracted by the facility. -Maintenance was going to contact his boss to obtain further instructions to correct the water temperatures. Review of the facility's water temperature logs revealed: -There was documentation of water temperatures being checked every week by Maintenance. -The last recorded water temperatures were checked on 2/4/2016 at 1:00 pm. -The last recorded water temperatures on 2/4/2016 ranged from 101.8 degrees - 111.4 degrees in the residents' rooms. -The 200 hall ranges were 105.9 degrees - 107.3 degrees on 2/4/2016. -The 300 hall ranges were 107.6 degrees - 111.4 degrees on 2/4/2016. -The 400 hall ranges were 101.6 degrees - 102.3 degrees on 2/4/2016.	D 113		

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D 113	Continued From page 4 -The log did not specify how many fixtures should be checked. -There were only six to ten fixtures being checked each week. -There were some of temperatures on the logs that had temperatures that were out of the 100-116 degree range. -There was no documentation that those temperatures were reported or how they were corrected. Interview with Maintenance on 2/12/2016 at 11:50 AM revealed he would begin recording the temperature obtained when first checked and the recheck results if the temperature was out of the range of 100-116 degrees.	D 113		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure table service included a non-disposable place setting consisting of at least a knife, fork, and spoon, in the dining room for residents that required feeding assistance.	D 287	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 solely as a matter of compliance with State law. It is the policy of Ahoskie House to provide adequate table service to include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers unless documented exceptions have been made based on individual need or preference.	

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D 287	Continued From page 5 The findings are: Observation of the lunch meal in the facility dining room on 2/11/16 at 12:27pm revealed: -Twelve residents were seated at a long table along the wall on the right side of the dining room. -Table service included one napkin, a plastic spoon, and beverage containers of water and tea. -Staff served the lunch meals on non-disposable plates. -Interview with a Personal Care Aide (PCA) on 2/11/15 at 12:30pm revealed the residents seated at the long table were the "feeders;" the residents who require feeding assistance. Observation of a staff feeding a resident in room #209 on 2/11/16 at 1:00pm revealed: -The resident was sitting up in a Geri-chair. -The resident was non-verbal. -The staff was feeding the resident with a plastic spoon. -No other disposable items were being used. Interview with the staff on 2/11/16 at 1:02pm revealed: -Staff usually get the resident up and assist the resident with eating in the dining room. -The residents who required assistance with feeding were fed with plastic spoons so that the residents did not bite the spoons. Interview with the Dietary Manager/Business Office Manager on 2/11/16 at 2:00 pm revealed: -The residents who sit at the back table required feeding assistance from the staff. -Those residents were fed with plastic spoons because the residents tended to bite the silverware. -It was done for the residents' safety.	D 287	Executive Director instructed dietary and nursing to use only non-disposable place settings. Executive Director will review the requirements/rule area will all nursing and dietary staff. Executive Director, Resident Care Manager and Dietary Manager will monitor meal service to ensure non-disposable table settings are being used unless otherwise documented based on need or preference.	2/12/16 3/22/16 3/22/16 ongoing

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D 287	Continued From page 6 -All the other residents got non-disposable silverware, including a knife, fork, and spoon. Observation of the supper meal in the facility dining room on 2/11/16 at 5:15pm revealed fourteen residents seated at the long table who required feeding assistance and were provided table service that consisted of a napkin, a plastic spoon, and beverage containers of water and tea. Observation of a resident who was not seated at the long table/feeding assistance table on 2/11/16 at 5:30pm revealed: -A dietary staff told a second dietary staff that the resident was not supposed to have a fork. -The second dietary staff took the non-disposable fork out of the resident's hand and told the resident to use the plastic spoon. -The resident was served a Regular diet supper meal. Interview with the Dietary Manager/Business Office Manager on 2/11/16 at 5:40pm revealed: -The resident whose fork was taken from her took utensils, mainly knives to her room. -The resident's roommate was afraid of the resident, so the resident was only supposed to have a plastic spoon. -No additional interventions had been attempted to keep the resident from taking the utensils from the dining room. -A knife was found in the resident's room yesterday. Interview with the Memory Care Coordinator on 2/12/16 at 7:55am revealed: -The residents were fed with plastic spoons for their safety. -The facility had been doing that for years, ever since the facility switched to a Special Care Unit.	D 287		

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D 287	Continued From page 7 -There was a resident who put silverware in her pockets and the family was aware and okay with using plastic spoons. -The doctor was asked if it was okay for the residents to be served with plastic spoons. -The doctor approved it but there was no documentation of that. -The facility tried to keep the residents' safety the priority.	D 287		
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: Based on observations, interviews and record reviews the facility failed to ensure 1 of 7 residents (#2) was treated with respect, consideration, and dignity, related to the bedroom door being locked preventing the resident from freely entering and exiting the room without the need to ask for staff assistance. The findings are: Review of Resident #2's FL-2 dated 9/29/15 revealed: -Diagnoses Including Alzheimer's dementia; Unspecified Hypothyroidism; Unspecifies Hyperlipidemia; Pernicious Anemia. -Resident is intermittently disoriented. -Incontinent of bladder and bowels at times. Review of Resident #2's Resident Register revealed an admission date of 10/1/15.	D 338	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. It is the policy of Ahoskie House to assure that the rights of all residents are guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	

