

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/20/2016
NAME OF PROVIDER OR SUPPLIER LAKE JAMES LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 LAKEVIEW DRIVE MARION, NC 28752		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the McDowell County Department of Social Services conducted annual and follow-up surveys, and complaint investigations, from May 18, 2016 to May 20, 2016. The McDowell County Department of Social Services initiated the complaint investigations on April 1, 2016.	D 000		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. The findings are: Review of the facility's sanitation grade report dated 10/2/15 revealed: -A documented a score of 83. -Sanitation issues included: floors shall be kept clean, walls and ceilings must be clean and in good repair, mold on ceiling and other furniture,	D 077		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 077	Continued From page 1 bathrooms and laundry areas must be clean, all storage of supplies and equipment shall be kept neat and clean, drinking fountain must be properly regulated, utensils on medication carts must be handled in a sanitary manner, mattresses and other furniture must be in good repair. Observations during the survey revealed: -Facility floors, walls and ceilings were clean and in good repair. -No unpleasant odors. -Furniture clean and in good repair. -Repairs being made to baseboard molding and common bathroom commodes. -Designated housekeeping staff responsible for laundry services. Interview with Maintenance staff on 5/20/16 at 10:00am revealed; -He has been working at the facility for about four months. -He was aware of the sanitation score. -When informed of a maintenance issue he made a list of supplies, discuss repairs and needs with the Director and prioritized issues requiring immediate attention. -He kept a record of maintenance issues and documented when issues were completed or repaired. Interview with Facility Director on 5/20/16 at 10:15am revealed: -She has been working at the facility since the beginning of April, 2016. -She has had contact with the County Environmental Health Inspector, asking for the facility to be re-inspected due to the areas in the report had been addressed. -When an inspection is completed, she would	D 077		

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D 077	Continued From page 2 take the findings and hold a meeting with relevant staff, including maintenance, housekeeping and direct care staff. All staff are involved with making improvements to the facility. Telephone voicemail message from the County Environmental Health Inspector on 5/20/16 at 3:23pm revealed a re-inspection of the facility was on their "to do list" sometime between now until the end of June (2016). Interview with Facility Administrator on 5/18/16 at 2:15pm revealed: -He was aware and not satisfied with the current sanitation score. -When the County Environmental Health Inspector conducted the last kitchen inspection (3/1/16), he had asked for the facility to be re-inspected due to the areas in the report had been addressed.	D 077		
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, interviews, and record reviews, the facility failed to assure the place	D 287		

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D 287	Continued From page 3 setting for all residents included a knife, fork, and spoon without an assessment of each resident and exceptions made on an individual basis. The findings are: Observation of dietary staff setting the dining room tables on 5/18/16 at 11:25am and 5/19/16 at 11:15am revealed: -All place settings at all tables included a paper napkin, metal fork, and a metal spoon. -None of the place settings included a table knife. Observation of the lunch time meal on 5/18/16 at 11:35am and 5/19/16 at 11:30am revealed none of the served food needed to be cut with a knife. Interviews with six residents on 5/18/16 and 5/19/16 revealed: -Two residents stated there was a fork and spoon at the table when they came to eat. -Two stated they would receive a knife from staff if needed. -One said he used his fork to cut his food. -Another indicated he did not want a knife, even if there was one at the table. -Three residents said not having a knife did not bother them. -Staff never gave us a table knife. -Some residents are not allowed to have a knife. -Staff will cut up your food for you if you asked. -One resident would like to cut up her own food. She had never asked for a knife. -One resident said didn't care if he had a knife or not. -The food was good. -Sometimes we had ham or pork chops that needed to be cut. A lot of ham gets thrown away because residents can't cut it. -Residents are never given knives, "they stay in	D 287		

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D 287	Continued From page 4 the kitchen where they (staff) can watch them." -Sometimes we have ham or pork chops and I can cut them with a fork or spoon. Review of 6 of 6 residents records revealed a physician and resident signed form that stated, "Due to residents at the facility having a diagnosis of MI (mental impairment) and/or dementia, for safety reasons, knives will not be used at Lake James Lodge." Interview with a Personal Care Aide (PCA) on 5/19/16 at 11:25am revealed: -The facility had plenty of silverware, including knives. -Knives will be placed at the tables if what was being served required one, or if a resident asked for one. -Knives were not put out at the table because a former resident used to steal them. Interview with the Kitchen Manager on 5/19/16 at 1:35pm revealed: -Knives were put out on the tables depending upon what was being served. Spaghetti was served at lunch using egg noodles so a knife wasn't needed. -Knives are not always put out at the tables because residents had a history of taking knives and flushing them down the toilet. -When a resident asked for a knife he would alert staff supervising the dining room to keep an eye on the knife. -Staff monitored the silverware going out and coming back in at the end of the meal. Interview with a Medication Aide on 5/19/16 at 3:15pm revealed: -Knives were not always placed at the table. -She would give a resident a knife if they asked	D 287			

