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
	[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	903 N SALISBURY AVENUE SPENCER, NC 28159

(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 conducted an annual survey, follow-up survey, and complaint investigations on May 10-13, 2016 with an exit conference via telephone on May 13, 2016. The complaint investigations were initiated by the Rowan County Department of Social Services on April 19, 2016 and May 4, 2016.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure floors were kept clean and in good repair as evidence by the kitchen entrance metal or threshold which was broken, torn, and jagged. The findings are: Observation during the initial tour of the facility on 5/10/16 between 10:00 am and 11:30 am revealed: -An entrance door to the kitchen used by staff for transferring the meal cart to the south dining room area. -The kitchen entrance floor had a black thick rubber threshold that transitioned into the hallway which was secured to the flooring approximately 1.5 inches in height and 14 inches in width. -An area of the black rubber threshold was torn and jagged and in some areas, the black rubber	D 074	Addendum made per telephone call with Administrator on 7-1-2016 @ 9:00 AM HnP Threshold repaired Exhibit 1A Refer to tag -76 for monitoring HnP 7-1-2016	5/12/16

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature]
TITLE Administrator (X6) DATE 6/21/16

✓ Accepted c̄ Addendums As noted on pages 1, 20, + 32.
[signature] 7-1-2016

Clean Copy of Statement of Deficiencies attached

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
	945343	A. BUILDING _____ B. WING _____	05/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	928 N SALISBURY AVENUE SPENCER, NC 28159

(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) COMPLETION DATE
E 074	Continued From page 1 threshold was missing spanning the floor. -This unit area was used by staff only. Review of the kitchen's ventilation score revealed an inspection done of 3/21/18 and a score of 97.0. Interview on 5/15/18 at 2:30 pm with a kitchen dietary aide revealed: -She had worked in the facility kitchen for 3 months. -The trash mat(s) observed under the entrance door to the kitchen had been that way since she started working in the kitchen. -About a month ago she attempted to push the rolling wheeled cart to the south dining room area with the residents dinner meal on the cart, the wheels on the cart caught on the rug and jiggled a piece of black rubber threshold and the cart turned over. -I think some of the damage to the threshold was done then." -She had not reported the broken threshold to maintenance.	E 074		
	Interview on 5/15/18 at 2:45 pm with a Personal Care Aide revealed: -She had worked in the facility for over one year and the kitchen floor threshold had been torn and jagged since she had started work. -I think maintenance knows they are just looking at it."			
	Interview on 5/16/18 at 2:05 pm with the two facility maintenance men revealed: -The facility had two maintenance men and they both worked Monday through Friday. -They stated they were busy with a lot of projects in the facility. -The kitchen floor black rubber threshold had been torn and jagged for about 2 weeks.			

PRINTED: [illegible]
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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
	[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	[illegible] N SALISBURY AVENUE SPENCER, NC 28159

(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 074	Continued From page 2 -If they went to the Administrator for repairs and supplies, they were never denied fixing the areas or ordering supplies the facility needed. -The maintenance men were not aware if the Administrator had known of the torn and jagged threshold in the kitchen area. Interview on 5/15/18 at 3:10 pm with the Administrator in training revealed: -He was not aware of the kitchen back rubber threshold flooring being torn and jagged. -He relied on maintenance to make repairs in the facility. -No staff or resident had complained about the kitchen flooring threshold to him. -If he had known he would have had the threshold entrance flooring in the kitchen repaired. -He would get the kitchen entrance threshold repaired as soon as possible. -He initiated a work order program for the maintenance men since he had been in the position of Administrator in training a few months ago.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (5) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure furniture in the resident's living room area was kept clean and in good repair as	D 079		

Division of Health Service Regulation
STATE FORM [illegible] [illegible] If continuation sheet [illegible]

Division of Health Service Regulation

[illegible]	[illegible] HCL [illegible]	[illegible] A. BUILDING ______ B. WING ______	[illegible] R-C [illegible]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	300 N SALISBURY AVENUE SPENCER, NC 28159

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
[illegible]	Continued From page 3 evidence by the couch and a chair had torn cushions. The findings are: Observation during the initial tour of the facility on 6/15/16 between 10:50 am and 11:30 am revealed: -The living room consisted of 2 chairs, couch, tables and a television. -The couch cushion on the right side was torn approximately 12 inches which exposed the foam inside the cushion. -The chair cushion was torn in the back area approximately 8 inches and exposed the foam inside the cushion. Confidential interviews with four residents revealed: -The cushions and the living room furniture had been torn "for a while". -Some of the residents watched television in their rooms. -The residents said staff was aware of the torn cushions in the living room area. -The residents would like new furniture in the living room area, but had not said anything to the Administrator about this. Interview on 6/15/16 at 2:55 pm with the facility maintenance man revealed: -They were both unaware the living room couch and chair had torn cushions. -None of the residents had complained to them about the torn cushions. Interview on 6/13/16 at 3:10 pm with the Administrator in training revealed: -He was unaware the living room couch and chair had torn cushions.	[illegible]	Cushion repaired on leather sofa. Chair with torn cushion has been disposed. Admin will monitor monthly for needed repairs and report to maintenance staff Two new sofas installed 3/15/2016 Exhibits 1B1, 1B2, 1C, 1D, 1D1, 1D2, 1D3	6/1/16

PRINTED: 06/07/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) DATE SURVEY COMPLETED	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION
	06/16/2016	[illegible]	[illegible]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTONS RETIREMENT CENTER	900 WALLBERRY AVENUE SPENCER, NC 28159

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)	COMPLETE DATE
S 000	Continued From page 4 -None of the staff or residents had complained to him about the condition of the furniture. -He would have maintenance repair the stuffing on both the chair and the couch in the Living room area as soon as possible.	S 000		
S 0921	10A NCAC 13F .0908(a)(8) Housekeeping And Furnishings 10A NCAC 13F .0908 Housekeeping And Furnishings (a) Adult care home shall: (8) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide adequate window blinds to ensure resident privacy in the living room area and in 2 of 12 occupied resident rooms located on one North hall (Rooms 5 and 11). The findings are: Observation during the initial tour of the facility on 6/16/16 between 10:00 a.m. and 11:30 a.m. revealed: -Room 5 on the North hall had broken blinds that did not cover the entire window and faced the side entrance parking lot of the facility. -Room 11 North hall had broken blinds that did not cover the entire window and faced the resident's smoking area located in the back of the facility. -The living room had broken blinds that did not cover the entire window and faced the front of the	S 0921	New blinds installed in room 5. New blind installed room 11, blinds repaired in living room. Admin will monitor monthly and assign work orders to maintenance staff Exhibit 1E, 1F, 1G	6/16/16

FORM CMS-2567(02-99)	PREVIOUS VERSIONS OBSOLETE	EVENT ID: [illegible]	FACILITY ID: [illegible]	If continuation sheet 5 of 22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	[illegible] N SALISBURY AVENUE SPENCER, NC 28159

(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 032	Continued From page 5 facility visible to the parking lot. Interview on 5/12/16 at 11:50 am with the resident who occupied room 3 on the North hall revealed: -He had moved from a room on the South hall into the room 3 North hall a month ago. -His bed was directly under the broken blinds. -He liked the room, but the blinds had been broken ever since he moved in. -He became use to the broken blinds and never dressed or changed clothes in his room; He used the bathroom or shower room to change his clothes in. -He was told by maintenance staff the room was suppose to be re-done because the resident who lived in the room prior to him moving in had torn the blinds. Interview on 5/12/16 at 2:45 pm and on 5/13/16 at 3:45 pm with the Resident who occupied room 11 north was unsuccessful. Confidential interviews with 3 facility residents revealed: -They never noticed the broken blinds in the living room area. -They liked to watch television in the living room area, but did not pay attention to the broken blinds. Interview on 5/13/16 at 2:50 pm with the facility maintenance man revealed: -They were not aware of the broken blinds in room 3 North hall, room 11 North hall, or the living room area. -They replaced blinds every two weeks in the facility and guessed they had missed those areas. -No residents had complained to them about the broken blinds in the rooms or the living room	D 032		

PRINTED: 05/11/2016
FORM APPROVED

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
	HA1230026	A. BUILDING _____ B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	515 N SALISBURY AVENUE SPENCER, NC 28159

(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) COMPLETION DATE
D 063	Continued From page 6	D063		

8/16.

Interview on 5/10/16 at 3:10 pm with the Administrator in training revealed:
-He was unaware the blinds were broken in rooms 9 and room 11 North east.
-He was unaware the blinds were broken in the living room area.
-He relies on maintenance to report broken blinds to him and he would replace them. Unfortunately, the staff had reported the broken blinds in room 9 and room 11 North hall in the living area to him. The maids assure resident privacy and order new blinds for room 9 and room 11 North hall and the living room area.

D 113	10A NCAC 13F .0317(g) Other Requirements	D113		

10A NCAC 13F .0317 Other Requirements
(g) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, all dressing rooms and tub 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 and interviews, the facility failed to ensure hot water temperatures were maintained between a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 2 of 2 units located in shared restroom bathroom on the center hall (rooms #7-8, and rooms #9-4). 1 sink fixture located in room 8-15.

There were no problems with water checks on facility monthly charts. ~~Last~~ last inspection County inspection water temperature was correct on both inspections. Maintenance will continue to monitor water temps monthly and any required change will be made. Facilities water gauge will be adjusted 2 degrees to compensate incorrect previous measurements.

5/16/16
4/27/16
3/31/16

(PRINTED) 09/05/15
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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
	345455	A. BUILDING _____ B. WING _____	R-C 09/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	505 S SALISBURY AVENUE SPENCER, NC 28159

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 ACCOMPLISHED OR EACH DEFICIENCY SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
0113	Continued From page 7 and 2 of 2 fixtures (1 sink and 1 tub) located in room #3. The findings are: Observations of the facility on 9/10/15 of hot water temperatures revealed: -At 10:30 am, the hot water temperature at the sink in the shared bathroom for rooms #5-6 was 120 degrees F. -At 10:35 am, the hot water temperature at the sink in the bathroom in room #16 was 120 degrees F. -At 10:44 am, the hot water temperature at the sink in the bathroom in room #5 was 116 degrees F. - At 10:48 am, the hot water temperature at the showerhead in the bathroom in room #5 was 116 degrees F. -At 10:48 am, the hot water temperature at the sink in the shared bathroom for rooms #3-4 was 116 degrees F. No steam was on the from any fixture. Interviews on 9/10/15 from 10:50am to 10:55 am with 3 residents residing on the center that revealed: -One resident had never had a problem with the water temperature being too hot. If the water temperature was too hot, he mixed the hot water with cold water. -One resident stated the water was a little hotter than she liked when she washed her hands, but she adjusted the water temperature by adding cold water. -One resident stated the hot water temperature was fine. Interview on 9/10/15 at 10:55 am with a Quality Assurance Consultant revealed no residents had complained to her about the hot water.	0116	Exhibit 1H1, 1H2, 1H3	

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	HAL[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	[illegible] AVENUE SPENCER, NC [illegible]

(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 113	Continued From page 8	D 113		

temperature being too hot on the center hall.

Interview on 5/13/16 at 10:55 am with the Resident Care Director (RCD) revealed:
-No resident or staff had complained to her about the hot water temperature being too hot on the center hall.
-The maintenance staff was responsible for monitoring hot water temperatures throughout the building.
-She was unaware of the last hot water temperature monitoring.

Interview on 5/13/16 at 11:00 am with the Business Office Manager (BOM) revealed:
-The maintenance staff monitored random hot water temperatures throughout the building at least once a month.
-The hot water temperature log records were kept in the BOM's office.
-A hot water temperature was logged for room S-1[illegible] on [illegible] for 112.[illegible] at the sink. (There were no additional hot water temperature checks after [illegible] for room S-1[illegible]).
-She was unaware the hot water temperatures were above 116 degrees F. for the center hall.

Interview on 5/13/16 at 11:10 am with the Maintenance Supervisor and the Maintenance Assistant revealed:
-Hot water temperatures were monitored by the assistant.
-The thermometer routinely used to monitor hot water temperatures was not available at present but would be in 30 minutes because the thermometer was located in a service truck that was not at the facility.
-The thermostat for the hot water heater for the center hall was partially exposed in the closet that the maintenance and housekeeping staff used

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	200 N SALISBURY AVENUE SPENCER, NC 28159

(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 113	Continued From page 9 recently. The thermostat may have been bumped accidentally by staff cleaning carts or mop buckets. -The hot water heater thermostat was adjusted to slightly cooler by the Maintenance Assistant at 11:20 am. -Maintenance staff would notify the surveyor when the hot water temperature was below 116 degrees F. On 5/17/16 at 11:45 am, calibration of thermometers, using an ice-water slurry, revealed: -The surveyor's thermometer read 32 degrees F. -The facility's thermometer read 30 degrees F. On 5/17/16 at 11:50 am, signs were posted outside the affected bathrooms informing residents and staff of elevated hot water temperatures and advising residents to have staff assist with using hot water. Interview on 5/17/16 at 12:08 pm with the Administrator in Training (AIT) revealed: -He was not aware the facility had elevated hot water temperatures for the center hall of the facility. -The facility had been inspected by the local health department within the last couple of months and the hot water temperatures were within range at that time. Recheck on 5/17/16 of hot water temperatures in the center of the facility revealed: -At 2:05 pm, the hot water temperature at the sink in the bathroom in room E-13 was 101 degrees F. -At 2:10 pm, the hot water temperature at the sink in the bathroom in room #6 was 104 degrees F. -At 2:12 pm, the hot water temperature at the tub/shower in the bathroom in room #6 was 104	D 113		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080014	A. BUILDING: ______ B. WING ______	R-C 05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	[illegible] N SALISBURY AVENUE SPENCER, NC 28159

(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 113	Continued From page 10 degrees F. -At 2:15 pm, the hot water temperature at the sink in the shared bathroom for rooms #3-4 was 104 degrees F. -At 2:19 pm, the hot water temperature at the sink in the shared bathroom for rooms #7-8 was 104 degrees F. On 05/18/16 at 2:22 pm the Maintenance Supervisor was informed the signs posted regarding hot water needs to be removed.	D 113		
D 221	10A NCAC 13F .0702 (e) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (e) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (c)(1) of this Rule; or (2) reasons under Subparagraphs (c)(2), (c)(3), and (c)(4) of this Rule exist. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that notices of discharge and appeal rights were given at least 30 days before a resident was discharged for 1 of 3 sampled residents (Resident #13). The findings are: Review of Resident #13's Resident Register revealed the date of admission to the facility was	D 221	Facility will notify the appropriate person in the case of emergency discharge. Any verbal discharge notice will follow with a written notice as soon as practicable. Staff training on emergency discharge procedures scheduled for 7/1/16. Administrator will monitor procedures during emergency discharge and contact the appropriate person to facilitate a smooth transition. DMA-ACH (12/99) has been amended to notify admin immediately upon emergency transfer. Exhibit 4	6/3/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34-[illegible]	A. BUILDING _____ B. WING _____	5-C 05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	928 N GALLOWAY AVENUE SPENCER, NC 28159

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
0 257	Continued From page 11	0 257	

2/9/16.

Review of Resident #13's current F12 dated 2/9/16 revealed:
-Diagnoses included non-psychotic mental disorder, dementia, congestive heart failure, and depression.
-Required assistance with personal care (bathing, dressing and toilet use).

Review of Resident #13's record revealed:
-An order for home health services for wandering dated 2 times weekly prn as needed.
-Resident #13 was transported to the Emergency Room (ER) on 4/15/16 via Emergency Medical Services (EMS).

Review of the local hospital ER notes dated 4/15/16 revealed:
-Resident #13 arrived at the ER on 4/15/16 at 8:23 pm with a diagnoses of "acute confusion, dysfunction."
-Documentation on Resident #13 was noted in the ER and discharged back to the facility on 4/16/16 at 7:10 pm.
-Documentation the ER Nurse called the facility on 4/16/16 at 8:54 pm and was told they were not taking Resident #13 back due to "Sundowner he would not take his medications and they think he needs to be in a psychiatric hospital."
-Documentation on 4/16/16 at 11:25 pm the ER Nurse called the facility and spoke to the Medication Aide (MA). The MA refused to take Resident #13 back due to the facility owner and Resident #13 required a locked nursing facility and per the Administrator they were not to take Resident #13 back.
-Documentation on 4/16/16 at 10:31 am the facility Administrator returned the call to the ER.
-The Administrator and Resident #13 was sent to

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	345239	A. BUILDING _____ B. WING _____	05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	105 N SALISBURY AVENUE SPENCER, NC 28159

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 ACCOMPLISHED FOR OR BEFORE THE APPROPRIATE DATE)	COMPLETE DATE
0 227	Continued from page 12	0 227		

the ER on 4/15/16 after he was seen by the house doctor and Resident #13 was not eating or drinking, or taking his medications for three days. The ER Nurse said they were not made aware of this, only the laxatives were working. The ER Nurse contacted the Administrator's phone number for the hospital social worker to contact. Consequently the ER Nurse contacted the hospital's social worker and advised her the facility had refused to take Resident #13 back after treated and discharged on 4/15/16 from the ER.

