STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068003	A. BUILDING: _____ B. WING _____	05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLINES REST HOME	401 WEST QUEEN STREET HILLSBORO, NC 27278

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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey 5/17/16 and 5/18/16.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation and interview, the facility failed to assure each resident were to be treated with respect, dignity, and right to privacy based on 1 of 3 sampled staff (Staff A) scolding residents, raising her voice in an unkind tone to residents, not providing privacy while toileting residents, and handling residents too roughly while toileting them. The findings are: Observation of medication pass on 5/17/16 at 12:00pm revealed: -Staff A was trying to locate a resident. -Staff A was repeatedly yelling a resident's name down the main hall of the facility. -Staff A was yelling while most residents were seated at the dining room tables for lunch. -The Administrator (Adm) told Staff A the resident was not in her room but seated in the dining room. -Staff A rushed Resident #1 back in her room and stated in a very loud, demeaning manner, "What are you doing out there? I told you to be in your room when I gave you these eye drops. I told you	D 338		

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D 338	Continued From page 1	D 338		

the state was here and had to watch me give them to you."
-The Adm had no further comments regarding staff's behavior at that time.
- The resident appeared very embarrassed and apologized to staff A.

Confidential interview with a health professional revealed:
-Staff A had been observed toileting a female resident recently with the bathroom door "wide open "to the main hall.
-Staff A was attempting to toilet a resident while the resident was holding on to a grab bar when Staff A jerked the resident at the waist to push her down on the toilet.
-Staff A was not aware she was being observed.
-She did not know the resident's name and the resident could not give an interview.
-Staff A was "very rough" with the resident, "Plopping her down on the toilet."
-Staff A' s tone when talking to residents at times can be very harsh and demeaning.
-An example was as follows: "If you're going to the bathroom, you need to go now cause I don't know when I'll have time to take you again."

Observation on 5/18/16 at 7:30am revealed:
-Staff A was belittling Resident #2 during breakfast in front of the other residents.
-Staff A stated, "Now look what you've done. You've gone and made a mess."

An attempted interview with Resident #2 revealed;
-She would not comment on how it made her feel to be spoken to in this manner.
-The same resident gave a good interview the previous day.

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D 338	Continued From page 2 A staff interview revealed: -Only 3 residents at the facility could give an interview. -Staff A can be "rough" handling residents sometimes. - "I don't think she means to be mean." -"She will command residents to do things sometimes instead of requesting or talking to them kindly." -Other staff had to call down Staff A at times. -The Administrator had to call her down at times and remind Staff A to lower her voice and not talk "so rough." -A few times Staff A had been observed pulling on a resident too roughly. -No residents had complained to her about Staff A. -It made this staff sad when she heard Staff A talk "short" to the residents. A second staff interview revealed: -There had been no complaints about Staff A from residents because none of the residents would complain. -Other staff had observed Staff A being very rough toileting residents. -"She basically drops them down on the toilet when the residents don't or can't move fast enough for her. " -"I have seen her being rough in the way she pulls at their arms when she gets them back up too." -Staff A speaks to the residents sometimes like "she's the boss." -An example is as follows: "Get over here like I told you, get down this hall now." A third staff interview revealed: -Staff A loved the residents. -She could talk "rough" to them at times. -Staff A could be very loud at times.	D 338		

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D 338	Continued From page 3 Three family interviews on 5/17/16 at (12:30pm, 1:50pm, 3:15pm), revealed they had not heard or seen any disrespect from staff while they were visiting their loved ones. Three resident interviews on 5/17/16 at (9:30am, 9:45am, 10:05am, revealed: -The resident was very timid about mentioning anything about Staff A because of fear of being discharged from the facility. -"I've just gotten used to the way Staff A talks and acts." -The Adm knew about Staff A's behavior. -"Sometimes you just have to eat crow around here." -"Sometimes staff talk nice to you, sometimes it's rough. What good does it do to talk about it?" Interview with Staff A (Nursing Assistant/Medication Aide) on 5/18/16 at 2:40pm revealed: -Staff A was aware of resident's rights and staff received yearly training on this subject. -Staff A thought there was enough staff at the facility. -The Adm had talked to her about lowering her voice and her tone today and a week ago. -"I try to watch how I talk to them, I'm not intentionally trying to be mean." -"I love these residents and I don't want to come across like I'm scolding them or talking down to them." -"Sometimes when I'm trying to get a resident to do something, the 2nd time I say it, it comes across as scolding them." -"When I first started working here, the residents were very different. Now with sundowners and their dementia, they don't want to cooperate." -"I try to walk away and re-approach residents	D 338		