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D 338	Continued From page 8 Review of Resident #2's Care Plan dated 10/1/15 revealed: -The resident required limited assistance with transfers and ambulation. -She required extensive assistance with toileting. -She required limited assistance with dressing. Observation of Resident #2 on 2/11/16 at 5:50 pm revealed Resident #2 standing at the door to the front office talking to staff. Interview with a Medication Aide (MA) on 2/11/16 at 5:50 pm revealed: -Resident #2 wants to go to her room. -Resident #2's room is locked when residents are not in the room. -Resident #2 is allowed in the room with staff when she has to use the bathroom. -Resident #2 is not allowed in her room after eating dinner because staff wants her food to digest. -Resident #2 had a "tendency" to undress and get into bed after eating her meals. Interview with Resident #2 on 2/11/16 at 5:55 pm revealed: -Resident #2 appeared to be upset because she wanted to go to sleep. -Resident #2 stated "I want to go to bed" and she did not know who to talk to. Observation of Resident #2's bedroom door on 2/11/16 at 6:00 pm revealed that it was locked and unable to be opened without a key. Observation on 2/11/16 at 6:00 pm revealed that staff guided Resident #2 to sit in a chair in the area in the front of the facility.	D 338	Executive Director provided education and training on Resident's right to freely enter and exit their room without hindrance or requiring staff assistance. Documentation of training available upon request. Resident room doors unlocked immediately for resident access at will. Door will remain unlocked unless resident desires to exercise their right to privacy. Executive Director verified that all resident rooms are accessible at will for each resident without hindrance. Executive Director and Care Manager will make routine rounds to monitor compliance. Declaration of Resident Rights training provided by East Carolina Behavior Health on 2/23 & 2/25/16.	2/12/16 2/12/16 2/12/16 2/12/16 2/23/16 & 2/25/16

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D 338	Continued From page 9 Interview with a Personal Care Aide (PCA) on 2/11/16 at 6:00 pm revealed: -Resident #2's room is kept locked when she and her roommate is not in it. -Resident #2 had just ate and staff wanted her food to digest before allowing resident to go to bed. -Resident #2 is always saying that she wants to go to bed. -Resident #2 only asked to go to her room "every once in a while". Observation of Resident #2 on 2/11/16 at 6:05 pm revealed that staff took her to her room and unlocked the door with a key to allow her to use the bathroom. Interview with a second Medication Aide (MA) on 2/11/16 at 6:07 pm revealed: -Resident #2's room door was kept locked because after meals she sometimes went to her room and tried to put her night clothes on to go to bed. -"If she does try to change her clothes by herself she may fall and we don't want her to fall." -It is a regular occurrence for the past two months that Resident #2's door is kept locked only when both residents are out of room. -Both residents are kept in the common area to the front of the facility most of the day except for when they are taken to the bathroom or taking a nap. -It was passed on in report that Resident #2's bedroom door is to remain locked during the day when residents are out of bedroom. -Resident #2 is one of the residents that try to get up and need to be watched all the time. -She is kept up front where she can be watched. -The facility started locking Resident #2's bedroom door during the day when residents are	D 338		

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D 338	Continued From page 10 out of room for about a couple of months. -The facility normally tries to keep residents up for around 30 to 40 minutes after they eat before they are allowed to go to bed. -Resident #2 is one of the first residents to get put to bed. Interview with Home Health Nurse (HHN) on 2/12/16 at 10:45 am revealed: -She was there to see Resident #2's roommate. -The last couple of visits the bedroom door has been locked. -Facility staff has had to unlock door. Observation of Resident #2 on 2/12/16 at 11:05 am revealed the she went down the hall to her bedroom, used the bathroom then came out of room and closed door. Interview with Resident #2 on 2/12/16 at 11:09 am revealed: -She stated that she was okay. -She stated that she had to use the bathroom. Resident #2's roommate was not able to be interviewed. Interview with Memory Care Manager (MCM) on 2/12/16 at 10:07 am revealed: -Resident #2 goes into her bedroom when it is not locked and takes her clothes off. -She will then put on 2-3 sets of clothes on at the same time if she can get to some clothes. -When she does put that many clothes on at the same time it creates a safety hazard which may cause her to fall. -Her family is aware that her bedroom is kept locked during the day when residents are out of it to prevent Resident #2 from going into her bedroom and falling and getting hurt.	D 338		