Telephone interview on 5/10/16 at 4:45 pm with the hospital social worker revealed:
-Resident #13 arrived to the ER via EMS on 4/15/16 with a locking deodorant cap.
-After Resident #13 was treated in the ER the facility would not take him back.
-The ER staff had contacted the social worker with the concern the facility had refused to take Resident #13 back.
-She called the facility and had spoken to several staff members and was told Resident #13 was not eating or drinking for 3 days and the facility doctor had written an order not to take Resident #13 back. "He required a higher level of care."
-The hospital social worker contacted Resident #13's Guardian on 4/14/16 in regards to the facility refusing to take Resident #13 back to the facility. The guardian was unaware Resident #13 was in the ER, unaware of the higher level of care recommendation, or the refusing to take Resident #13 back to the facility.
-Resident #13 was/was in the ER from 4/15/16 to 4/23/16, he developed urinary retention and was admit to the hospital on 4/23/16 and discharged on 5/11/16 when he was discharged to a skilled nursing facility.
-The facility had not followed a 30 day discharge

Office of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	M C 05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	500 N SALISBURY AVENUE SPENCER, NC 28159

(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) COMPLETION DATE
O 227	Continued From page 13 notice to Resident #13, "I feel the facility dumped him in the ER." Telephone interview on 5/11/18 at 9:40 am with Home Health Nurse revealed: -Home Health started care for Resident #13 on 3/2/18 for ileostomy care. -She visited Resident #13 two times weekly and as needed. -Her last visit was on 4/14/18 and the bag needed the ileostomy bag at that time. -Resident #13 was noncompliant with ileostomy care and sometimes had refused care. -She was aware Resident #13 was transported to the ER on 4/16/18 but thought it was for psychiatric issues not a leaking ileostomy bag. -She said if Resident #13's ileostomy bag was leaking the facility should call her or the home health on-call service for after hours visits. -She was not called on 4/15/18, nor was the home health office on-call services contacted on 4/15/18. -"We do not expect the facility to send a resident to the ER when we are providing the treatment and care to that resident." Telephone interview on 5/17/18 at 10:30 am with the Primary Medical Nurse Practitioner (PMP) revealed: -She last seen Resident #13 on 4/15/18. -The facility staff had informed her Resident #13 was not eating, drink or taking his medications. -On 4/15/18 she asked the facility to monitor Resident #13's input and output and to call her if unable to obtain vital signs daily. -On 4/15/18 she examined Resident #13 he was not dehydrated and his ileostomy stoma had good output. -She contacted the mental health provider on 4/15/18 with the facility concerns Resident #13	O 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. WING _____ B. WING _____	R-D 05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	604 N SALISBURY AVENUE SPENCER, NC 28159

(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) COMPLETION DATE
S 257	Continued From page 14 was refusing insulin and medications. -She was unaware Resident #13 had refused her medications in March 2016 or April 2016 until April 19, 2016 when the facility staff made her aware of his refusals. Review of the Primary Medical MD notes dated 4/19/16 revealed: -Resident #13 was seen on 4/12/16 per facility request due to Resident #13 refusing to eat meals cooked at the facility, refusing medications and inappropriate behavior with Celtony care. -Documentation Resident #13 was well nourished, well developed and in no acute distress. -Diagnoses included polymyalgia rheumatica and schizophrenia/ anxiety. -Advised to record B.P. if taken on the Medication Administration Record (MAR) as much as possible, daily vital signs, notify provider if systolic blood pressure was less than 100 or if patient had not voided in 8 hours. -Interview on 5/12/16 at 10:30 am with the Medical Health Nurse Practitioner revealed: -She had seen Resident #13 on 4/12/16 and noticed a change in his behaviors and was adjusting his medications. -The medical provider contacted her on 4/15/16 in regards to Resident #13 not eating, drinking or taking his psychiatric medications. -She was aware Resident #13 was noncompliant with medications but not consistently noncompliant. -She was unaware Resident #13 had gone to the ER on 4/15/16. -She had not written or given a verbal order to send Resident #13 out to the ER on 4/15/16. -The facility staff called on 4/19/16 and requested a higher level of care for Resident #13.	S 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING: ______ B. WING ______	R-C [illegible]/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	321 N SALISBURY AVENUE SPENCER, NC 28159

(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 227	Continued From page 15	D 227		

-She was unaware Resident #13 had eaten a sandwich fixed by the staff on 4/13/16.
-She was not aware Resident #13 had refused his medications on 4/12/16 at 8:00 am, but took them at 11:00 am.
-She was not aware on 4/14/16 Resident #13 refused breakfast, but ate lunch.
-She was unaware on 4/13/16 Resident #13 refused ostomy care at 8:00 am but agreed to have Ostomy bag replaced later that day prior to the ER visit.

Review of the Mental Health NP note dated 4/15/16 revealed:
-Chief complaint was documented as "per staff report: Staff asked to request higher level of care."
-Plan of care "This level of care is not appropriate for this resident at this time due to non-compliance with medications and care, combative behaviors toward staff and therefore poses a risk of harm to himself and or other residents and staff."

Review of the Mental Health NP note dated 5/12/16 revealed:
-Chief complaint was documented as "supervisor chart review".
-Documentation acute issues began on 4/7/16. Resident #13 had refused some medications and adjustments were made to his psychiatric medications.
-Documentation on 4/15/16 the Primary NP had seen Resident #13 and noted refusing medications, refusing to eat meals prepared here, and uncooperative behaviors with Ostomy care. Instructed staff to send Resident out if he continues to refuse medications or is combative due to safety concerns.
-Documentation Resident #13 was sent to the ER

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
	HA1125025	A. BUILDING _____ B. WING _____	C 05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECHRIST RETIREMENT CENTER	2224 SALISBURY AVENUE SPENCER, NC 28159

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)	COMPLETE DATE
S 237	Continued From page 15 per this plan on 4/19/16. -Communication the mental health provider had completed the ER and spoken to the ER doctor on 4/19/16 with the determination Resident #13 should not return to the facility due to safety risk of non compliance. -Communication Resident #13's level of risk to himself due to non compliance was too high to allow him to continue in his current setting. Telephone interview on 5/11/16 at 12:30 pm with Resident #13's guardian revealed: -Resident #13 had been in the facility since February 2014, and the facility had no problem meeting his needs or providing care or treatment. -She was unaware Resident #13 was seen in the ER on 4/13/16 until 4/19/16 when the hospital social worker had contacted her. -She was unaware Resident #13 was not sent back to the facility after the ER visit on 4/13/16. -The guardian said a family member had heard Resident #13 was not eating and not behaving and was concerned. -The family member contacted the Sheriff's department and EMS to intercept Resident #13 to the ER on 4/13/16. -Resident #13 refused to go to the ER on 4/13/16. -The guardian called the facility again on 4/14/16 and spoke to the BOM about Resident #13's care and treatment and was told Resident #13 was doing fine. Interview on 5/11/16 at 3:20 pm with the Resident Care Director (RCD) revealed: -She had worked on 4/13/16. -She informed the Medical Provider Resident #13 had not eaten or drank in 3 days. He was also refusing medications. -She had gone into Resident #13's room with the medical provider to talk with Resident #13 as	S 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080030	A. BUILDING: ______ B. WING ______	R-C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	333 N SALISBURY AVENUE SPENCER, NC 28159

(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 237	Continued From page 17	D 237		

4/15/16.
-She said the medical provider gave a verbal order, if Resident #13 refused treatment or care, send him out to the ER for evaluation.
-The RCC was not a nurse and was aware she could not take a verbal order from a medical provider.
-The facility fax machine was down over the weekend on 4/15/16 to 4/18/16 so she assumed the order to send Resident #13 out if refused meals, medications and treatment would arrived when the fax machine was fixed.
-She said the facility could not meet Resident #13's needs and he required a higher level of care.

Interview on 5/11/16 at 5:35 pm with the Administrator revealed:
-Staff had made her aware on 4/15/16 Resident #13 was not eating, drinking, or taking his medications.
-The medical provider had seen Resident #13 on 4/15/16 and gave a verbal order to send the resident out if he refused his care and treatment.
-The facility fax machine was not working over the weekend of 4/15/16 to 4/18/16 so the facility could not receive the order from the medical provider in regard to Resident #13.
-She said the staff was just following orders per the medical provider when they sent Resident #13 to the ER on 4/15/16 because he refused his medication that evening.
-She said Resident #13 required a higher level of care and that was the reason they did not take the Resident #13 back from the ER on 4/15/16.

Interview on 5/12/16 at 12:40 pm with the Administrator in Training revealed:
-He was not aware the facility had refused to take Resident #13 back from the ER on 4/15/16. He

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
	HAL080024	A. BUILDING: ______ B. WING ______	R-C 05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	115 N SALISBURY AVENUE SPENCER, NC 28159

(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 227	Continued From page 18 thought the medical provider had given an order and the staff had followed it. -He was not aware Resident #13 had refused medications and treatment several times over the last three months. -He was aware a 30 day discharge was to be issued prior to discharging a resident from the facility. -He had never spoken to the guardian for Resident #13 concerning a 30-day discharge. Interview on 5/10/19 at 3:45 pm with the Business Office Manager (BOM) revealed: -She had completed a discharge on 4/15/19 for Resident #13 and faxed to the emergency on 4/18/19. -The reason on the discharge notice for Resident #13, it is necessary for your welfare and your needs cannot be met at this facility. -She contacted the guardian on 4/18/19 and informed her the facility medical provider had ordered to send Resident #13 out due to requiring a higher level of care.	D 227		
D 273	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 interviews, record reviews, and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING: ______ B. WING ______	R-C [illegible]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	[illegible] N SALISBURY AVENUE SPENCER, NC [illegible]

(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 259	Continued From page 19	D 259	Completed staff training on documentation of orders. To cross reference new orders staff will double check pharmacy input on new orders and sign med order sheet.	6/3/16
	statements, the facility failed to provide supervision and monitoring for 2 of 6 sampled residents related to a resident drinking rubbing alcohol resulting in a fall with injury (Resident #10) and failing to ensure the whereabouts of a resident with dementia which resulted in the resident missing for several hours (Resident #11).		Our pharmacy, [redacted] enters the Doctors orders directly onto the MARs. We made them aware that this order was missed in their documentation. They have implemented a new follow up and training program to ensures no doctors orders are missed.	6/3/16
	The findings are:		Exhibit 5-1, 5-2	
	A. Review of Resident #10's FL2 dated [illegible] revealed diagnoses included multiple falls, schizophrenia, hypokalemia, insomnia, urinary tract infections, diabetes mellitus, hypertension, syncope, chronic obstructive pulmonary disease, transient ischemic attack, status post cholecystectomy and hyperlipidemia.		Staff was retrained on elopement issues. All staff will report any missing client to administrator, police and guardian immediately. Employee that left [redacted] premises without client was terminated. Administrator will monitor staff and charts during this procedure. Facility engages [redacted] monthly to assist with any elopement issues.	6/3/16
	Review of Resident #10's record revealed diagnoses included chronic alcohol abuse.		Exhibit 6, 6-1	
	Review of Resident #10's Primary Care Physician's Visit Note dated [illegible] revealed: -Diagnoses included a recent hospitalization for a "gastrointestinal bleed questionably secondary to non-ethanol alcohol ingestion". -A physician's order to have staff "CHECK ROOM DAILY FOR ALCOHOL/RUBBING ALCOHOL AND REMOVE - RECORD ON MAR." -Resident #10 was assessed as a moderate fall risk.			
	Review of Resident #10's Care Plan dated [illegible] revealed there was no indication for a need for increased supervision related to fall risk or alcohol consumption.			
	Review of Resident #10's Primary Care Physician's Visit Note dated [illegible] revealed a Physician's order to "REMOVE ANY RUBBING		[illegible] 7-1-2016 per phone c̄ A [illegible]	

Administrator or Designee will monitor personal care & supervision ongoing & at least monthly. [illegible]

Date of completion is 6/3/2016 per [illegible] [illegible]

PRINTED: 06/21/2016
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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
	HAL080003	A. BUILDING: ______ B. WING ______	R-C 05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	806 N SALISBURY AVENUE SPENCER, NC 28159

(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 270	Continued From page 20	D 270		

Continued From page 20

ALCOHOL FROM THE PATIENT'S ROOM."

Review of Resident #10's February and March 2016 electronic Medication Administration Records (eMARs) revealed there was no documentation of checking room for alcohol/rubbing alcohol and removing it from the resident's room.

Review of Resident #10's Psychiatric [illegible] Visit Note dated 3/2/16 revealed:
-Staff reported frequent intoxication of rubbing alcohol and Resident #10 was found intoxicated at the facility on several occasions.
-Resident #10 drinks a bottle of rubbing alcohol several times a week.
-Resident #10 occasionally smoked marijuana with last usage on 2/24/16.

Review of Resident #10's Nurses Notes revealed:
-On 3/13/16 Resident #10 was drunk and having difficulty taking medications.
-On 3/15/16 at 10:24 am Resident #10 was found by staff face down outside on the sidewalk near the road and an ambulance transported Resident #10 to the local emergency department.

Review of Resident #10's Emergency Medical Service (EMS) Call Report dated 3/16/16 revealed:
-The protocol implemented was "overdose/poison ingestion".
-Resident #10 had an altered level of consciousness and the smell of alcohol was on her breath.
-The facility staff reported that the patient had been drinking rubbing alcohol and mixing it with aspirin.

Further review of Resident #10's Nurses Notes

Division of Health Service Regulation

PRINTED: 05/31/2016
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			R-C 05/13/2016

BETHANY RETIREMENT CENTER

905 N SALISBURY AVENUE
SPENCER, NC 28159

D 270	Continued From page 21 revealed: -On 3/19/16, Resident #10 was staggering when walking and had slurry speech. -On 3/23/16, Resident #10 was laying down and barely able to lift her head up and smelled of alcohol. -A second entry on 3/23/16, Resident #10 was in her room, staggering and fell to the floor and was limping on her left leg. -On 3/24/16, Resident #10 was laying on the floor and complaining of pain in her left hip. Resident #10 had bruising on her left hip, could not stand and was transported to the hospital via ambulance. -There was no documentation of increased monitoring after the falls on 3/23/16 or 3/24/16. Review of Facility Incident and Accident Reports revealed: -There was no report dated 3/13/16 when the resident was found outside of the facility on the sidewalk face down and sent to the ER. -A report dated 3/23/16 when Resident #10 was found on the floor with complaint of left hip pain. -A report dated 3/24/16 when Resident #10 was found on the floor with complaint of left hip pain, swelling and an abrasion present and was transported to the emergency department via ambulance. Interview with a Medication Aide (MA) on 5/12/16 at 9:20 am revealed: -Resident #10 was sent to the hospital on 3/24/16 and was now at a nursing center recovering from a broken hip she sustained from the fall. -Resident #10 would walk to the local store and buy rubbing alcohol. -Resident #10's family member would also bring in rubbing alcohol and asked staff to dilute it with water.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	333 N SALISBURY AVENUE SPENCER, NC 28159

(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 275	Continued From page 22	D 275		

-Resident #10 would become physically aggressive if staff tried to get near her alcohol.
-Resident #10 wore a blue bag she carried all the time and that she kept her alcohol in and staff could never get close to it to remove the alcohol.
-Resident #10 also obtained [illegible] from the store and would mix it with her rubbing alcohol before she drank it.
-When Resident #10 fell, the MA was able to get into her bag and the bottle of rubbing alcohol was completely empty. There were 2 bottles of [illegible] that were both half empty.
-The staff did not perform daily checks of Resident #10's room and if staff did check her room for alcohol staff did not document the room check and did not document the findings.

Interview with a Personal Care Aide (PCA) on 5/12/16 at 4:38 pm revealed:
-Resident #10 was sent to the hospital on 5/2/16 and was now in a nursing center recovering from a broken hip she sustained from the fall.
-There was no increased supervision for Resident #10 to monitor for alcohol ingestion or after falls.
-She never removed alcohol from Resident #10's room.
-She knew Resident #10 drank alcohol but she did not see any in her room.
-Resident #10 was known to drink rubbing alcohol but she never intervened.

Interview with a second PCA on 5/12/16 at 4:12 pm revealed:
-She knew of residents that had diabetes or other illnesses that she kept a closer eye on, but she did not know to monitor Resident #10 for drinking alcohol or for safety related to falls.
-She did not know to check Resident #10's room for rubbing alcohol therefore there was no documentation related to Resident #10's

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Department of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATAWBA VALLEY REHABILITATION CENTER	928 N SALISBURY AVENUE SPENCER, NC 28159

(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) COMPLETION DATE
E 278	Continued From page 13	E 278		

Staff used incorrect protocol to follow room checks for absence of alcohol consumption.

Interview with Business Office Manager on 5/19/16 at 11:40 am revealed:
-The facility could not do anything about Resident #10's drinking nothing could.
-They had been in the past to take it out of her room, but she would locate the facility supplies.
-The facility staff had tried to water the rubbing alcohol down, but Resident #10 caught on to this.
-A long time ago Resident #10 drank a bottle of rubbing alcohol and walked straight into a cement wall.
-She had a discussion with Resident #10's family member and told her that she could not supply her with rubbing alcohol, but did not know when the discussion took place.
-Resident #10 was sent to the hospital on 5/2/16 and was now in a nursing center recovering from a broken hip and scheduled from there.