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D 287	Continued From page 5 for one. -Kitchen staff will cut up a resident's food if needed. Interview with the Facility Director on 5/19/16 at 2:30pm revealed: -No one got a table knife, only a fork and spoon. -"They never needed to have one." -Some residents are violent. -If a resident asked for a knife, we would give it to them, watch them use it, and take it back. -No one had never asked for a knife. -If a resident asked, we would cut up their food for them. -She believed the facility's physician had assessed residents for their safety with knives. Interview with the facility's physician on 5/19/16 at 4:25pm revealed: -He had never assessed individual residents for their safety with table knives. -He did recall one unnamed resident who stated "seeing knives made her want to cut herself."	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: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to ensure placement of one resident (#2) to the secured unit was	D 338		

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D 338	Continued From page 6 appropriate as evidenced by the resident's diagnoses and cognitive functioning. The findings are: Review of Resident #2's current FL-2 dated 12/28/15 revealed: -Diagnoses included: Schizophrenia, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD) and Hypercholesterolemia. -The resident was documented as a wanderer and ambulatory. -No information concerning if the resident was disoriented. Review of Resident Face Sheet revealed Resident #2 was admitted to the facility on 12/28/15. Review of current FL-2 dated 12/28/16 revealed medications included: -Fluphenazine 0.5ml, 12.5mg intramuscular every two weeks. (Fluphenazine is used to treat thought disorders). -Fluphenazine 5mg twice a day. -Lorazepam 0.5mg 1 tablet four times per day as needed. (Loazepam is used to treat anxiety). Review of hospital discharge report for Resident #2 dated 12/28/15 revealed: -Resident #2 arrived at hospital on 12/11/15. -Resident #2 was discharged from hospital on 12/28/15. -Primary diagnosis was Schizophrenia. -Other diagnosis includes: Hyperlipidemia, GERD, Cellulitis-resolved, Hypertension, -Agitation-resolved and Cellulitis left hand-resolved.	D 338		

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D 338	Continued From page 7 Review of Facility Smoking Assessment form for Resident #2 dated 12/28/15 revealed: -The Resident did not require smoking restrictions at that time. -Form was completed by former Resident Care Coordinator (RCC). Review of Resident #2's record revealed: -He was deemed incompetent in 2003 and a family member was appointed guardianship. -On 3/20/15, a local guardianship service provider was appointed guardianship for Resident #2 due to his refusal of treatment, non-compliance with medications and increased behavioral issues. Review of Comprehensive Clinical Assessment for Resident #2 dated 8/12/15 revealed: -The Assertive Community Treatment Team (ACTT) was recommended due to client's severe and persistent mental illness (SPMI) diagnosis of Schizophrenia. -Resident currently lived in an assisted living facility (ALF) but he has been clinically assessed to be able to live in a more independent setting if ACTT is involved and the proper supports are also put in place. Review of Report of Accident/Incident for Resident #2 dated 1/4/16 at 11:40am revealed: -"Resident walked off during lunch. He was found down on the main road. After contact with him by the cook, he disappeared. He had stated he was coming back up the hill to the facility. By the time the cook got to the road to meet him, he was gone. All contacts including his brother and mother were contacted. None had info from him about his whereabouts. Local law enforcement came out to look for him. No further information at this time. RCC and Supervisor in Charge (SIC) contacted."	D 338		