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later when that happens."
-Sometimes Staff A asked for assistance while toileting residents.
-"If the residents lock their knees and don't want to sit down, I put them back in the wheelchair if they are dry and I will try later."
-"I may have plopped somebody down on the toilet too roughly before."
-"I don't fight or wrestle with them; I will ask for help."
-"I will try to literally slow myself down more and not feel like forcing them to toilet. I was trying to avoid skin breakdown. I will re-approach later. I will let them be and try again later and ask for help."
-No resident had complained to her about the way she talked to them or the way they were toileted.

Interview with the Administrator on 5/18/16 at 4pm revealed:
-Staff had been reprimanded about how she comes across to the residents twice this year.
-"She does have consequences and I have told her she might have to look for another job."
-"Staff A never works alone."
-"I deal with her tone and attitude on a case by case situation."
-There were cameras throughout the facility but not in private care areas.
-The Adm was not aware Staff A had toileted a resident with the door open to the main hall.
-No residents had complained to her about Staff A, but the residents would not complain about anything.
-"I guess Staff A should be asking for more assistance with activities of daily living and toileting."
-The Adm had scheduled a resident rights training for June 2016.
-The Adm would sit down and talk with Staff A

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D 338	Continued From page 5 and request that she take more time when toileting residents and to ask for more assistance. -The Adm would request that Staff A lower her voice when talking to residents and that she not scold or talk down to the residents. _____ The facility provided the following Plan of Protection: -The Administrator will have a discussion about resident rights with Staff A 5/20/16. -The discussion will include the fact Staff A will be evaluated weekly and if no improvement by the end of the week Staff A will receive 1 wriiten warning and the next offense will mean termination. -Every week Staff A will be evaluated times 1 month and quarterly afterwards. - A resident rights class is scheduled for all staff June 2016. THE CORRECTION DATE FOR THIS B VIOLATION SHALL NOT EXCEED JULY 2, 2016	D 338		
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 observation and interview, the facility failed to assure each resident be treated with respect, dignity, and right to privacy based on 1 of 3 sampled staff (Staff A) scolding residents, raising her voice in an unkind tone to residents, not providing privacy while toileting rsidents, and	D911		

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D911	Continued From page 6 handling residents too roughly while toileting them. Based on observation and interview, the facility failed to assure each resident be treated with respect, dignity, and right to privacy based on 1 of 3 sampled staff (Staff A) scolding residents, raising her voice in an unkind tone to residents, not providing privacy while toileting rsidents, and handling residents too roughly while toileting them related to 1 of 3 sampled staff (Staff A). [Refer to Tag 338 10A NCAC 13F.0909 Resident Rights. (Type B Violation).]	D911		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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D935	Continued From page 7 (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to assure documentation of the medication clinical skills check off list for 1 of 2 sampled staff (Staff A) before administering medications at the facility. The findings are: Review of Staff A's personnel files revealed: -Staff A's hire date was documented as 7/9/10. -Staff A passed the state required medication aide exam 11/7/08. -There was current documentation of 6 hours annual medication administration training. -There was no documentation of a medication clinical skills check off list. -There was no verification of employment as a	D935		

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D935	Continued From page 8 medication aide from her previous job. Interview with the Administrator (ADM) on 5/18/16 at 9:30am revealed: -She believed she had all current documentation for Staff A. -Staff A had been working at present facility for 5 years. -Staff A passed medications and worked as a nursing assistant. -The Adm could not account for this missing record. -The Adm believed Staff A should have provided this documentation during her hiring process. Interview on 5/17/16 with the RN Nurse trainer at 9:35am revealed she could not provide any information regarding Staff A's missing record. Interview with Staff A on 5/18/16 at 10am revealed: -Staff A had worked at the present facility 5 years. -She passed her med exam in 2008. -She remembered working on a med cart and being checked off for medication administration. -She worked as a medication aide at her previous job. -Staff A could not recall the exact date but believed she was validated for passing medications in 2008. -One of her previous places of employment had closed. -She would continue to call and another previous employer to obtain her medication clinical check-off list.	D935		