Interview with Resident #10's family member on 5/12/16 at 12:02 pm revealed:
-The family member did bring Resident #10 rubbing alcohol because she did not Resident #10 would walk down the road to the store and not getting hit by a car.
-She did ask the facility staff to water the alcohol down, but knew that Resident #10 detected this and became angry.
-The facility did ask her not to bring it in on one occasion but did not recall when.
-The facility staff, the family member and Resident #10 did not discuss other things to implement that may have been effective in curbing this behavior.
-The facility staff, the family member and Resident #10 did not discuss options such as

FORM CMS-2567(02-99)	PREVIOUS VERSIONS OBSOLETE	EVENT ID:	Continuation sheet Page 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255028	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	909 N SALISBURY AVENUE SPENCER, NC 28159

(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) COMPLETION DATE
S 240	Continued From page 24 Alcoholics Anonymous or alcohol rehabilitation. -The facility staff, the family member and Resident #10 did not discuss changing Resident #10's level of care to increase supervision in efforts to prevent the drinking of nonliquor alcohol. -Resident #10 was hospitalized and was admitted to a nursing facility recovering from a broken left hip she sustained during the fall documented on 3/24/16. Interview with the Administrator on 04/07/16 at 11:01 am revealed: -She was aware that Resident #10 drank nonliquor alcohol. -Resident #10 liked to put nonliquor alcohol on her legs and feet. -She told Resident #10 on several occasions she could not have nonliquor alcohol and if she wanted it on her hands and feet the facility would keep it on the medication cart and she could apply it with supervision. She did not know the times these discussions occurred. -The facility staff had thrown several bottles of nonliquor alcohol away, but she did not know how many or when and she was not disappointed. -The facility staff did not routinely check her room for nonliquor alcohol. -The facility staff would be prompted to check her room after a Resident #10 had a family member visit. -She was aware that Resident #10 walked to the local markets and was drinking alcohol, but it was not that often because Resident #10 did not have a lot of money. -She met with Resident #10 and the family members and informed them that Resident #10 was not to have nonliquor alcohol and they denied Resident #10 drank it. She did not know when this meeting took place. -She told the family member that she would call	S 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING ______ B. WING ______	R-C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	609 N SALISBURY AVENUE SPENCER, NC 28159

(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 270	Continued From page 25 Adult Protective Services if she continued to supply the rubbing alcohol. -She never called Adult Protective Services. Interview with Resident #10's primary care's Physician Assistant (PA) on [illegible] at [illegible] am revealed: -She had not been notified of Resident #10 drinking rubbing alcohol recently. -Every time the PA visited the facility, she discussed with the staff that the rubbing alcohol must be removed from Resident #10's room. -She wrote orders Resident #10's room should be monitored for rubbing alcohol on a daily, on going basis. -She did not think the facility ever educated or followed up on these orders because each visit there were repeat occurrences of Resident #10 drinking and she would have to have repeat discussions about removing the rubbing alcohol from Resident #10's room. B. Review of Resident #11's FL2 dated [illegible] revealed: -Diagnoses included dementia, schizophrenia, hypertension, hypertriglycemia and history of basal cell carcinoma. -A recommendation statement, "Recommend, yet not report to work." Review of Resident #11's record revealed Resident #11 was deemed incompetent and had a court appointed guardian. Review of Resident #11's Resident Register revealed the resident was admitted to the facility on [illegible]. Review of Resident #11's Care Plan signed by the physician on [illegible] revealed:	D 270		

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
	345265	A. BUILDING _____ B. WING _____	05/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	220 N SALISBURY AVENUE SPENCER, NC 28159

(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)	COMPLETE DATE
D 279	Continued from page 25	D 279		

-The resident currently receives medication to treat dementia.
-The resident was independent at Activities of Daily Living (ADL's).

Review of Resident #11's Nursing Notes revealed:
-Resident #11 was noted not to be at the facility at 5:15 pm on 3/22/15.
-The facility was to pick up Resident #11 at the local hospital at 2:30 pm on 3/22/15 and they failed to do so.
-A Medication Aide (MA) was sent to the hospital to pick up the resident and he was not there.
-The hospital police provided the local city police because he could not be located on hospital grounds at that time.
-When the hospital police reported to the MA how serious this was for Resident #11, the MA proceeded to tell the police that Resident #11 had left the hospital on his own in the past.
-Resident #11 was found to have gotten on the wrong public transportation bus and was en route back to the hospital.
-Facility staff met him at the hospital and returned him to the facility at 7:00 pm.

Review of the local police Police Report dated 3/22/15 revealed:
-The police call was received at 5:40 pm and was in reference to a missing person.
-The officer obtained a description of Resident #11 and searched Building 6 and all of the surrounding buildings and streets for Resident #11.
-The officer questioned every employee he saw, but no one had seen the man with the matching description.
-The officer went on bicycle patrol of the streets in search of Resident #11 and he saw a man walking in front of Building 2 and it was Resident

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	(X5) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X6) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X7) COMPLETE DATE
E 278	Continued From page 27 911 -Resident #11 was confused and not of sound thought which was a big reason the facility was so worried of his whereabouts" -The official contacted the facility and walked with Resident #11 until the RN picked him up. Interview with the Transportation Aide on 5/12/16 at 8:21 am revealed: -She transported Resident #11 to the hospital for his volunteer work every day and picked him up at 2:30pm. -Resident #11 was very repetitive and every day on the way to the hospital he would say, "You're going to get me at 2:30, right" several times over. -He was always dropped off and picked up in the same place. -She was not aware of there ever being an employee of the hospital overseeing him to make sure he stayed at the pick up point. -She was not working on 5/05/16 and there was a substitute driver that day. -She did not sign out residents when she transported because they were all listed on an approved list. Interview with the substitute Transportation Aide on 5/12/16 at 10:04 am revealed: -She dropped off Resident #11 at the hospital for volunteer on the morning of 5/05/16. -She did not sign Resident #11 out of the facility prior to taking him to the hospital. -She returned to pick up Resident #11 and he was not at the pick up point at 2:30pm on 5/05/16. -She waited 10 minutes and left because at the point it was past 2:30 pm Resident #11 would have the bus back to the facility. -She reported to facility staff on that shift and requested they inform second shift that she did	E 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING: ________ B. WING ________	R-C [illegible]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	[illegible] N SALISBURY AVENUE SPENCER, NC [illegible]

(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 270	Continued From page 28 not pick up Resident #11. -She returned the van key to the supervisor and checked out. Interview with the Resident Care Director (RCD) on 3/15/16 at 9:30 am revealed: -The facility did not routinely do a head count except the census count that was done every night at mid-night. -Resident #11 went to the hospital to volunteer everyday with a group of other residents and when the activities/Transportation Aide picked up the residents she overlooked that Resident #11 was not present for the pick up. -Resident #11 has missed the ride in the past and when this occurred he would get on a bus and get off at a local bus stop. -The RCD instructed staff to go and look for Resident #11 at that bus stop on 3/08/16 but he was not there. -She then sent a NA to the hospital police and reported that the facility had a missing resident. -The police found Resident #11 on the wrong bus and this bus brought Resident #11 to the local bus stop and staff picked him up at the bus stop. -Residents leaving to volunteer, for classes, or appointments were expected to sign out prior to leaving. -The RCD did not notice any cognitive changes prior to him getting lost on 3/08/16. -Since Resident #11 had been staying at the facility during the day she had noticed a cognitive decline. -The facility did not do routine cognitive assessments or elopement/exit assessments. Interview with the Business Office Manager on 3/13/16 at 11:25 am revealed: -In case of a missing person, the policy was to search the building, and then to call the RCD, the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HA1700006	A. BUILDING _____ B. WING _____	NUC 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHAFF RETIREMENT CENTER	900 N SALISBURY AVENUE SPENCER, NC 28159

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)	COMPLETE DATE
F279	Continued From page 22 Administrator and the office manager. -If a person has been missing for 24 hours the policy was to call Face a Silver Alert. -The facility had an in-service on 11/03/15 in regards to missing persons and 19 staff attended the in-service. -In the case of a missing resident staff was expected to start the county, SRT and photocopy the resident's demographic sheet and a photo to give to the authorities. -Each resident had a bag with an article of clothing that they had worn in case a Silver Alert was initiated. -A Silver Alert had not been initiated by this facility. -Staff had also been instructed to go out and look for residents when they were missing. -This facility was an assisted living facility and if the residents want to walk down the street they can walk, but it was policy for residents to sign in and out of the facility. Interview with the second shift Supervisor on staff when Resident #11 was missing on 3/13/15 at 12:04 pm revealed: -Staff noticed at dinner Resident #11 was missing and so she called the staff at the hospital to locate him. -The hospital staff could not locate him so she called the local police. -The local police called the hospital police and the hospital police found him along outside the gate. -Resident #11's dementia had been getting worse. -She did not remember calling the Responsible Party about Resident #11's absence. -The Supervisor called the RNC and the Administrator. -The first shift did not tell her that Resident #11	F279		

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	HAL[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	[illegible] N SALISBURY AVENUE SPENCER, NC 28159

(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 27[illegible]	Continued From page 30 was not picked up at 2:30 pm. -Staff do not do regular "head counts" but she knew her residents' behaviors and when one did not show up for a meal or snacks or another for [illegible] then she knew to go investigate based off of the change in patterned behaviors. -Staff did look for changes in the residents and she noted a decline in his cognitive and functional status. -She did not document changes noted, but discussed them with SCD and other staff. -Resident #11 was observed having increased difficulty changing his clothes, [illegible], and finding the dining room. Interview with Resident #11's Responsible Party on 5/1[illegible]/16 at 12:[illegible] pm revealed: -She was the appointed Guardian for Resident #11 and a social worker at the county Department of Social Services. -She was not notified of Resident #11's being missing until she read about the incident in Resident #11's record. -She inquired about the incident and was told that the [illegible] person left at 2:30 pm and it was not until 5:00 pm until staff noticed his absence. -At that time they sent staff to locate Resident #11 and that staff member reported that he got on a bus and police were then notified. -The bus took him back to the facility. -The staff member that dropped him off apparently did not know to go back and get him. -The facility did not call her and notify her that Resident #11 was missing. ______ A Plan of Protection was provided by the facility on May 12, 2016 as follows: -Effective immediately, staff will look for residents who need supervision. -Staff will monitor accordingly and if a [illegible] [illegible]	D 27[illegible]		

PRINTED: 05/24/2016
FORM APPROVED

Division of Health Service Regulation

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	HAL000000	A. BUILDING: ______ B. WING ______	R-C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	301 N SALISBURY AVENUE SPENCER, NC 28159

(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 270	Continued From page 31 staff will promptly notify the RCD and provider. -The RCD will follow up on shift to shift meetings and will take management aware of needs. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 15, 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 observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 7 sampled residents with regards to low blood pressure (BP) (Resident #7) and refusal of medications and meals (Resident #13). The findings are: A. Review of Resident #7's current FL2 dated 4/27/15 revealed: -The diagnoses included acute congestive heart failure, coronary artery disease, hypertension and urinary retention. -The medication section with the words "see attached" and there was no attachment. Review of Resident #7's record revealed a	D 273	Staff has been retrained to communicate directly with doctor and not rely on on [redacted] nurse to report low BP's and refusal of medications and meals. RCD will monitor BP sheet daily for one month, weekly for two months and monthly there after. Exhibit 7, 7-1 RCD will monitor Health Care Referral and Follow ups including BP charts daily per one month, weekly for two months and monthly thereafter. KLP 7-1-2016 @ 9:03 Am	Verified 5/3/16 KLP 7-1-2016 via phone call [illegible]

Division of Health Service Regulation

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	[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	103 N SALISBURY AVENUE SPENCER, NC [illegible]

(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 279	Continued From page 32 Physician's order dated 12/08/15 for blood pressures to be taken daily. Review of Discharge Summary dated 2/25/16 revealed: -Physician order's to discontinue furosemide 20mg (a diuretic used to decrease blood pressure). Review of the Discharge Summary from a local hospital dated 2/29/16 revealed: -Physician's orders to discontinue furosemide 20mg (a diuretic used to treat congestive heart failure and hypertension), isosorbide mononitrate 30mg 24hr tablet (a long acting medication used to treat and prevent chest pain), metoprolol succinate 25mg 24hr tablet (a long acting medication used treat high BP, chest pain, and heart failure.) -Physician's orders to add amlodipine 2.5mg 1 tablet daily (a medication used to treat high BP and chest pain), metoprolol tartrate 25mg one tablet twice daily (a medication used to treat high BP and prevent chest pain), and nitroglycerin 0.2mg/hr patch - one patch daily (a medication used to treat chest pain). Review of the March 2016 eMAR revealed: -An entry for amlodipine 2.5mg 1 tablet daily and documented as administered at 9:00 am 3/01-3/25/16. -An entry for furosemide 20mg 1 tablet daily and documented as administered at 9:00 am 3/01-3/25/16. -An entry for isosorbide mononitrate 30mg ER 1 tablet daily and documented as administered at 9:00 am 3/01-3/25/16. -An entry for metoprolol tartrate 25mg 1 tablet twice daily and documented as administered at 9:00am and 8:00pm 3/01-3/25/16.	D 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	909 S SALISBURY AVENUE SPENCER, NC 28159

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F 279	Continued From page 33 -An entry for nitroglycerin 0.2 mg/hr - apply one patch daily and documented to be administered at 8:00 on 3/01-3/10/16. -An entry for BP to be taken daily at 12:00 pm and documented as 118/61 on 3/01, 96/48 on 3/02, 110/48 on 3/03, 92/57 on 3/04, 78/49 on 3/05, 82/61 on 3/06, 94/63 on 3/07 and 84/42 on 3/08/16. Further review of Resident #7's Nurses Notes revealed: -An entry dated 3/27/16 where BP was recorded as 112/57. -An entry dated 3/28/16 where Resident #7 was discharged and continued taking 2-0.2mg pm pills. -An entry dated 3/29/16 where BP was recorded as 96/48 (as entered on MAR). -An entry dated 3/30/16 where BP was recorded as 78/49 (as entered on MAR). -An entry dated 3/31/16 where BP was recorded as 82/61 (as entered on MAR). -An entry dated 3/08/16 where BP was recorded as 84/42 (as entered on MAR). -An entry dated 3/08/16 where Resident #7's family member called and informed facility staff that he was admitted to the hospital. -There was no documentation that staff called Resident #7's physician in regards to the low BP. Interview with a Medication Aide (MA) on 5/10/16 at 12:45 pm revealed: -It was their policy to recheck a BP if the first reading was outside of normal range. -If the second BP was abnormal they were to report this to the Resident Care Director (RCD). -The RCD or the MA would call the physician and report the abnormal result. -She did not report the abnormally low BP to the RCD. -She may have reported the low BP to the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING: ______ B. WING ______	R-C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RETIREMENT CENTER	999 N SALISBURY AVENUE SPENCER, NC 28159

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D 273	Continued From page 34 physician but can not remember. Interview with a second MA on 5/10/16 at 10:50 am revealed: -She considered 80/40 to be a BP in "the danger zone" and would call the physician if the BP was this low. -She considered anything above 140/90 or below 80/40 to be abnormal. -She would also notify the RCD of the abnormal reading. -She did not report the low BP to the RCD or the physician but thinks she discussed it with the Home Health Nurse. -Resident #7 was really weak, short of breath and more confused than usual before he went to the hospital on 3/03/16. Interview with a third MA on 5/11/16 at 11:34 am revealed: -She considered 80/60 to be a low BP that would require physician notification. -She would call the physician after rechecking the BP. -She would report the hypotension to the RCD but does not remember if she reported any low readings to the RCD. -Resident #7 was more confused, disoriented and weak before he went to the hospital on 3/05/16. -She recalled having called Resident #7's physician and left a message in regards to the low BP but does not recall when and she did not document this in the resident record. -She did not know if the physician called back but had not by the end of her shift. -She notified the Home Health Nurse when she was visiting but did not remember when. -She did not document when she reported this to the Home Health Nurse.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080006	A. BUILDING: _____ B. WING _____	R 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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 conducted an annual survey, follow-up survey, and complaint investigations on May 10-13, 2016 with an exit conference via telephone on May 16, 2016. The complaint investigations were initiated by the Rowan County Department of Social Services on April 19, 2016 and May 4, 2016.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure floors were kept clean and in good repair as evidence by the kitchen entrance corridor threshold which was broken, torn, and jagged. The findings are: Observation during the initial tour of the facility on 5/10/16 between 10:00 am and 11:30 am revealed: -An entrance door to the kitchen used by staff for transferring the meal cart to the south dining room area. -The kitchen entrance floor had a black thick rubber threshold that transitioned into the hallway which was secured to the flooring approximately 1.5 inches in height and 14 inches in width. -An area of the black rubber threshold was torn and jagged and in some areas, the black rubber	D 074		

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	HAL080006	A. BUILDING: _____ B. WING _____	R 05/16/2016

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BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