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D 338	Continued From page 8 -Facility had contacted the Guardian. Guardian told facility staff to contact the police. Review of police report dated 1/4/16 revealed: -They received a call about (Resident #2) missing at 12:08pm. -The time last seen was at 11:15am. -(Resident #2) was last seen by cook who made contact with him, but he was gone when the cook went to the end of the road. -The resident did have a history of walking away, is also newer to facility. -Guardian advised that (Resident #2) has hidden in the woods before. Interview with Resident #2 at his home on 5/11/16 at 7:15am revealed: -Resident #2 continued to reside at his home since leaving facility on 1/4/16. -He became upset, stating he did not know the interviewer and did not have anything to say. -He asked the interviewer to leave his property or he would contact law enforcement. Observation of Resident #2 on 5/11/16 at 7:15am revealed: -Resident #2 was clean and appropriately dressed in a pair of jeans, button up shirt, black jacket, shoes and socks. -He was very clear in his speech. -Resident #2 was able to make his desires known by asking the interviewer to leave his property or law enforcement would be contacted. Review of a written statement from the first shift SIC, dated 1/4/16 revealed "On 1/4/16 at 11:40am Resident #2 was seen walking through the main parking lot at facility. At that time I, went to tell an aide she needed to watch over the back hall where he (Resident #2) is a residing resident.	D 338		

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D 338	Continued From page 9 I found her and other staff personnel in the kitchen making plates for lunch. I preceded to go outside to tell (Resident #2) he could not go that far across the parking lot. When I did not see him, (a PCA) helped look. They saw Resident #2 at the property line on the main road. The PCA went to proceed to the road where he met Resident #2. By the time (the PCA) walked around the property to meet him at the road, he (Resident #2) had vanished. Staff, and also the Sheriff [department] conducted a search that came up empty. When I spoke to the guardian at 12:06pm; he expressed that (Resident #2) had a history of skipping out on facilities in the past. He also said this was normal for him to leave like this. He stated he would contact ACTT and for us to contact our local police department to look for him. I also spoke with his brother and mother who also said he had a history of leaving facilities." Interview with first shift SIC, on 4/25/16 at 12:15pm revealed: -She did not think Resident #2 was a wanderer, he knew what he was doing when he left. -There were no concerns with Resident #2 trying to walk off before this incident on 1/4/16. -Guardian for Resident #2 did not seem concerned when she called to report Resident #2 had walked off, stating that was "normal behavior". Interview with a kitchen staff on 4/15/16 at 11:30am revealed: -He was in the kitchen cooking the day Resident #2 walked off on 1/4/16. -Back Hall residents were in the dining room eating lunch. -He heard someone yell at him to come outside to help get Resident #2 back. -He ran across parking lot to the bank and told	D 338		

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D 338	Continued From page 10 Resident #2 to come back up the driveway. -Resident #2 stated to him he was coming back. -By the time he walked across the yard and down the driveway, Resident #2 was gone. -He thinks Resident #2 got in the car with someone. -Resident #2 was on the phone earlier that morning before he walked off. -Resident #2 had been brought to the dining room to eat and wanted to go smoke outside of dining room area and had walked straight out the door and across the parking lot. Second interview with the kitchen staff on 5/6/16 at 1:30pm revealed: -When he called Resident #2's family member to inform him Resident #2 had walked off, the family member indicated Resident #2 had done this at a former facility and went back to his home in (a neighboring county). -Resident #2 knew what he was doing. -Resident #2 did not act confused while he was at facility. -He talked to Resident #2 every day. -He did not think Resident #2 was a wanderer, but (Resident #2) called someone that morning to come and pick him up. -Resident #2 never acted out while at the facility. -Resident #2 told him he wanted to return to his home. Interview with a PCA on 4/14/16 at 12:35pm revealed: -Resident #2 should not have been placed on secured unit. -She had went to assess Resident #2 at admission. -Resident #2 was not confused or disoriented but very smart. -Resident #2's guardian was the one who asked	D 338		

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D 338	Continued From page 11 for Resident #2 to be placed on the secured unit. -Guardian probably wanted to put Resident #2 back there to keep him from running off. Interview with a second SIC on 4/14/16 at 3:06 pm revealed: -Resident #2 was not a wanderer, no confusion, very alert. -He thought Resident #2 know exactly what he was doing when he left. Interview with a second PCA, on 5/6/16 at 1:35pm revealed: -Resident #2 had never tried to walk off during his shift. -Resident #2 was always making phone calls, but he was not sure who Resident #2 was calling. -He believed Resident #2 was oriented to person, place and time and was very high functioning, not a wanderer. -He thought Resident #2 knew what he was doing the day Resident #2 walked off, Resident #2 saw an opportunity to leave during lunch and took it. Interview with a third PCA, on 5/3/16 at 3:20pm revealed: -Resident #2 was only at facility for one week. -She did not think Resident #2 was a wanderer, he was "very smart and manipulative". -She never understood why Resident #2 was on the secured unit. -She thought Resident #2 got to know the routine of the staff and saw an opportunity to leave and took it. -Resident #2 was on the phone a lot and had visitors while at the facility. Interview with a third SIC on 5/6/16 at 2:04pm revealed: -He was not working the day Resident #2 walked	D 338			