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D 338	Continued From page 11 -Family told facility about Resident #2 taking clothes off and putting on more than one set of clothes at the same time. -MCM states that her family said she did the same thing at home. -Resident #2 is kept up front in the common area to prevent her from going into her bedroom to put on more than one set of clothing because it is a trip hazard. -She is placed up front in the common area so that staff can keep a better eye on her. Attempts made to reach to reach Resident #2's family for interview were not successful by exit. Interview with Executive Director (ED) on 2/12/16 at 11:00 am revealed: -Sometimes the staff do lock Resident #2's bedroom door. -The door is kept open during the bedtime hours. -There was an incident in her bedroom where she had a hard time breathing. -She is placed out front in the common area where someone monitors her at all times. -ED denies having told Resident #2's family that her bedroom door is kept locked at times. -Family knows that we are monitoring her more closely. -Facility does not deny her access to her room. -If resident wants to go to her room staff just takes her. -Resident #2 is the only resident that we lock her bedroom door. -When her bedroom door is unlocked she will go in take her clothes off and pee on the floor which causes a fall hazard.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

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D 438	Continued From page 12 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to report allegations of verbal abuse to health care personnel registry for 1 of 1 staff (Staff A). The findings are: Interview with Memory Care Manager (MCM) on 2/12/16 at 8:20 am revealed: -Staff reported that Staff (A) told Resident #2 "bring you A_ _ back this way". -The MCM talked with Staff A regarding the alleged incident and was given a verbal warning. -The MCM told Staff A that the facility does not tolerate any type of verbal abuse towards residents. -The MCM did not investigate the allegations, she only talked to Staff A and the staff who reported it. "I monitored Staff A for three days after the allegation", " I did not talk to other staff or residents", " I just monitored Staff A". - The MCM monitored Staff A while working with residents for the next three days after the alleged occurrence. - There was no documentation completed regarding the alleged incident. -The MCM reported the alleged incident to the Administrator.	D 438	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 solely as a matter of compliance with State law. It is the policy of Ahoskie House to report allegations of verbal abuse to the health care personnel registry.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL046004	A. BUILDING: _____ B. WING _____	C 02/12/2016

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D 438	Continued From page 13 Interview with the Administrator on 2/12/16 at 9:20 am revealed; -The MCM reported that Staff A had spoken to Resident #2 in a harsh manner. -The MCM did not say exactly what was said. -"I was not at the facility at the time". -The MCM talked with Staff A and would watch the care provided. -The Administrator should have reported to health care personnel registry. -"I did not receive any documentation from the MCM and did not think she had documented the incident". -The MCM monitored Staff A periodically or as often as needed. -"I did not complete an investigation", " I didn't know that I should have at the time". " I know now that an investigation should have been done". Telephone interview with Staff A on 2/12/16 at 8:50 am revealed: -Staff A had tried to redirect Resident #2 because the resident would wander and like to go to her room, get in bed and take off her clothes. "I was redirecting the resident back to the front room". -The MCM had spoken to me "about receiving an allegation that I said get your A- - backup front " . -Staff A said "you need to go back to the front room" . Resident #2 turned around and went back up front with Staff A. Telephone Interview with Staff B on 2/12/16 at 9:55am revealed: -Staff B was waiting for a meeting to begin in the private dining room. -Staff B heard Staff A tell Resident #2 "I am not going to chase you up and down the hall you need to get your A - - back down here and sit down" .	D 438	The Executive Director completed a 24 hr report and submitted to the HealthCare Personnel Registry. Senior Director of Operations & Clinical Services conducted an internal investigation onsite 2/12/16, which included interviews with staff on duty 2/2/16. Internal investigation concluded with no substantiated findings. Executive Director completed a 5 day report and submitted it the the Health Care Personnel Registry. Licensed Nurse provided training on the requirements of reporting allegations to the Health Care Personnel Registry. Executive Director, Quality Assurance Nurse, Clinical Support Team & RDO will monitor compliance with Health Care Personnel Registry reporting. Ahoskie House received a letter from the Health Care Personnel Registry stating an investigation would not be conducted in this case.	2/12/16 2/12/16 2/12/16 3/4/16 3/4/16 3/3/16

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D 438	Continued From page 14 -Staff B reported the incident to the MCM at that time. -Staff are supposed to report to the supervisors "if we see or hear anything against a resident, not sure what is done after it is reported". Plan of protection provided by the facility on 2/12/16 revealed: -The MCM will document verbal communication that was conducted on 2/2/16 with employee in question. -The Administrator will complete health care personnel registry 24 hour report. -The Senior Director of Operations conducted an internal investigation on 2/12/16 to include interviews with staff on duty 2/2/16 with no substantiated findings. -The five day Health Care Personnel Registry report will be completed and submitted. -Training on when to report to the Health Care Personnel Registry will be conducted by the nurse. -The Quality Assurance nurse and clinical support team will monitor compliance with Health Care Personnel Registry reporting. -Annual training on Health Care Personnel requirements will be conducted in addition to new hire orientation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 28, 2016.	D 438	Annual training will be conducted on Health Care Personnel reporting requirements and will be conducted in addition to new hire orientation.	3/28/16
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 15 This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure residents rights were maintained. The findings are: Based on interviews and record reviews the facility failed to report allegations of verbal abuse to health care personnel registry for 1 of 1 staff (Staff A)[Refer to tag D438, 10A NCAC 13F. 1205 (Type B Violation)]	D914	Please refer to Plan of Correction for tag D438, 10A NCAC 13F. 1205 (Type B Violation)	