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D 074	Continued From page 1 threshold was missing exposing the floor. -The entrance was used by staff only. Review of the kitchen's sanitation score revealed an inspection date of 3/31/16 and a score of 97.5. Interview on 5/13/16 at 2:30 pm with a kitchen dietary aide revealed: -She had worked in the facility kitchen for 3 months. -The black rubber threshold under the entrance door to the kitchen had been that way since she started working in the kitchen. -About a month ago she attempted to push the rolling wheeled cart to the south dining room area with the resident's dinner meal on the cart, the wheels on the cart caught on the torn and jagged areas of black rubber threshold and the cart turned over. -"I think some of the damage to the threshold was done then." -She had not reported the broken threshold to maintenance. Interview on 5/13/16 at 2:45 pm with a Personal Care Aide revealed: -She had worked in the facility for over one year and the kitchen floor threshold had been torn and jagged since she had started work. -"I think maintenance know they are just too busy to fix." Interview on 5/13/16 at 2:55 pm with the two facility maintenance men revealed: -The facility had two maintenance men and they both worked Monday through Friday. -They stated they were busy with a lot of projects in the facility. -The kitchen floor black rubber threshold had been torn and jagged for about 2 weeks.	D 074		

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D 074	Continued From page 2 -If they went to the Administrator for repairs and supplies, they were never denied fixing the areas or ordering supplies the facility needed. -The maintenance men were not aware if the Adminsitrator had known of the torn and jagged threshold in the kitchen area. Interview on 5/13/16 at 3:10 pm with the Administrator in training revealed: -He was not aware of the kitchen black rubber threshold flooring being torn and jagged. -He relied on maintenance to make repairs in the facility. -No staff or resident had complained about the kitchen flooring threshold to him. -If he had known he would have had the threshold entrance flooring in the kitchen repaired. -He would get the kitchen entrance threshold repaired as soon as possible. -He initated a work order program for the maintenance men since he had been in the position of Administrator in training a few months ago.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure furniture in the resident's living room area was kept clean and in good repair as	D 076		

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BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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 076	Continued From page 3 evidence by the couch and a chair had torn cushions. The findings are: Observation during the initial tour of the facility on 5/10/16 between 10:00 am and 11:30 am revealed: -The living room consisted of 2 chairs, couch, tables and a television. -The couch cushion on the right side was torn approximately 12 inches which exposed the foam inside the cushion. -The chair cushion was torn in the back area approximately 8 inches and exposed the form inside the cushion. Confidential interviews with four residents revealed: -The residents said the living room furniture had been torn "for a while". -Some of the residents watched television in their rooms. -The residents said staff was aware of the torn cushions in the living room area. -The resident would like new furniture in the living room area, but had not said anything to the Administrator about this. Interview on 5/13/16 at 2:55 pm with the facility maintenance men revealed: -They were both unaware the living room couch and chair had torn cushions. -None of the residents had complained to them about the torn cushions. Interview on 5/13/16 at 3:10 pm with the Administrator in training revealed: -He was unaware the living couch and chair had torn cushions.	D 076		

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D 076	Continued From page 4 -None of the staff or residents had complained to him about the condition of the furniture. -He would have maintenance repair the cushion on both the chair and the couch in the living room area as soon as possible.	D 076		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide adequate window blinds to assure residents' privacy in the living room area and in 2 of 10 occupied resident's rooms located on the North hall (Rooms 3 and 11). The findings are: Observation during the initial tour of the facility on 5/10/16 between 10:00 am and 11:30 am revealed: -Room 3 on the North hall had broken blinds that did not cover the entire window and faced the side entrance parking lot of the facility. -Room 11 North hall had broken blinds that did not cover the entire window and faced the resident's smoking area located in the back of the facility. -The living room had broken blinds that did not cover the entire window and faced the front of the	D 083		

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D 083	Continued From page 5 facility visible to the parking lot. Interview on 5/12/16 at 11:00 am with the resident who occupied room 3 on the North hall revealed: -He had moved from a room on the South hall into the room 3 North hall a month ago. -His bed was directly under the broken blinds. -He liked the room, but the blinds had been broken ever since he moved in. -He became use to the broken blinds and never dressed or changed clothes in his room. He used the bathroom or shower room to change his clothes in. -He was told by maintenance staff the room was suppose to be re-done because the resident who lived in the room prior to him moving in had torn the blinds. Interview on 5/12/16 at 2:45 pm and on 5/13/16 at 3:45 pm with the Resident who occupied room 11 north was unsuccessful. Confidential interviews with 3 facility residents revealed: -They never noticed the broken blinds in the living room area. -They liked to watch television in the living room area, but did not pay attention to the broken blinds. Interview on 5/13/16 at 2:55 pm with the facility maintenance men revealed: -They were not aware of the broken blinds in room 3 North hall, room 11 North hall, or the living room area. -They replaced blinds every two weeks in the facility and guessed they had missed those areas. -No residents had complained to them about the broken blinds in the rooms or the living room	D 083		

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D 083	Continued From page 6 area. Interview on 5/13/16 at 3:10 pm with the Administrator in training revealed: -He was unaware the blinds were broken in rooms 3 and room 11 North hall. -He was unaware the blinds were broken in the living room area. -He relied on maintenance to report broken blinds to him and he would replaced them immediately. -No staff had reported the broken blinds in room 3 and room 11 North hall or the living area to him. -He would assure resdient privacy and order new blinds for rooms 3 and room 11 North hall and the living room area.	D 083		
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, and interviews, the facility failed to assure hot water temperatures were maintained between a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 2 of 2 sinks located in shared residents' bathroom on the center hall (rooms #7-8, and rooms # 3-4), 1 sink fixture located in room S-19,	D 113		

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D 113	Continued From page 7 and 2 of 2 fixtures (1 sink and 1 tub) located in room #5. The findings are: Observations in the facility on 5/10/16 of hot water temperatures revealed: -At 10:30 am, the hot water temperature at the sink in the shared bathroom for rooms #7-8 was 120 degrees F. -At 10:35 am, the hot water temperature at the sink in the bathroom in room S-19 was 120 degrees F. -At 10:44 am, the hot water temperature at the sink in the bathroom in room #5 was 116 degrees F. - At 10:46 am, the hot water temperature at the tub/shower in the bathroom in room #5 was 118 degrees F. -At 10:48 am, the hot water temperature at the sink in the shared bathroom for rooms #3-4 was 118 degrees F. -No steam was visible from any fixture. Interview 5/10/16 from 10:50am to 10:55 am with 3 residents residing on the center hall revealed: -One resident had never had a problem with the water temperature being too hot; if the water temperature was too hot, he mixed the hot water with cold water. -One resident stated the water was a little hotter than she liked when she washed her hands, but she adjusted the water temperature by adding cold water. -One resident stated the hot water temperature was fine. Interview on 5/10/16 at 10:56 am with a first shift Personal Care Aide revealed no resident had complained to her about the hot water	D 113		

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D 113	Continued From page 8 temperature being too hot on the center hall. Interview on 5/10/16 at 10:58 am with the Resident Care Director (RCD) revealed: -No resident or staff had complained to her about the hot water temperature being too hot on the center hall. -The maintenance staff was responsible for monitoring hot water temperatures throughout the building. -She was unaware of the last hot water temperature monitoring. Interview on 5/10/16 at 11:00 am with the Business Office Manager (BOM) revealed: -The maintenance staff monitored random hot water temperatures throughout the building at least once a month. -The hot water temperature log records were kept in the BOM's office. -A hot water temperature was logged for room S-19 on 3/28/16 for 112.3 at the sink. (There were no additional hot water temperature checks after 3/28/16 for room S-19.) -She was unaware the hot water temperatures were above 116 degrees F. for the center hall. Interview on 5/10/16 at 11:10 am with the Maintenance Supervisor and the Maintenance Assistant revealed: -Hot water temperatures were monitored by the assistant. -The thermometer routinely used to monitor hot water temperatures was not available at present but would be in 30 minutes because the thermometer was located in a service truck that was not at the facility. -The thermostat for the hot water heater for the center hall was partially exposed in the closet that maintenance and housekeeping staff used	D 113		

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routinely. The thermostat may have been bumped accidentally by staff cleaning carts or mop buckets.
-The hot water heater thermostat was adjusted to slightly colder by the Maintenance Assistant at 11:20 am.
-Maintenance staff would notify the surveyor when the hot water temperature ws below 116 degrees F.

On 5/10/16 at 11:45 am, calibration of thermometers, using an ice-water slurry, revealed:
-The surveyor's thermometer read 32 degrees F.
-The facility's thermometer read 30 degrees F.

On 5/10/16 at 11:55 am, signs were posted outside the affected bathrooms informing residents and staff of elevated hot water temperatures and advising residents to have staff assist with using hot water.

Interview on 5/10/16 at 12:08 pm with the Administrator in Training (AIT) revealed:
-He was not aware the facility had elevated hot water temperatures for the center hall of the facility.
-The facility had been inspected by the local health department within the last couple of months and the hot water temperatures were within range at that time.

Recheck on 5/10/16 of hot water temperatures in the center of the facility revealed:
-At 2;05 pm, the hot water temperature at the sink in the bathroom in room S-19 was 101 degrees F.
-At 2:10 pm, the hot water temperature at the sink in the bathroom in room #5 was 104 degrees F.
- At 2:12 pm, the hot water temperature at the tub/shower in the bathroom in room #5 was 104

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D 113	Continued From page 10 degrees F. -At 2:15 pm, the hot water temperature at the sink in the shared bathroom for rooms #3-4 was 104 degrees F. -At 2:18 pm, the hot water temperature at the sink in the shared bathroom for rooms #7-8 was 104 degrees F. On 05/10/16 at 2:22 pm the Maintenance Supervisor was informed the signs posted regarding hot water could be removed.	D 113		
D 227	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or (2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that notices of discharge and appeal rights were given at least 30 days before a resident were discharged for 1 of 3 sampled residents (Resident #13). The findings are: Review of Resident #13's Resident Register revealed the date of admission to the facility was	D 227		

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D 227	Continued From page 11 2/8/16. Review of Resident #13's current FL2 dated 2/8/16 revealed: -Diagnoses included non-psychotic mental disorders, ileostomy, congested heart failure, and depression. -Required assistance with personal care bathing, dressing and bowel and bladder. Review of Resident #13's record revealed: -An order for home health services for ileostomy care 2 times weekly and as needed. -Resident #13 was transported to the Emergency Room (ER) on 4/15/16 via Emergency Medical Services (EMS). Review of the local hospital ER notes dated 4/15/16 revealed: -Resident #13 arrived at the ER on 4/15/16 at 6:03 pm with a diagnoses of ileostomy dysfunction. -Documentation Resident #13 was treated in the ER and discharged back to the facility on 4/15/16 at 7:19 pm. -Documentation the ER Nurse called the facility on 4/15/16 at 9:54 pm and was told they were not taking Resident #13 back due to "Sometimes he would not take his medications and they think he needs to be in a psychiatric hospital." -Documentation on 4/15/16 at 11:25 pm the ER Nurse called the facility and spoke to the Medication Aide (MA), the MA refused to take Resident #13 back due to the facility doctor said Resident #13 required a skilled nursing facility and per the Administrator they were not to take Resident #13 back. -Documentation on 4/16/15 at 10:21 am the facility Administrator returned the call to the ER. The Administrator said Resident #13 was sent to	D 227		

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the ER on 4/15/16 after he was seen by the house doctor and Resident #13 was not eating, drinking, or taking his medications for three days. The ER Nurse said they were not made aware of this; only the ileostomy was not working. The ER Nurse obtained the Administrator's phone number for the hospital social worker to contact.
-Documentation the ER Nurse contacted the hospital's social worker and advised her the facility had refused to take Resident #13 back after treated and discharged on 4/15/16 from the ER.

Telephone interview on 5/10/16 at 4:45 pm with the hospital social worker revealed:
-Resident #13 arrived in the ER via EMS on 4/15/16 with a leaking ileostomy bag.
-After Resident #13 was treated in the ER the facility would not take him back.
-The ER staff had contacted the social worker with the concern the facility had refused to take Resident #13 back.
-She called the facility and had spoken to several staff members and was told Resident #13 was not eating or drinking for 3 days and the facility doctor had written an order not to take Resident #13 back, "He required a higher level of care."
-The hospital social worker contacted Resident #13's Guardian on 4/14/16 in regards to the facility refusing to take Resident #13 back to the facility, the guardian was unaware Resident #13 was in the ER, unaware of the higher level of care recommendation, or the refusing to take Resident #13 back to the facility.
-Resident #13 stayed in the ER from 4/15/16 to 4/23/16, he developed urinary retention and was admit to the hospital on 4/23/16 and remained till 5/10/16 when he was discharged to a skilled nursing facility.
-The facility had not issued a 30 day discharge

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D 227	Continued From page 13 notice to Resident #13, "I feel the facility dumped him in the ER." Telephone interview on 5/11/16 at 9:40 am with Home Health Nurse revealed: -Home Health started care for Resident #13 on 2/9/16 for ileostomy care. -She visited Resident #13 two times weekly and as needed. -Her last visit was on 4/14/16 and she had replaced the ileostomy bag at that time. -Resident #13 was noncompliant with ileostomy care and sometimes had refused care. -She was aware Resident #13 was transported to the ER on 4/15/16 but thought it was for psychiatric issues not a leaking ileostomy bag. -She said if Resident #13's ileostomy bag was leaking the facility should called her or the home health on-call services for after-hours needs. -She was not called on 4/15/16 nor was the home health office on-call services contacted on 4/15/16. -"We do not expect the facility to send a resident to the ER when we are providing the treatment and care to that resident". Telephone interview on 5/11/16 at 10:30 am with the Primary Medical Nurse Practitioner (NP) revealed: -She had seen Resident #13 on 4/15/16. -The facility staff had informed her Resident #13 was not eating, drink or taking his medications. -On 4/15/16 she asked the facility to monitor Resident #13's input and output and to keep a record of this, as well as obtain vital signs daily. -On 4/15/16 she examined Resident #13 he was not dehydrated and his ileostomy stoma had good output. -She contacted the mental health provider on 4/15/16 with the facility concerns Resident #13	D 227		

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D 227	Continued From page 14 was refusing psychiatric medications. -She was unaware Resident #13 had refused his medications in March 2016 or April 2016 until April 15, 2016 when the facility staff made her aware of his refusals. Review of the Primary Medical NP note date 4/15/16 revealed: -Resident #13 was seen on 4/15/16 per facility request due to Resident #13 refusing to eat meals cooked at the facility, refusing medications and uncooperative behavior with Ostomy care. -Documentation Resident #13 was well nourished, well developed and in no acute distress. -Diagnoses included protein/calorie malnutrition and schizophrenia/ anxiety. -An order to record fluid intake on the Medication Administration Record (MAR) as much as possible, daily vital signs, notify provider if systolic blood pressure was less than 100 or if patient had not voided in 8 hours. Interview on 5/12/13 at 10:30 am with the Mental Health Nurse Practitioner revealed: -She had seen Resident #13 on 4/7/16 and noticed a change in his behaviors and was adjusting his medications. -The medical provider contacted her on 4/15/16 in regards to Resident #13 not eating, drinking or taking his psychiatric medications. -She was aware Resident #13 was noncompliant with medications but not consistently noncompliant. -She was unaware Resident #13 had gone to the ER on 4/15/16. -She had not wrtten or given a verbal order to send Resident #13 out to the ER on 4/15/16. -The facility staff called on 4/18/16 and requested a higher level of care for Resident #13.	D 227		

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-She was unaware Resident #13 had eaten a sandwich fixed by the staff on 4/13/16.
-She was not aware Resident #13 had refused his medications on 4/12/16 at 8:00 am, but took them at 11:00 am.
-She was not aware on 4/14/16 Resident #13 refused breakfast, but ate lunch.
-She was unaware on 4/15/16 Resident #13 refused ileostomy care at 8:00 am but agreed to have Ostomy bag replaced later that day prior to the ER visit.

Review of the Mental Health NP note dated 4/18/16 revealed:
-Chief complaint was documented as "per staff report: Staff called to request higher level of care."
-Plan of care "This level of care is not appropriate for this resident at this time due to non-compliance with medications and care, combative behaviors toward staff and therefore poses a risk of harm to himself and or other residents and staff".

Review of the Mental Health NP note dated 5/12/16 revealed:
-Chief complaint was documented as "supervisor chart review."
-Documentation acute issues began on 4/7/16, Resident #13 had refused some medications and adjustments were made to his psychiatric medications.
-Documentation on 4/15/16 the Primary NP had seen Resident #13 and noted refusing medications, refusing to eat meals prepared here, and uncooperative behaviors with Ostomy care, instructed staff to send Resident out if he continues to refuse medications or is combative due to safety concerns.
-Documentation Resident #13 was sent to the ER

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per this plan on 4/15/16.
-Documentation the mental health provider had contacted the ER and spoken to the ER doctor on 4/18/16 with the recommendation Resident #13 should not return to the facility due to safety risk or non compliance.
-Documentation Resident #13's level of risk to himself due to non compliance was too high to allow him to continue in his current setting.

Telephone interview on 5/11/16 at 12:30 pm with Resident #13's guardian revealed:
-Resident #13 had been in the facility since February 2016, and the facility had no problem meeting his needs or providing care or treatment.
-She was unaware Resident #13 was seen in the ER on 4/15/16 until 4/16/16 when the hospital social worker had contacted her.
-She was unaware Resident #13 was not sent back to the facility after his ER visit on 4/15/16.
-The guardian said a family member had heard Resident #13 was not eating and not drinking and was concerned.
-The family member contacted the Sheriff's department and EMS to transport Resident #13 to the ER on 4/13/16.
-Resident #13 refused to go to the ER on 4/13/16.
-The guardian called the facility again on 4/14/16 and spoke to the BOM about Resident #13's care and treatment and was told Resident #13 was doing fine.