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D 338	Continued From page 12 off. -He did not think Resident #2 was a wanderer, no confusion, was stable and clear. -Resident #2 never tried to leave facility while he was working. -Resident #2 had told him Resident #2 wanted to go home because he felt like his ex-wife and daughter were trying to take his stuff. -He found out later that Resident #2 had walked off from another facility before, but he did not know this while Resident #2 was at the facility. Interview with Home Health Registered Nurse on 4/14/16 at 11:16am revealed: -She had started care on Resident #2 two days before he left. -She did not think Resident #2 was confused or disoriented, not a dementia patient at all. -Resident #2 was a psychiatric patient only and should not have been placed on the back hall. -She thinks Resident #2 needed more independence. Review of Adult Care Home Notice of Transfer/ Discharge for Resident #2 dated 1/7/16 revealed: -Reason for discharge was due to diagnosis of Schizophrenia, walking off property, not being able to redirect resident and not able to provide appropriate supervision. -Planned discharge location was home. -Notification was given to Resident #2's Guardian. Interview with current RCC on 4/14/16 at 1:05pm revealed: -She was not working at facility when Resident #2 walked off. -She only knew about Resident #2 walking off from incident report and staff statements in Resident #2's record.	D 338		

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D 338	Continued From page 13 Interview with current Director on 4/14/16 at 1:00pm revealed: -She was not working at facility when Resident #2 walked off. -Since coming on staff she has hired more staff to assist with supervision of residents. Interview with Resident #2's Guardian on 5/6/16 at 10:15am revealed: -He had no concerns with the way facility handled walk off of Resident #2. -He had requested placement in facility's secured unit due to the resident's history of elopements at a previous facility. The RCC indicated to be in the secured unit, 'wanderer' had to be indicted on the FL2. He had asked the facility's RCC to contact the discharging hospital and request 'wanderer' be checked on the FL2. -Resident #2 was very high functioning and not a wanderer. -Resident #2 knew what he was doing when he left the facility. -Resident #2 had walked off from other facilities in the past to go back to his home. -Resident #2 had only been at facility a few days when he walked off. -Resident #2 was found at his home two days after leaving facility and has been living there ever since. -He continues to work with Resident #2 along with the ACTT mental health provider. -He has never seen a diagnosis for dementia, wandering or any other cognitive impairments for Resident #2. Interview with an ACTT supervisor on 5/17/16 at 9:15am revealed: -She had worked with Resident #2 since placement at a facility before admission to this facility on 12/28/15.	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/20/2016
NAME OF PROVIDER OR SUPPLIER LAKE JAMES LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 LAKEVIEW DRIVE MARION, NC 28752		
(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 338	Continued From page 14 -She described Resident #2 as "brilliant", but psychiatrically unstable when he refuses to take his meds. -Resident #2 was capable of working, budgeting his own money and is very reasonable, just very paranoid. -She did not think Resident #2 was a wanderer, but had a plan to leave facility and go back home. -Resident #2 had been at his home since walking off from facility on 1/4/16 and being discharged from facility on 1/7/16. A Plan of Protection was submitted by the facility on June 7, 2016 that included: -Have a physician evaluate present residents to ensure appropriate placement of current population. -Better care will be taken during potential admit status, utilizing assessment tool to ensure appropriate placement, i.e., age, demographic, diagnoses, history and physical. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 22, 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, interviews and record reviews, the facility failed to ensure residents were treated with respect, consideration, dignity	D911			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/20/2016
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D911	Continued From page 15 and full recognition of his or her individuality as evidenced by the failure to have individual assessments regarding the provision of knives for eating and using a blanket physician order to prohibit the provision of knives based on residents' diagnoses of mental health and no individual assessments, and failed to ensure placement for one resident in the secured unit was appropriate. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure the place setting for all residents included a knife, fork, and spoon without an assessment of each resident and exceptions made on an individual basis [Refer to Rule 10A NCAC 13F .0904(b)(2)]. 2. Based on observation, interview and record review, the facility failed to ensure placement of one resident (#2) to the secured unit was appropriate as evidenced by the resident's diagnoses and cognitive functioning [Refer to Rule 10A NCAC 13F .0909 (Type B Violation)].	D911			