Interview on 5/11/16 at 5:20 pm with the Resident Care Director (RCD) revealed:
-She had worked on 4/15/16.
-She informed the Medical Provider Resident #13 had not eaten or drank in 3 days, he was also refusing medications.
-She had gone into Resident #13's room with the medical provider to talk with Resident #13 on

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4/15/16.
-She said the medical provider gave a verbal order, if Resident #13 refused treatment or care, send him out to the ER for evaluation.
-The RCC was not a nurse and was aware she could not take a verbal order from a medical provider.
-The facility fax machine was down over the weekend on 4/15/16 to 4/18/16 so she assumed the order to send Resident #13 out if refused meals, medications and treatment would arrived when the fax machine was fixed.
-She said the facility could not meet Resident #13's needs and he required a higher level of care.

Interview on 5/11/16 at 5:35 pm with the Administrator revealed:
-Staff had made her aware on 4/13/16 Resident #13 was not eating, drinking, or taking his medications.
-The medical provider had seen Resident #13 on 4/15/16 and gave a verbal order to send the resident out if he refused his care and treatment.
-The facility fax machine was not working over the weekend of 4/15/16 to 4/18/16 so the facility could not receive the order from the medical provider in regard to Resident #13.
-She said the staff was just following orders per the medical provider when they sent Resident #13 to the ER on 4/15/16 because he refused his medication that evening.
-She said Resident #13 required a higher level of care and that was the reason they did not take the Resident #13 back from the ER on 4/15/16.

Interview on 5/12/16 at 12:40 pm with the Administrator in Training revealed:
-He was not aware the facility had refused to take Resident #13 back from the ER on 4/15/16; he

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D 227	Continued From page 18 thought the medical provider had given an order and the staff had followed it. -He was not aware Resident #13 had refused medications and treatment several times over the last three months. -He was aware a 30 day discharge was to be issued prior to discharging a resident from the facility. -He had never spoken to the guardian or Resident #13 concerning a 30 day discharge. Interview on 5/10/16 at 3:45 pm with the Business Office Manager (BOM) revealed: -She had completed a discharge on 4/18/16 for Resident #13 and faxed to the emergency on 4/18/16. -The reason on the discharge notice for Resident #13, It is necessary for your welfare and your needs cannot be met at this facility. -She contacted the guardian on 4/18/16 and informed her the facility medical provider had ordered to send Resdient #13 out due to requiring a higher level of care.	D 227		
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 interviews, record reviews, and	D 270		

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observations, the facility failed to provide supervision and monitoring for 2 of 6 sampled residents related to a resident drinking rubbing alcohol resulting in a fall with injury (Resident #10) and failing to secure the whereabouts of a resident with dementia which resulted in the resident missing for several hours (Resident #11).

The findings are:

A. Review of Resident #10's FL2 dated 8/27/15 revealed diagnoses included multiple falls, schizophrenia, hypokalemia, insomnia, urinary tract infections, diabetes mellitus, hypertension, syncope, chronic obstructive pulmonary disease, transient ischemic attack, status post cholecystectomy and hyperlipidemia.

Review of Resident #10's record revealed diagnoses included chronic alcohol abuse.

Review of Resident #10's Primary Care Physician's Visit Note dated 2/19/16 revealed:
-Diagnoses included a recent hospitalization for a "gastrointestinal bleed questionably secondary to non-ethanol alcohol ingestion".
-A physician's order to have staff "CHECK ROOM DAILY FOR ALCOHOL/RUBBING ALCOHOL AND REMOVE - RECORD ON MAR."
-Resident #10 was assessed as a moderate fall risk.

Review of Resident #10's Care Plan dated 9/03/14 revealed there was no indication for a need for increased supervision related to fall risk or alcohol consumption.

Review of Resident #10's Primary Care Physician's Visit Note dated 3/02/16 revealed a Physician's order to "REMOVE ANY RUBBING

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D 270	Continued From page 20 ALCOHOL FROM THE PATIENT'S ROOM." Review of Resident #10's February and March 2016 electronic Medication Administration Records (eMARs) revealed there was no documentation of checking room for alcohol/rubbing alcohol and removing it from the resident's room. Review of Resident #10's Psychologist's Visit Note dated 3/07/16 revealed: -Staff reported frequent intoxication of rubbing alcohol and Resident #10 was found intoxicated at the facility on several occasions. -Resident #10 drinks a bottle of rubbing alcohol several times a week. -Resident #10 occasionally smoked marijuana with last usage on 2/24/16. Review of Resident #10's Nurses Notes revealed: -On 3/131/6 Resident #10 was drunk and having difficulty taking medications. -On 3/15/16 at 10:24 am Resident #10 was found by staff face down outside on the sidewalk near the road and an ambulance transported Resident #10 to the local emergency department. Review of Resident #10's Emergency Medical Service (EMS) Call Report dated 3/15/16 revealed: -The protocol implemented was "overdose/toxic ingestion". -Resident #10 had an altered level of consciousness and the smell of alcohol was on her breath. -The facility staff reported that the patient had been drinking rubbing alcohol and mixing it with aspirin. Further review of Resident #10's Nurses Notes	D 270		

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D 270	Continued From page 21 revealed: -On 3/19/16, Resident #10 was staggering when walking and had blurry vision. -On 3/23/16, Resident #10 was laying down and barely able to lift her head up and smelled of alcohol. -A second entry on 3/23/16, Resident #10 was in her room, staggering and fell to the floor and was limping on her left leg. -On 3/24/16, Resident #10 was laying on the floor and complaining of pain in her left hip. Resident #10 had bruising on her left hip, could not stand and was transported to the hospital via ambulance. -There was no documentation of increased monitoring after the falls on 3/23/16 to 3/24/16. Review of Facility Incident and Accident Reports revealed: -There was no report dated 3/15/16 when the resident was found outside of the facility on the sidewalk face down and sent to the ER. -A report dated 3/23/16 when Resident #10 was found on the floor with complaint of left hip pain. -A report dated 3/24/16 when Resident #10 was found on the floor with complaint of left hip pain, swelling and an abrasion present and was transported to the emergency department via ambulance. Interview with a Medication Aide (MA) on 5/12/16 at 9:20 am revealed: -Resident #10 was sent to the hospital on 3/24/16 and was now in a nursing center recovering from a broken hip she sustained from the fall. -Resident #10 would walk to the local store and buy rubbing alcohol. -Resident #10's family member would also bring in rubbing alcohol and asked staff to dilute it with water.	D 270		

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-Resident #10 would become physically aggressive if staff tried to get near her alcohol.
-Resident #10 wore a blue bag she carried all the time and that she kept her alcohol in and staff could never get close to it to remove the alcohol.
-Resident #10 also obtained aspirin from the store and would mix it with her rubbing alcohol before she drank it.
-When Resident #10 fell, the MA was able to get into her bag and the bottle of rubbing alcohol was completely empty. There were 2 bottles of aspirin that were both half empty.
-The staff did not perform daily checks of Resident #10's room and if staff did check her room for alcohol staff did not document the room check and did not document the findings.

Interview with a Personal Care Aide (PCA) on 5/13/16 at 4:08 pm revealed:
-Resident #10 was sent to the hospital on 3/24/16 and was now in a nursing center recovering from a broken hip she sustained from the fall.
-There was no increased supervision for Resident #10 to monitor for alcohol ingestion or after falls.
-She never removed alcohol from Resident #10's room.
-She knew Resident #10 drank alcohol but did not see any in her room.
-Resident #10 was known to drink rubbing alcohol but she never intervened.

Interview with a second PCA on 5/12/16 at 4:12 pm revealed:
-She knew of residents that had diabetes or other illnesses that she kept a closer eye on, but she did not know to monitor Resident #10 for drinking alcohol or for safety related to falls.
-She did not know to check Resident #10's room for rubbing alcohol therefore there was no documentation related to Resident #10's

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D 270	Continued From page 23 increased monitoring related to falls, room checks for alcohol or alcohol consumption. Interview with Business Office Manager on 5/12/16 at 11:40 am revealed: -The facility could not do anything about Resident #10's drinking rubbing alcohol. -They had tried in the past to take it out of her room, but she would become physically aggressive. -The facility staff had tried to water the rubbing alcohol down, but Resident #10 caught on to this. -A long time ago Resident #10 drank a bottle of rubbing alcohol and walked straight into a cement wall. -She had a discussion with Resident #10's family member and told her that she could not supply her with rubbing alcohol, but did not know when the discussion took place. -Resident #10 was sent to the hospital on 3/24/16 and was now in a nursing center recovering from a broken hip she sustained from the fall. Interview with Resident #10's family member on 5/12/16 at 12:22 pm revealed: -The family member did bring Resident #10 rubbing alcohol because if she did not Resident #10 would walk down the road to the store and risk getting hit by a car. -She did ask the facility staff to water the alcohol down, but knew that Resident #10 detected this and became angry. -The facility did ask her not to bring it in on one occasion but did not recall when. -The facility staff, the family member and Resident #10 did not discuss other things to implement that may have been effective in curbing this behavior. -The facility staff, the family member and Resident #10 did not discuss options such as	D 270		

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Alcoholics Anonymous or alcohol rehabilitation.
-The facility staff, the family member and Resident #10 did not discuss changing Resident #10's level of care to increase supervision in efforts to prevent the drinking of rubbing alcohol.
-Resident #10 was hospitalized and was currently in a nursing facility recovering from a broken left hip she sustained during the fall documented on 3/24/16.

Interview with the Administrator on 5/16/16 at 11:01 am revealed:
-She was aware that Resident #10 drank rubbing alcohol.
-Resident #10 liked to put rubbing alcohol on her legs and feet.
-She told Resident #10 on several occasions she could not have rubbing alcohol and if she wanted it on her hands and feet the facility would keep it on the medication cart and she could apply it with supervision. She did not know the when these discussions occurred.
-The facility staff had thrown several bottles of rubbing alcohol away, but she did not know how many or when and this was not documented.
-The facility staff did not routinely check her room for rubbing alcohol.
-The facility staff would be prompted to check her room after a Resident #10 had a family member visit.
-She was aware that Resident #10 walked to the local store to purchase rubbing alcohol, but it was not that often because Resident #10 did not have a lot of money.
-She met with Resident #10 and the family member and informed them that Resident #10 was not to have rubbing alcohol and they denied Resident #10 drank it. She did not know when this meeting took place.
-She told the family member that she would call

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Adult Protective Services if she continued to supply the rubbing alcohol.
-She never called Adult Protective Services.

Interview with Resident #10's primary care's Physician Assistant (PA) on 5/16/16 at 9:01 am revealed:
-She had not been notified of Resident #10 drinking rubbing alcohol recently.
-Every time the PA visited the facility, she discussed with the staff that the rubbing alcohol must be removed from Resident #10's room.
-She wrote orders Resident #10's room should be monitored for rubbing alcohol on a daily, on going basis.
-She did not think the facility ever executed or followed up on these orders because each visit there were repeat occurrences of Resident #10 drinking and she would have to have repeat discussions about removing the rubbing alcohol from Resident #10's room.

B. Review of Resident #11's FL2 dated 10/08/15 revealed:
-Diagnoses included dementia, schizophrenia, hypertension, hyperlipidemia and history of basal cell carcinoma.
-A documentation statement, "Recommend Vet not report to work."

Review of Resident #11's record revealed Resident #11 was deemed incompetent and had a court appointed guardian.

Review of Resident #11's Resident Register revealed the resident was admitted to the facility on 10/08/15.

Review of Resident #11's Care Plan signed by the physician on 11/04/15 revealed:

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D 270	Continued From page 26 -The resident currently received medication to treat dementia. -The resident was independent of all Activities of Daily Living (ADLs). Review of Resident #11's Nurses Notes revealed: -Resident #11 was noted not to be at the facility at 5:10 pm on 3/08/16. -The facility was to pick up Resident #11 at the local hospital at 2:30 pm on 3/08/16 and they failed to do so. -A Medication Aide (MA) was sent to the hospital to pick up the resident and he was not there. -The hospital police involved the local city police because he could not be located on hospital grounds at that time. -When the hospital police reported to the MA how serious this was for Resident #11 the MA proceeded to tell the police that Resident #11 had left the hospital on his own in the past. -Resident #11 was found to have gotten on the wrong public transportation bus and was en route back to the hospital. -Facility staff met him at the hospital and returned him to the facility at 7:00 pm. Review of the local hospital Police Report dated 3/08/16 revealed: -The initial call was received at 5:40 pm and was in reference to a missing person. -The officer obtained a description of Resident #11 and searched Building 6 and all of the surrounding buildings and streets for Resident #11. -The officer questioned every employee he saw, but no one had seen the man with the matching description. -The officer went on bicycle patrol of the streets in search of Resident #11 and he saw a man walking in front of Building 2 and it was Resident	D 270		

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#11.
-Resident #11 was confused and not of sound thought which was a "big reason the facility was so worried of his whereabouts".
-The officer contacted the facility and waited with Resident #11 until the MA picked him up.

Interview with the Transportation Aide on 5/12/16 at 8:21 am revealed:
-She transported Resident #11 to the hospital for his volunteer work every day and picked him up at 2:30 pm.
-Resident #11 was very repetitive and every day on the way to the hospital he would say, "You're going to get me at 2:30, right" several times over.
-He was always dropped off and picked up in the same place.
-She was not aware of there ever being an employee of the hospital overseeing him to make sure he stayed at the pick up point.
-She was not working on 3/08/16 and there was a substitute driver that day.
-She did not sign out residents when she transported because they were all listed on an appointment list.

Interview with the substitute Transportation Aide on 5/12/16 at 10:04 am revealed:
-She dropped off Resident #11 at the hospital to volunteer on the morning of 3/08/16.
-She did not sign Resident #11 out of the facility prior to taking him to the hospital .
-She returned to pick up Resident #11 and he was not at the pick up point at 2:30pm on 3/08/16.
-She waited 10 minutes and left because in the past if it was past 2:30 pm Resident #11 would take the bus back to the facility.
-She reported to facility staff on first shift and requested they inform second shift that she did

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not pick up Resident #11.
-She returned the van key to the supervisor and clocked out.

Interview with the Resident Care Director (RCD) on 5/12/16 at 9:33 am revealed:
-The facility did not routinely do a head count except the census count that was done every night at mid-night.
-Resident #11 went to the hospital to volunteer everyday with a group of other residents and when the substitution Transportation Aide picked up the residents she overlooked that Resident #11 was not present for the pick up.
-Resident #11 had missed the ride in the past and when this occurred he would get on a bus and get off at a local bus stop.
-The RCD instructed staff to go and look for Resident #11 at that bus stop on 3/08/16 but he was not there.
-She then sent a MA to the hospital police and reported that the facility had a missing resident.
-The police found Resident #11 on the wrong bus and this bus brought Resident #11 to the local bus stop and staff picked him up at the bus stop.
-Residents leaving to volunteer, for classes or appointments were expected to sign out prior to leaving.
-The RCD did not notice any cognitive changes prior to him getting lost on 3/08/16.
-Since Resident #11 had been staying at the facility during the day she had noticed a cognitive decline.
-The facility did not do routine cognitive assessments or elopement risk assessments.

Interview with the Business Office Manager on 5/12/16 at 11:25 am revealed:
-In case of a missing person, the policy was to search the building, the then to call the RCD, the

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Administrator and the office manager.
-If a person had been missing for 24 hours the policy was to initiate a Silver Alert.
-The facility had an in-service on 11/13/15 in regards to missing persons and 19 staff attended the in-service.
-In the case of a missing resident staff was expected to alert the county, 911 and photocopy the resident's demographic sheet and a photo to give to the authorities.
-Each resident had a bag with an article of clothing that they had worn in case a Silver Alert was initiated.
-A Silver Alert had not been initiated by this facility.
-Staff had also been instructed to go out and look for residents when they were missing.
-This facility was an assisted living facility and if the residents want to walk down the street they can walk, but it was policy for residents to sign in and out of the facility.

Interview with the second shift Supervisor on staff when Resident #11 was missing on 5/12/16 at 12:04 pm revealed:
-Staff noticed at dinner Resident #11 was missing and so she called the staff at the hospital to locate him.
-The hospital staff could not locate him so she called the local police.
-The local police called the hospital police and the hospital police found him sitting outside "the gate".
-Resident #11's dementia had been getting worse.
-She did not remember calling the Responsible Party about Resident #11's absence.
-The Supervisor called the RCD and the Administrator.
-The first shift did not tell her that Resident #11

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was not picked up at 2:30 pm.
-Staff do not do regular "head counts" but she knew her residents' behaviors and when one did not show up for a meal or snacks or another for medicine then she knew to go investigate based off of the change in patterned behaviors.
-Staff did look for changes in the residents and she noted a decline in his cognitive and functional status.
-She did not document changes noted, but discussed them with RCD and other staff.
-Resident #11 was observed having increased difficulty changing his clothes (order) and finding the dining room.

Interview with Resident #11's Responsible Party on 5/10/16 at 12:05 pm revealed:
-She was the appointed Guardian for Resident #11 and a social worker at the county Department of Social Services.
-She was not notified of Resident #11's being missing until she read about the incident in Resident #11's record.
-She inquired about the incident and was told that the transport person left at 2:00 pm and it was not until 5:00 pm until staff noticed his absence.
-At that time they sent staff to locate Resident #11 and that staff member reported that he got on a bus and police were then notified.
-The bus took him back to the facility.
-The staff member that dropped him off apparently did not know to go back and get him.
-The facility did not call her and notify her that Resident #11 was missing.

_____

A Plan of Protection was provided by the facility on May 12, 2016 as follows:
-Effective immediately, staff will look for residents who need supervision.
-Staff will monitor accordingly and if a need arises

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D 270	Continued From page 31 staff will promptly notify the RCD and provider. -The RCD will follow up on shift to shift meetings and will take management aware of needs. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 15, 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 observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 7 sampled residents with regards to low blood pressures (BP) (Resident #7) and refusal of medications and meals (Resident #13). The findings are: A. Review of Resident #7's current FL2 dated 8/07/15 revealed: -The diagnoses included acute congestive heart failure, coronary artery disease, hypertension and urinary retention. -The medication section with the words "see attached" and there was no attachment. Review of Resident #7's record revealed a	D 273		

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D 273	Continued From page 32 Physician's order dated 12/09/15 for blood pressures to be taken daily. Review of Discharge Summary dated 2/25/16 revealed: -Physician order's to discontinue furosemide 20mg (a diuretic used to decrease blood pressure), Review of the Discharge Summary from a local hospital dated 2/25/16 revealed: -Physician's orders to discontinue furosemide 20mg (a diuretic used to treat congestive heart failure and hypertension), isosorbide mononitrate 30mg 24hr tablet (a long acting medication used to treat and prevent chest pain), metoprolol succinate 25mg 24hr tablet (a long acting medication used treat high BP, chest pain, and heart failure.) -Physician's orders to add amlodipine 2.5mg 1 tablet daily (a medication used to treat high BP and chest pain), metoprolol tartrate 25mg one tablet twice daily (a medication used to treat high BP and prevent chest pain), and nitroglycerin 0.2mg/hr patch - one patch daily (a medication used to treat chest pain). Review of the March 2016 eMAR revealed: -An entry for amlodipine 2.5mg 1 tablet daily and documented as administered at 8:00 am 3/01-3/08/16. -An entry for furosemide 20mg 1 tablet daily and documented as administered at 8:00 am 3/01-3/08/16. -An entry for isosorbide mononitrate 30mg ER 1 tablet daily and documented as administered at 8:00 am 3/01-3/08/16. -An entry for metoprolol tartrate 25mg 1 tablet twice daily and documented as administered at 8:00am and 8:00pm 3/01-3/08/16.	D 273		

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-An entry for nitroglycerin 0.2mg/hr - apply one patch daily and documented as administered at 8:00 am 3/01-3/08/16.
-An entry for BP to be taken daily at 12:00 pm and documented as 111/51 on 3/01, 95/48 on 3/02, 113/48 on 3/03, 92/57 on 3/04, 78/49 on 3/05, 82/61 on 3/06, 94/68 on 3/07 and 84/43 on 3/08/16.

Further review of Resident #7's Nurses Notes revealed:
-An entry dated 2/27/16 where BP was recorded as 112/57.
-An entry dated 2/28/16 where Resident #7 was disoriented and confused during 3-11:00 pm shift.
-An entry dated 3/02/16 where BP was recorded as 95/48 (as entered on MAR).
-An entry dated 3/05/16 where BP was recorded as 78/49 (as entered on MAR).
-An entry dated 3/06/16 where BP was recorded as 82/61 (as entered on MAR).
-An entry dated 3/08/16 where BP was recorded as 84/43 (as entered on MAR).
-An entry dated 3/08/16 where Resident #7's family member called and informed facility staff that he was admitted to the hospital.
-There was no documentation that staff called Resident #7's physician in regards to the low BP.

Interview with a Medication Aide (MA) on 5/10/16 at 10:49 am revealed:
-It was their policy to recheck a BP if the first reading was outside of normal range.
-If the second BP was abnormal they were to report this to the Resident Care Director (RCD).
-The RCD or the MA would call the physician and report the abnormal result.
-She did not report the abnormally low BP to the RCD.
-She may have reported the low BP to the

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D 273	Continued From page 34 physician but can not remember. Interview with a second MA on 5/10/16 at 10:59 am revealed: -She considered 80/40 to be a BP in "the danger zone" and would call the physician if the BP was this low. -She considered anything above 140/80 or below 80/40 to be abnormal. -She would also notify the RCD of the abnormal reading. -She did not report the low BP to the RCD or the physician but thinks she discussed it with the Home Health Nurse. -Resident #7 was really weak, short of breath and more confused than usual before he went to the hospital on 3/08/16. Interview with a third MA on 5/11/16 at 11:04 am revealed: -She considered 80/60 to be a low BP that would require physician notification. -She would call the physician after rechecking the BP. -She would report the hypotension to the RCD but does not remember if she reported any low readings to the RCD. -Resident #7 was more confused, disoriented and weak before he went to the hospital on 3/08/16. -She recalled having called Resident #7's physician and left a message in regards to the low BP but does not recall when and she did not document this in the resident record. -She did not know if the physician called back, but had not by the end of her shift. -She notified the Home Health Nurse when she was visiting but did not remember when. -She did not document when she reported this to the Home Health Nurse.	D 273		

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D 273	Continued From page 35 Interview with the RCD on 5/11/16 at 11:20 am revealed: -The MAs were to recheck any vital sign if an abnormal reading was obtained. -The MAs were to call the resident's physicians if they obtained an abnormal vital sign. -After they called the physician's office they were to notify her. -Staff had not reported these low BPs. -She considered a BP of 80/60 or 70/50 low and would contact the resident's physician if a resident presented with this low of a pressure. -She was not aware that Resident #7 had low BPs. -She thought someone sent Resident #7 to the hospital on 3/05/16 because he had low BP. -Resident was weak and confused and could tell it was a result of the recent medication changes. -She reported her concerns to the home health nurse. -She did not report the low BP or change in condition to the primary care physician. Review of Resident #7's Emergency Service Patient Care Record dated 3/05/16 revealed: -The facility staff called Emergency Services for transport because Resident #7 had blood in his urine. -Resident #7 reported that the blood was discovered around his catheter site. -Resident #7's BP was recorded as 117/43 and 107/54 during transport. A telephone interview with a representative from Resident #7's Physician's Office on 5/12/16 at 9:01 am revealed: -On 2/29/16 the facility called the office to report that Resident #7 had been in the hospital for pneumonia but no reports about his blood pressure.	D 273		

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D 273	Continued From page 36 -On 2/29/16 the office contacted facility staff to inquire about Resident #7's status and make a follow up appointment. Staff told caller Resident #7 was more confused and disoriented but seemed ok and they made a follow up appointment for 3/08/16. -On 3/03/16 the Home Health Nurse called and reported her skin evaluation and dressing changes. -There was no other phone messages between 2/25/16 and 3/08/16. Interview with the Home Health Nurse on 5/12/16 at 4:59 pm revealed: -His hospitalization with the discharge date 2/25/16 started his decline in medical condition. -She expected the facility staff to contact the physican if a resident had low BP. -She contact the physician with updates and order requests with the last call being on 3/03/16. Interview with the Administrator on 5/11/16 revealed: -She expected that the MAs would call the physician if an abnormal vital sign was obtained. -She expected that the MAs would call and inform the RCD after calling the physician. Interview with the Home Health Nurse on 5/12/16 at 4:59 pm revealed: -His hospitalization with the discharge date 2/25/16 started his decline in medical condition. -She did remove a nitroglycerin patch on 3/08/16 prior to his seeing his primary care doctor. -She expected the facility staff to contact the physican if a resident had low BP. -She contact the physician with updates and order requests with the last call being on 3/03/16. -She would have called the physician on 3/08/16 but knew that he was going to see his physician	D 273		

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in office shortly thereafter.
-She was not aware that the discontinued medications had not been discontinued.
-She did not observe more than one patch one Resident #7, but did not remove his clothing to inspect for other patches.

Interview with Resident #7's Responsible Party (RP) on 5/10/16 at 2:10pm revealed:
-Resident #7 was physically weak but suffered a very rapid decline after he was hospitalized in February 2016.
-She went with Resident #7 to the follow up office visit and Resident #7's BP was so low they could not obtain a pressure.
-They sent him straight over to the emergency room where they discovered he was wearing two patches.
-He spent three days in the hospital and was transferred to a nursing home where he passed away on 4/07/16.

Interview with Resident #7's Physician on 5/11/16 at 9:58 am revealed:
-Resident #7's BP was so low in his office he could not auscultate his pressure.
-Resident #7 was conscious at the office visit on 3/08/16.
-The Physician was not aware of the medication changes that were made at the hospital.
-He would expect that if facility staff obtained abnormal vital signs such as the low BP that the facility staff report them to the prescribing practitioner.

B. Review of Resident #13's current FL2 dated 2/8/16 revealed:
-Diagnoses included non-psychotic mental disorders, congested heart failure, and depression.

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-Medications ordered included Carbamazapine 200 mg (a mood stabilizer) three times daily, citalopram 40 mg (a antidepressant) at night, and risperidone 2 mg (a antipsychotic) two times daily.

Review of Resident #13's record revealed:
-A physican order dated 3/24/16 to start divalproex 125 mg (used to treat depression) three times daily.
-A physican order dated 4/8/16 to change divalproex 125 mg to one time daily at night.
-Resident #13 was transported to the Emergency Room (ER) on 4/15/16 via Emergency Medical Services (EMS).

Review of Resident #13's February 2016 electronic Medication Administration Record (eMAR) revealed:
-An entry for risperidone 2mg tablets take 1 tablet two time daily scheduled for administration at 8:00 am and 8:00 pm.
-Documentation Resident #13 refused risperidone 2 mg on 2/21/16 at 9:08 am and on 2/22/16 at 7:58 am.

Review of Resident #13's March 2016 eMAR revealed:
-Foot soaks with warm water, betadine and epsom salt were entered on the eMAR two times daily at 8:00 am and 8:00 pm.
-Documentation Resident #13 had refused foot soaks from 3/23/15 to 3/30/16.
-An entry for Risperdone 2mg take 1 tablet two times daily to be administered at 8:00 am and 8:00 pm.
-Documentation Resident #13 refused risperdone 2 mg on 3/20/16 at 10:08 am, 3/30/16 at 9:26 am, 3/30/16 at 8:00 pm, and on 3/31/16 at 7:24 pm.
-An entry for divalproex 125 mg take one tablet three times daily and scheduled for administration

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at 8:00 am, 2:00 pm, and 8:00 pm.
-Documentation Resident #13 refused divalproex 125 mg on 3/30/16 at 9:26 am, 3/30/16 at 8:00 pm, and on 3/31/16 at 7:24 pm.
-An entry on the eMAR for citalopram 40 mg take one tablet every night to be administered at 8:00 pm.
-Documentation Resident #13 refused citalopram 40 mg on 3/30/16 at 8:00 pm, and on 3/31/16 at 7:24 pm.
-An entry for cephalexin 500 mg take 1 tablet two times daily for 10 days scheduled at 8:00 am and 8:00 pm.
-Documentation Resident #13 refused cephalexin 500 mg on 3/30/16 at 9:26 am, 3/30/16 at 8:00 pm, and on 3/31/16 at 7:24 pm.

Review of Resident #13's April 2016 eMAR revealed:
-An entry on April 1st through the 5th documenting that Resident #13 refused foot soak treatment.
-An entry for divalproex 125 mg take one tablet three times daily and scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm.
-Documentation Resident #13 refused divalproex 125 mg on 4/3/16 at 2:25 pm, 4/4/16 at 8:56 am, 4/6/16 at 2:32 pm, and on 4/8/16 at 8:53 pm.
-An entry for Risperdone 2mg take 1 tablet two times daily to be administered at 8:00 am and 8:00 pm.
-Documentation Resident #13 refused risperdone on 4/4/16 at 8:56 am, 4/11/6 at 9:12 am, 4/13/16 at 10:01 am, and on 4/15/16 at 9:53 am.

Telephone interview on 5/11/16 at 10:30 am with Resident #13's Medical Nurse Practitioner (NP) revealed:
-She had seen Resident #13 on 4/15/16 at the facility.

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-The facility staff informed her on 4/15/16 Resident #13 was not eating, drink, or taking his medications for the last three days.
-The NP had known Resident #13 had refused meals and ileostomy care in the past but thought it was getting better.
-The NP was unaware Resident #13 had refused any medications during three days 4/13/16 to 4/15/16 until the staff informed her of this on 4/15/16.
-She had written orders on 4/15/16 to record Resident #13's input and output on the eMAR, and to to obtain vital signs daily.
-She notified on 4/15/16 Resident #13's mental health provider of the resident's medication refusals due to all the medications were psychiatric medications.

Review of the nurse's notes for Resident #13 revealed:
-On 3/21/16 by first shift staff, Resident #13 refused breakfast but ate lunch.
-On 3/23/16 by second shift staff, Resident #13 refused dinner.
-On 3/25/16 by first shift staff, Resident #13 refused breakfast but was supervised at lunch.
-On 3/30/16 by first shift staff, Resident #13 refused breakfast.
-On 3/31/16 by first shift staff, Resident #13 refused breakfast, lunch, and dinner.

Review of the nurse's notes Resident #13 revealed:
-On 4/2/16 by first shift staff, Resident #13 refused both breakfast and lunch.
-On 4/3/16 by second shift staff, Resident #13 was in bed all second shift, did not eat dinner or snacks.
-On 4/4/16 by first shift staff, Resident #13 refused all 8:00 am medications and all meals.

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D 273	Continued From page 41 -On 4/5/16 by first shift staff, Resident #13 refused breakfast, lunch, and foot soak. -On 4/7/16 by first shift staff, Resident #13 refused breakfast and dinner. -On 4/8/16 by first and second shift staff, Resident #13 refused lunch and dinner meals. -On 4/9/16 by second shift staff, Resident #13 refused dinner. -On 4/11/16 by first shift staff, Resident #13 refused breakfast and lunch meals. -On 4/11/16 at 8:00 am Resident #13 refused 8:00 am medications and ileostomy care but then took 8:00 am medications and had ileostomy care completed at 10:00 am. -On 4/11/16 at 11:30 am Resident #13 refused to get up and eat lunch. -On 4/11/16 by second shift staff, Resident #13 refused dinner meal. -On 4/12/16 by first shift staff, Resident #13 refused 8:00 am medications. -On 4/12/16 by first shift staff, Resident #13 refused meals "due to having snacks in his room." -On 4/12/16 by second shift staff, Resident #13 refused dinner but took his 8:00 pm medications. -On 4/13/16 by first shift staff, Resident #13 refused his 8:00 am medications. -On 4/13/16 by second shift staff, Resident #13 refused his dinner but staff fixed him a sandwich in his room at 8:45 pm. -On 4/14/16 by first shift staff, Resident #13 refused breakfast but was supervised for the lunch meal. -On 4/15/16 by first shift staff, Resident #13 refused both breakfast and lunch meals, but staff changed his ileostomy bag. -On 4/15/16 by first shift staff, Resident #13 refused 8:00 am medications. -On 4/15/16 by second shift staff, Resident #13 was sent to the ER via emergency medicial	D 273		

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D 273	Continued From page 42 services (EMS). Further review of Resident #13's record revealed no documentation the medical providers was notified prior to 4/15/16 of the missed meals or the missed medications for Resident #13. Confidential interviews with 8 facility staff revealed: -One staff member said, "I think Resident #13's doctor was aware he was not eating or drinking". -One staff member said, Resident #13 had been noncompliant from day one with his care and treatments. -One staff said, Resident #13 refused ileostomy care all the time. -A Personal Care Aide (PCA) said we document in one book and the Medication Aides (MAs) document in another book; "you are suppose to document daily". -Another staff member said, "Resident #13's mind was not right." -One staff member said, "The doctor was aware Resident #13 refused his medications and meals but I'm not sure if they knew every time." -Another staff member said, Resident #13 was doing better at one time then he started to withdraw from staff and other residents. -One staff member said, Resident #13 use to do activities like shoot pool but then stopped going to activities. Interview on 5/12/16 at 12:40 pm with the Administrator in Training revealed: -He was not aware Resident #13 had refused meals and medications numerous times since his admission to the facility in February 2016. -He relied on the MAs to contact the medical providers for changes in resident's behaviors or treatments.	D 273		

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D 273	Continued From page 43 -Documentation should be completed, and he was unsure why the MA had not documented calling Resident #13's guardian on 4/15/16 when Resident #13 was sent to the ER. -Education and training staff on documentation had been stressed numerous times to MAs and PCAs. _____ A Plan of Protection was provided by the facility on May 11, 2016 as follows: -Effective immediately, staff will be in-services for normal and abnormal vital signs and actions to be taken if vitals are found to be outside normal range. -Records will be reviewed for health care related issues that require follow up and document physician notifications. -The RCD will monitor all vitals signs everyday for a month to ensure proper procedure and once a week for the second month and then monthly thereafter. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 15, 2016.	D 273		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.	D 328		

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D 328	Continued From page 44 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to immediately notify law enforcement and the county Department of Social Services (DSS) when the whereabouts of a resident was unknown for 1 of 1 resident (Resident #11). The findings are: Review of Resident #11's FL2 dated 10/08/15 revealed: -Diagnoses included dementia, schizophrenia, hypertension, hyperlipidemia and history of basal cell carcinoma. -A documentation statement, "Recommend Vet not report to work." Review of Resident #11's record revealed Resident #11 was deemed incompetent and had a court appointed guardian. Review of Resident #11's Nurses Notes revealed: -Resident #11 was noted not to be at the facility at 5:10 pm on 3/08/16. -The facility was to pick up Resident #11 at the local hospital at 2:30 pm on 3/08/16 and they failed to do so. -A Medication Aide (MA) was sent to the hospital to pick up the resident and he was not there. -The hospital police involved the local city police because he could not be located on hospital grounds at that time. -When the hospital police reported to the Medication Aide (MA) how serious this was for Resident #11, the MA proceeded to tell the police that he had done this before. -Resident #11 was found to have gotten on the wrong public transportation bus and was en route back to the hospital.	D 328		

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D 328	Continued From page 45 -Facility staff met him at the hospital and returned him to the facility at 7:00 pm. Review of the local hospital Police Report dated 3/08/16 revealed: -The initial call was received at 5:40 pm and was in reference to a missing person. -The officer obtained a description of Resident #11 and searched Building 6 and all of the surrounding buildings and streets for Resident #11. -The officer questioned every employee he saw, but no one had seen the man with the matching description. -The officer went on bicycle patrol of the streets in search of Resident #11 and he saw a man walking in front of Building 2 and it was Resident #11. -Resident #11 was confused and not of sound thought which was a "big reason the facility was so worried of his whereabouts". -The officer contacted the facility and waited with Resident #11 until the MA picked him up. Interview with the second shift supervisor on staff when Resident #11 was missing on 5/12/16 at 12:04 pm revealed: -Staff noticed Resident #11 was missing and so she called the staff at the hospital to locate him. -The hospital staff could not locate him so she called the local police. -The local police called the hospital police and the hospital police found him sitting outside "the gate". -Resident #11's dementia had been getting worse. -She did not remember calling the Responsible Party about Resident #11's absence. -She did not notify the County Department of Social Services.	D 328		

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D 328	Continued From page 46 Interview with the Business Office Manager on 5/12/16 at 11:25 am revealed: -In case of a missing person the policy was to search the building, the then to call the RCD, the Administrator and the office manager. -If a person had been missing for 24 hours the policy was to initiate a Silver Alert. -In the case of a missing resident staff was expected to alert the county, 911 and photocopy the resident's demographic sheet and a photo to give to the authorities. -She did not notify the County Department of Social Services. Interview with the County Adult Home Specialist on 5/16/16 2:45 pm revealed there was never a report submitted or a phone call placed by the facility informing them about Resident #11 missing on 3/08/16.	D 328		
D 358	10A NCAC 13F .1004(a) Medication Administration 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 observations, interviews, and record reviews, the facility failed to ensure medications	D 358		

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were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #7 and #8) regarding administering blood pressure (BP) medications that had been discontinued (Resident #7) and administering anti-anxiety medication without a physician's order (Resident #8).

The findings are:

A. Review of Resident #7's current FL2 dated 8/07/15 revealed:
-The diagnoses included acute congestive heart failure, coronary artery disease, hypertension and urinary retention.
-The medication section with the words "see attached" and there was no attachment.

Review of Resident #7's Resident Register revealed an admission date of 8/07/15.

Review of the Discharge Summary from a local hospital dated 2/25/16 revealed:
-Physician's orders to discontinue furosemide 20mg (a diuretic used to treat congestive heart failure and hypertension), isosorbide mononitrate 30mg 24hr tablet (a long acting medication used to treat and prevent chest pain), metoprolol succinate 25mg 24hr tablet (a long acting medication used treat high BP, chest pain, and heart failure.)
-Physician's orders to add amlodipine 2.5mg 1 tablet daily (a medication used to treat high BP and chest pain), metoprolol tartrate 25mg one tablet twice daily (a medication used to treat high BP and prevent chest pain), and nitroglycerin 0.2mg/hr patch - one patch daily (a medication used to treat chest pain).

Review of the February 2016 electronic

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D 358	Continued From page 48 Medication Administration Record (eMAR) revealed: -An entry for amlodipine 2.5mg 1 tablet daily and documented as administered at 8:00 am 2/26, 2/27, 2/28 and 2/29/16. -An entry for furosemide 20mg 1 tablet daily and documented as administered at 8:00 am 2/01-2/20 and 2/26-2/29/16 (Resident #7 was hospitalized 2/21-2/25/16). -An entry for isosorbide mononitrate 30mg ER 1 tablet daily and documented as administered at 8:00 am 2/01-2/20 and 2/26-2/29/16 (Resident #7 was hospitalized 2/21-2/25/16). -An entry for metoprolol tartrate 25 mg ER 1/2 tablet twice daily and documented as administered at 8:00 am 2/01-2/25/16. -An entry for metoprolol tartrate 25 mg 1 tablet twice daily and documented as administered at 8:00 pm 2/25/16 and 8:00 am and 8:00pm from 2/26 to 2/29/16. -An entry for nitroglycerin 0.2mg/hr - apply one patch daily and documented as administered at 8:00 am 2/26-2/29/16. Review of the March 2016 eMAR revealed: -An entry for amlodipine 2.5mg 1 tablet daily and documented as administered at 8:00 am 3/01-3/08/16. -An entry for furosemide 20mg 1 tablet daily and documented as administered at 8:00 am 3/01-3/08/16. -An entry for isosorbide mononitrate 30mg ER 1 tablet daily and documented as administered at 8:00 am 3/01-3/08/16. -An entry for metoprolol tartrate 25mg 1 tablet twice daily and documented as administered at 8:00am and 8:00pm 3/01-3/08/16. -An entry for nitroglycerin 0.2mg/hr - apply one patch daily and documented as administered at 8:00 am 3/01-3/08/16.	D 358		

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D 358	Continued From page 49 -An entry for BP to be taken daily at 12:00 pm and documented as 111/51 on 3/01, 95/48 on 3/02, 113/48 on 3/03, 92/57 on 3/04, 78/49 on 3/05, 82/61 on 3/06, 94/68 on 3/07 and 84/43 on 3/08/16. Further review of Resident #7's nurses notes revealed: -An entry dated 2/27/16 BP was recorded as 112/57. -An entry dated 2/28/16 Resident #7 was disoriented and confused during 3-11:00 pm shift. -An entry dated 3/02/16 where BP was recorded as 95/48 (as entered on MAR). -An entry dated 3/05/16 where BP was recorded as 78/49 (as entered on MAR). -An entry dated 3/06/16 where BP was recorded as 82/61 (as entered on MAR). -An entry dated 3/08/16 where BP was recorded as 84/43 (as entered on MAR). -An entry dated 3/08/16 Resident #7's family member called and informed facility staff that he was admitted to the hospital. Review of the Emergency Department intake notes dated 3/08/16 revealed: -Resident #7's blood pressure was 68/44 upon intake. -A nitroglycerin patch was removed by a Home Health Nurse earlier that morning because his BP was low. -The emergency department nurse found 2 more patches on Resident #7's body. -Resident #7 was admitted for medication induced hypotension (low blood pressure). -Resident #7 was in the hospital from 3/08 - 3/11/16. Review of the Home Health Nurse's notes dated 3/0816 revealed:	D 358		

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D 358	Continued From page 50 -Resident #7 had a BP of 80/52. -The facility staff reported to the Nurse that Resident #7's BP had been low the past few days. -The Nurse instructed the facility staff to remove the nitroglycerin patch due to low BP. Interview with a Medication Aide (MA) on 5/10/16 at 10:49 am revealed: -It was their policy to recheck a BP if the first reading was outside of normal range. -If the second BP was abnormal they were to report this to the Resident Care Director (RCD). -The RCD or the MA would call the physician and report the abnormal result. -She did not report the abnormally low BP to the RCD. -She may have reported the low BP to the physician but can not remember. Interview with a second MA on 5/10/16 at 10:59 am revealed: -She considered 80/40 to be a BP in "the danger zone" and would call the physician if the BP was this low. -She considered anything above 140/80 or below 80/40 to be abnormal. -She did not report the BP to the RCD or the physician but thinks she discussed it with the home health nurse -She would also notify the RCD of the abnormal reading. -Resident #7 was really weak, short of breath and more confused than usual before he went to the hospital. Interview with a third MA on 5/11/16 at 11:04 am revealed: -She considered 80/60 to be a low BP that would require physician notification.	D 358		

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-She would call the physician after rechecking the BP.
-She would report the hypotension to the RCD.
-Resident #7 was more confused, disoriented and weak before he went to the hospital.
-She recalls having called Resident #7's physician and left a message in regards to the low BP but does not recall when.
-She does not know if they physician called back but had not by the end of her shift.
-She notified the home health nurse when she was visiting but does not remember when.

Interview with the RCD on 5/11/16 at 11:20 am revealed:
-The MAs were to recheck any vital sign if an abnormal reading was obtained.
-The MAs were to call the resident's physicians if they obtained an abnormal vital sign.
-After they called the physician's office they were to notify her.
-She considered a BP of 80/60 or 70/50 low and would contact the resident's physician if a resident presented with this low of a BP.
-She was not aware that Resident #7 had low BPs.
-She thought someone sent Resident #7 to the hospital on 3/05/16 because he had low BP.
-Resident was weak and confused and could tell it was a result of the recent medication changes.
-She reported her concerns to the home health nurse.
-She did not report the low BP or change in condition to the primary care physician.

Review of Resident #7's Emergency Service Patient Care Record dated 3/05/16 revealed:
-The facility staff called Emergency Services for transport because Resident #7 had blood in his urine.

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-Resident #7 reported that the blood was discovered around his catheter site.
-Resident #7's BP was recorded as 117/43 and 107/54 during transport.

A second interview with the RCD on 5/11/16 at 5:03 pm revealed:
-She was not aware that the medications furosemide and isosorbide were discontinued on the discharge summary dated 2/25/16.
-The MAs are supposed to go behind the pharmacy's entries and double check the for accuracy.
-The Supervisors on duty were responsible for reviewing discharge summaries and compare against the MARs to verify accuracy.
-She also double checked entries and does not know why these medications being discontinued were overlooked.
-She expected all the MAs knew to remove patches prior to applying a new patch.
-They had a class recently about the application and removal of patches.
-She was not aware that the MAs were not removing the nitroglycerin patches.

A telephone interview with a representative for Resident #7's Physician's Office on 5/12/16 at 9:01 am revealed:
-On 2/29/16 the facility called the office to report that Resident #7 had been in the hospital for pneumonia but no reports about his BP.
-On 2/29/16 the office contacted facility staff to inquire about Resident #7's status and make a follow up appointment. Staff told caller Resident #7 was more confused and disoriented but seemed ok and they made a follow up appointment for 3/08/16.
-On 3/03/16 the Home Health Nurse called and reported her skin evaluation and dressing

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changes.
-There was no other phone messages between 2/25/16 and 3/08/16.

Interview with the Administrator on 5/11/16 revealed:
-She expected that the Supervisors and MAs double rechecked all of the medication entries that were entered by the pharmacy.
-She expected that the MAs would call the physician if an abnormal vital sign was obtained.
-She expected that the MAs would call and inform the RCD after calling the physician.
-She was unaware that the discontinued medications were not discontinued.
-She was not aware that the nitroglycerin patches were being left on Resident #7.

Interview with a Pharmacist from the contracted pharmacy on 5/12/16 at 11:01am revealed:
-The "keyers" at the pharmacy were responsible for entering physician order's in to the electronic MAR.
-Most often the keyers would enter a time for a patch to be applied as well as for the patch to be removed.
-He did not know why a time for removal was not entered.
-He did not know why there were discrepancies on the eMAR as compared to the discharge summary but expected the facility to review the eMARs and call the pharmacy and alert them to any discrepancies.

Interview with the Home Health Nurse on 5/12/16 at 4:59 pm revealed:
-His hospitalization with the discharge date 2/25/16 started his decline in medical condition.
-She did remove a nitroglycerin patch on 3/08/16 prior to his seeing his primary care doctor.

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D 358	Continued From page 54 -She expected the facility staff to contact the physican if a resident had low BP. -She contact the physician with updates and order requests with the last call being on 3/03/16. -She would have called the physician on 3/08/16 but knew that he was going to see his physician in office shortly thereafter. -She was not aware that the discontinued medications had not been discontinued. -She did not observe more than one patch one Resident #7 but did not remove his clothing to inspect for other patches. Interview with Resident #7's Responsible Party (RP) on 5/10/16 at 2:10pm revealed: -Her father was a weak man but suffered a very rapid decline after he was hospitalized in February 2016. -She went with Resident #7 to the follow up in office visit and Resident #7's BP was so low they could not obtain a BP. -They sent him straight over to the emergency room where they discovered he was wearing two patches. -He spent three days in the hospital and was transferred to a nursing home where he passed away on 4/07/16. Interview with Resident #7's Physician on 5/11/16 at 9:58 am revealed: -Resident #7's BP was so low in his office he could not auscultate his pressure. -Resident #7 was conscious at the in office visit. -He was not aware of the medication changes that were made at the hospital. -He did not receive a copy of the discharge summary. -He was not aware that Resident #7 was taking furosemide, isosorbide, nitroglycerin patch, amlodipine and metoprolol 25mg all at the same	D 358		

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time.
-He was aware that there was more than one patch placed on Resident #7 after the emergency room reported this to him.
-The combination of medications and multiple patches could have led to dehydration as well as hypotension
-He would expect that if facility staff obtained abnormal vital signs such as the low BP that the facility staff report them to the prescribing practitioner.

B. Review of Resident #8's current hospital FL2 dated 3/03/16 revealed diagnoses included schizophrenia, hypertension, and seizure.

Review of Resident Register for Resident #8 revealed an admission date of 3/03/16.

Review of Resident #8's hospital discharge summary dated 3/03/16 revealed medications ordered included:
-Chlorpromazine 50 mg (used to treat schizophrenia) 2 times a day.
-Chlorpromazine 100 mg once daily.
-Divalproex Sodium 500 mg (used to treat seizures/schizophrenia) 2 times a day.
-Docusate Sodium 100 (used to treat constipation) 2 times a day.
-Lithium Carbonate 300 mg (used to treat schizoaffective disorder) 3 times a day.
-Melatonin 6 mg (used to treat sleep disorder) at bedtime.
-Meloxicam 15 mg (used to treat joint inflammation) once daily.
-Temazepam 15 mg (used to treat sleep disorder) at bedtime.
-Acetaminophen 500 mg (used to treat mild pain) one tablet every 6 hours as needed.

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D 358	Continued From page 56 Continued review of the hospital discharge summary dated 3/03/16 revealed "STOP taking these medications" listed on the discharge summary which included lorazepam 1 mg. (Lorazepam is used to treat anxiety. Lorazepam is a controlled substance which requires additional tracking of administration.) Review of Resident #8's current FL2 and hospital discharge summary dated 3/03/16 revealed no physician's order for lorazepam. Review of the facility's controlled substance record (CSR) log book on 5/11/16 revealed no documentation for Resident #8 having lorazepam dispensed to the resident. Continued review of the facility CSR log book on 5/11/16 revealed: -Administration of one lorazepam 2 mg at 8:30 pm on 3/03/16 to Resident #8 was documented as "borrowed for [Resident #8] per [Administrator]" on the CSR for another resident. Review of Resident #8's March 2016 electronic Medication Administration Record (eMAR) revealed: -Medications ordered on the discharge summary dated 3/03/16 were listed with documentation of administration from 3/03/16 to 3/14/16. -Lorazepam was not listed on the eMAR. Review of Resident #8's record, including the facility's Nurse Notes, revealed no documentation for administration of lorazepam 2 mg to the resident and no physician's order for lorazepam. Review of Resident #8's facility Nurse's Notes revealed: -Documentation in the Nurse's Notes dated	D 358		

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3/14/16 for disruptive behaviors, including yelling, hitting another resident, cursing, and scratching a staff member.
-The mental health crisis team was called and a member responded to the facility.
-The local police were dispatched to the facility. (Confirmed by police report dated 3/14/16.)
-Resident #8 was transported by the facility van, with police escort, to a local hospital for an involuntary commitment.

Resident #8 was not available for interview on 5/10/16 through 5/16/16.

Interviews on 5/11/16 at 5:40 pm and 6:30 pm with the Administrator revealed:
-Resident #8 was admitted to the facility from a local hospital.
-Resident #8 had "bad" behaviors the day she arrived (3/03/16), like cursing and being loud and disruptive with the staff.
-She left the facility after the resident calmed down some.
-The Administrator stated she was not aware of Resident #8 receiving lorazepam 2 mg on 3/03/16.
-She did not authorize medication aide staff to administer lorazepam 2 mg from another resident to Resident #8.

Interview on 5/11/16 at 6:15 pm with the Business Office Manager (BOM) revealed:
-Resident #8 came to the facility on 3/03/16 by ambulance.
-Resident #8 was "acting out" the day she came; cursing and combative towards the ambulance drivers and facility staff.
-The BOM was not aware if medication was administered to Resident #8.
-Resident #8 was calmer when the BOM left the

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D 358	Continued From page 58 facility sometime after 6:00 pm on 3/03/16. Interview on 5/12/16 at 8:43 am with a first shift Medication Aide (MA) revealed: -She was working the second shift on 3/03/16 as a Personal Care Aide (PCA). -She did not administered medications to Resident #8 on 3/03/16. -She did not witness administration of lorazepam 2 mg to Resident #8 on 3/03/16 -She did assist with the controlled drug reconciliation at the end of the shift. -She verified the lorazepam 2 mg inventory count, along with the scheduled second shift MA, and observed the documentation for borrowing medication from another resident for administration to Resident #8. -She stated Resident #8 was very upset and disruptive on 3/03/16 when she arrived at 3:00 pm for the second shift. -She thought the MA that administered the lorazepam to Resident #8 must have contacted somebody for a verbal order for lorazepam for the resident. Telephone interview on 5/12/16 at 11:05 am with a pharmacy provider representative revealed the pharmacy had no documentation for a physician's order for lorazepam for Resident #8. Interview on 5/12/16 at 11:35 am with the Resident Care Director (RCD) revealed: -She was not aware Resident #8 was administered lorazepam 2 mg on 3/03/16, which was documented as borrowed from another resident. -She did not have a system in place for routinely auditing entries on the controlled substance records compared to the eMARs. -Resident #8 did not have an order for lorazepam	D 358		

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D 358	Continued From page 59 2 mg as far as she knew. Interview on 5/12/16 at 11:50 am with a second shift MA revealed: -She was working the second shift on 3/03/16 when Resident #8 arrived at the facility. -Resident #8 was very upset with the ambulance drivers and the facility staff. -Management staff stayed for a while and then left. -Resident #8 continued to be upset and argumentative with staff. -She was instructed by the Administrator to find her a lorazepam tablet and she would get Resident #8 an order for lorazepam to be taken as needed. -She borrowed lorazepam from another resident and administered the medication, and documented on the other resident's CSR, but not on any record for Resident #8. -She was aware any borrowed controlled substance had to be documented in order for the controlled substance record to reflect any medication administered. Review of a faxed document sent from the facility and received on 5/16/16 at revealed: -The fax included a document written and signed by the second shift MA that administered the lorazepam 2 mg to Resident #8. -The document stated the MA had not given correct information during the previous interview concerning Resident #8. -The MA stated she "took it upon myself to borrow the Ativan (lorazepam is generic)" and gave Resident #8 lorazepam 2 mg borrowed from another resident without a physician's order. Telephone interview on 5/16/16 at 10:20 am with a family member for Resident #8 revealed:	D 358		

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D 358	Continued From page 60 -She was at the facility the day (3/14/16) Resident #8 was taken to a local hospital by the facility transportation van and local police. -She had visited Resident #8 at the facility a couple of times during her short stay at the facility. -Resident #8 had stayed with her from time to time but most recently had been in and out of the hospital and various assisted living facilities. -She was not aware if Resident #8 had medication ordered as needed for agitation or anxiety when she was admitted to the facility. -Resident #8 had been transferred from the local hospital to another nearby hospital but may be transferred to a higher level hospital for treating her mental illness. Telephone interview on 5/16/16 at 2:45 pm with a representative at the resident's mental health provider revealed no documentation for medications provided for Resident #8 until a visit on 3/10/16. No lorazepam was documented as ordered for Resident #8 by the mental health provider. A Plan of Protection was provided by the facility on May 11, 2016 as follows: -Effective immediately, the RCD will inform staff if any resident returns from the hospital or appointment the supervisor will verify and clarify any orders and a second MA will verify the orders. -The RCD will follow up and verify all orders. -Third shift will check all Medication Administration Records against FL2s and new orders for verify all orders are correct. -A medication class is scheduled for 5/12/16 to in-service staff on medication errors, matching medication orders with MARs. RCD will monitor for compliance everyday for 30 days and weekly for 4 weeks and then monthly.	D 358		

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D 358	Continued From page 61 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 15, 2016.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to assure medication administration records (MARs) were accurate and complete for 1 of 5 sampled Residents (Resident #12) regarding documentation for a medication ordered as needed for anxiety.	D 367		

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D 367	Continued From page 62 The findings are: A. Review of Resident 12's current FL2 dated 4/22/15 revealed diagnoses included chronic schizophrenia, and chronic obstructive pulmonary disease. Review of Resident #12's record revealed a physician's order dated 12/16/15 and a subsequent physician order dated 3/30/16 ordering lorazepam 2 mg every 12 hours, as needed for agitation. (Lorazepam in used to treat agitation.) Review of the facility's controlled substance record (CSR) sign-out sheet log book revealed Resident #12 had CSR sign-out sheets for lorazepam 2 mg one tablet every 12 hours as needed for agitation for a quantity of 60 tablets dispensed on 12/16/15. Review of Resident #12's electronic Medication Administration Record (eMAR) and controlled substance record (CSR) sign-out sheet for February 2016 revealed: -Lorazepam 2 mg every 12 hours, as needed for agitation was listed on the eMAR and scheduled "PRN" (as needed). (PRN medications must be documented for administration as well as for effectiveness.) -Lorazepam 2 mg was documented for administration and effectiveness, for 12 doses. -Lorazepam 2 mg was signed out on the CSR sign-out sheet for the 12 doses corresponding to the eMAR. Review of Resident #12's eMAR and CSR sign-out sheet for March 2016 revealed: -Lorazepam 2 mg every 12 hours, as needed for agitation was listed on the eMAR and scheduled	D 367		

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"PRN" (as needed) and documented administration, with effectiveness, for 3 doses.
-Lorazepam 2 mg was signed out for administration on the CSR sign-out sheet for 6 doses (with 3 doses corresponding to the eMAR).
-Lorazepam 2 mg was signed out on the CSR sign-out sheet with no documentation for administration or effectiveness recorded on the eMAR as follows: On 3/03/16 at 8:30 pm, with a notation for borrowed for another resident; On 3/07/16 at 11:35 pm; and on 3/20/16 at 9:30 pm.

Review of Resident #12's eMAR and CSR sign-out sheet for April 2016 revealed:
-Lorazepam 2 mg every 12 hours, as needed for agitation was listed on the eMAR and scheduled "PRN" (as needed) and documented administration, with effectiveness, for 12 doses.
-Lorazepam 2 mg was signed out for administration on the CSR sign-out sheet for 19 doses (with 12 doses corresponding to the eMAR).
-Lorazepam 2 mg was signed out on the CSR sign-out sheet with no documentation for administration or effectiveness recorded on the eMAR as follows: On 4/01/16 at 9:00 pm; On 4/09/16 at 8:00 pm; On 4/10/16 at 8:00 pm; On 4/17/16 at 8:00 pm; On 4/21/16 at 9:00 pm; On 4/27/16 at 8:00 pm; and on 4/28/16 at 8:00 am.

Review of Resident #12's eMAR and CSR sign-out sheet for May 2016 revealed:
-Lorazepam 2 mg every 12 hours, as needed for agitation was listed on the eMAR and scheduled "PRN" (as needed) and documented administration, with results, for 8 doses.
-Lorazepam 2 mg was signed out on the CSR sign-out sheet for the 8 doses corresponding to the eMAR.

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D 367	Continued From page 64 Interview on 5/11/16 at 12:20 pm with Resident #12 revealed: -He was aware he had a medication he could ask for it he felt anxious. -He did not know how often he received lorazepam 2 mg. Interviews on 5/11/16 at 4:50 pm and 5/12/16 at 11:35 with the Resident Care Director (RCD) revealed: -Medication Aides (MA) were responsible to document all administration of medications on the eMAR. -MA were also responsible to document of control substance administration on the CSR sign-out sheets sent by the pharmacy provider for each controlled substance. -She had reminded MAs on numerous occasions that medications signed out on the CSR sheets must also be documented on the eMAR. -The facility did not have a system in place to routinely audit residents' eMAR documentation compared to the CSR sign-out log sheets. -She was not aware Resident #12 had lorazepam 2 mg sign-out on the CSR sheets but not documented on the eMAR. Interview on 5/11/16 at 5:45 pm with the Administrator revealed: -MA staff were trained on eMAR documentation and accuracy at least once a year. -The facility had a mandatory in-service previously scheduled for 5/12/16, coming up tomorrow, with the pharmacy provider in regards to medication administration and documentation. -She was not aware Resident #12 had medication sign out on the CSR log sheets that were not documented on the eMARs. Telephone interview on 5/12/16 at 11:04 am with	D 367		

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D 367	Continued From page 65 a representative for the contract pharmacy provider revealed the pharmacy had not dispensed lorazepam 2 mg tablets for since 12/15/16.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the local department of social services about accidents involving 1 of 5 sampled residents (#10), who was missing, and had falls that resulted in a referral to the emergency room for an assessment and care. The findings are: A. Review of Resident #10's FL2 dated 8/27/15 revealed diagnoses included multiple falls, schizophrenia, hypokalemia, insomnia, urinary tract infections, diabetes mellitus, hypertension, syncope, chronic obstructive pulmonary disease, transient ischemic attack, status post cholecystectomy and hyperlipidemia. Review of Resident #10's record revealed diagnoses included schizophrenia and chronic alcohol abuse.	D 451		

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D 451	Continued From page 66 Review of Resident #10's Resident Register revealed the resident was admitted to the facility on 8/29/13. There was no Guardian or Power of Attorney for Resident #10. Review of Resident #10's Nurses Notes revealed on 3/15/16 at 10:24 am Resident #10 was found by staff face down outside on the sidewalk near the road and an ambulance transported Resident #10 to the local emergency department. Review of Resident #10's Emergency Medical Service (EMS) Call Report dated 3/15/16 revealed: -The protocol implemented was "overdose/toxic ingestion". -Resident #10 had an altered level of consciousness and the smell of alcohol was on her breath. -The facility staff reported that the patient had been drinking rubbing alcohol and mixing it with aspirin. -Resident #10 was transported to a local hospital on 3/15/16 at 10:38 am. Review of Resident #10's Emergency Department record dated 3/15/16 revealed: -Resident #10 was admitted to the emergency department for a fall. -Resident #10 was assessed by a physician and they ran bloodwork, a urinalysis, a chest x-ray, a computed tomography scan of the head and an electrocardiogram to rule out cause of fall and injury. -They did not draw a blood alcohol level specific to methanol alcohol. Interview with a Medication Aide on 5/12/16 at 12:08 pm revealed:	D 451		

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D 451	Continued From page 67 -She filled out an accident report any time a resident fell. -She was not on duty when Resident #10 fell on 3/15/16. -She filled out accident reports and once completed, she gave them to the Resident Care Director. -The Supervisors were responsible for completing accident reports. -She did not know who was responsible for faxing the reports to the county. Interview with the Business Office Manager on 5/12/16 at 11:38 revealed: -They always faxed the incident reports to the county and to their insurance company if a resident was sent to the emergency room. -She was responsible for faxing the reports and she kept all the faxed reports in her office. -There was not a report for Resident #10's fall on 3/15/16. -She was not aware of an incident on 3/15/16. Interview with the County Adult Home Specialist on 5/16/16 2:45 pm revealed there was never a report submitted by the facility on Resident #10 dated 3/15/16.	D 451		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:	D 454		

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	HAL080006	A. BUILDING: _____ B. WING _____	R 05/16/2016

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D 454	Continued From page 68 (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to immediately notify law enforcement and the county Department of Social Services (DSS) when a resident whereabouts were unknown for 1 resident (Resident #11) and failed to notify the guardian for 1 resident (Resident #13) who required an emergency room visit. The findings are: A. Review of Resident #11's FL2 dated 10/08/15 revealed: -Diagnoses included dementia, schizophrenia, hypertension, hyperlipidemia and history of basal cell carcinoma. -A documentation statement, "Recommend Vet not report to work." Review of Resident #11's record revealed Resident #11 was deemed incompetent and had a court appointed guardian.	D 454		

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D 454	Continued From page 69 Review of Resident #11's Nurses Notes revealed: -Resident #11 was noted not to be at the facility at 5:10 pm on 3/08/16. -The facility was to pick up Resident #11 at the local hospital at 2:30 pm on 3/08/16 and they failed to do so. -A Medication Aide (MA) was sent to the hospital to pick up the resident and he was not there. -The hospital police involved the local city police because he could not be located on hospital grounds at that time. -When the hospital police reported to the MA how serious this was for Resident #11 the MA proceeded to tell the police that he had done this before. -Resident #11 was found to have gotten on the wrong public transportation bus and was en route back to the hospital. -Facility staff met him at the hospital and returned him to the facility at 7:00 pm. -There was no documentation that Resident #11's Guardian was notified of him being missing. Review of the local hospital Police Report dated 3/08/16 revealed: -The initial call was received at 5:40 pm and was in reference to a missing person. -The officer obtained a description of Resident #11 and searched Building 6 and all of the surrounding buildings and streets for Resident #11. -The officer questioned every employee he saw, but no one had seen the man with the matching description. -The officer went on bicycle patrol of the streets in search of Resident #11 and he saw a man walking in front of Building 2 and it was Resident #11. -Resident #11 was confused and not of sound	D 454		

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D 454	Continued From page 70	D 454		

thought which was a "big reason the facility was so worried of his whereabouts".
-The officer contacted the facility and waited with Resident #11 until the MA picked him up.

Interview with the second shift supervisor on staff when Resident #11 was missing on 5/12/16 at 12:04 pm revealed:
-Staff noticed Resident #11 was missing and so she called the staff at the hospital to locate him.
-The hospital staff could not locate him so she called the local police.
-The local police called the hospital police and the hospital police found him sitting outside "the gate".
-She did not remember calling Resident #11's Guardian about Resident #11's absence.

Interview with the Business Office Manager on 5/12/16 at 11:25 am revealed:
-In case of a missing person the policy was to search the building, the then to call the RCD, the Administrator and the office manager.
-If a person had been missing for 24 hours the policy was to initiate a Silver Alert.
-In the case of a missing resident staff was expected to alert the county, 911 and photocopy the resident's demographic sheet and a photo to give to the authorities.
-She did not notify the Guardian and expected the supervisor filling out the incident report to do so.

Interview with Resident #11's Court appointed Guardian on 5/10/16 at 12:04 pm revealed:
-She was never notified by facility staff that Resident #11 was missing.
-She discovered his being missing on 3/08/15 during a routine visit by reading the nurses notes in Resident #11's record.
-Resident #11 was retired and enjoyed his

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volunteer work at the hospital but was now unable to participate with the hospital's volunteer program because of this event.
-She was in the facility after this occurred visiting another resident and none of the staff reported this episode to her.
-She expected the facility call her for any event such as this.

B. Review of Resident #13's current FL2 dated 2/8/16 revealed:
-Diagnoses included nonpsychotic mental disorders, ileostomy, congested heart failure, and depression.
-Documentation of orientation as intermittently.
-Documentation the resident required assist with bathing and dressing.
-Documentation the resident's ambulatory status and currently used a walker.

Review of Resident #13's Resident Register revealed:
-The date of admission to the facility was 2/8/16.
-Resident #13 had a legal guardian.

Review of Resident #13's record revealed Resident #13 was transported to the Emergency Room (ER) on 4/15/16 via Emergency Medical Services (EMS).

Review of the local hospital ER notes dated 4/15/16 revealed:
-Resident arrived at the ER on 4/15/16 at 6:03 pm with a diagnoses of ileostomy dysfunction.
-Documentation Resident #13 was treated in the ER and was appropriate for discharged back to the facility on 4/15/16 at 7:19 pm.
-Documentation the ER Nurse called the facility on 4/15/16 at 9:54 pm and was told they were not taking Resident #13 back.

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D 454	Continued From page 72 Telephone interview on 5/10/16 at 4:45 pm with the hospital social worker revealed: -Resident #13 arrived in the ER via EMS on 4/15/16 with a leaking ileostomy bag. -After Resident #13 was treated in the ER the facility would not take him back. -The hospital social worker contacted Resident #13's guardian on 4/14/16 in regards to the facility refusing to take Resident #13 back to the facility, the guardian was unaware Resident #13 was in the ER, or the facility refusing to take Resident #13 back to the facility. Telephone interview on 5/11/16 at 12:30 pm with Resident #13's guardian revealed: -Resident #13 had been in the facility since February 2016, and the facility had no problem meeting his needs or providing care or treatment. -She was unaware Resident #13 was sent to the ER on 4/15/16 until 4/16/16 when the hospital social worker had contacted her. -No one at the facility had contacted her on 4/15/16 when Resident #13 was sent to the ER nor had a doctor from the facility contacted her about Resident #13 requiring a higher level of care. -She expected the facility to contact her for anything regarding Resident #13 care, treatment, or not being able to meet his needs. Interview on 5/10/16 at 3:45 pm with the Business Office Manager (BOM) revealed: -She contacted the guardian on 4/18/16 and informed her the facility medical provider had ordered to send Resident #13 out due to requiring a higher level of care. -She was unaware the guardian was not notified on 4/15/16 Resident #13 was sent to the ER.	D 454		

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D 454	Continued From page 73 Interview on 5/12/16 at 11:00 am with a Medication Aide (MA) revealed: -She said, when you send a resident out to the ER you are to contact the doctor and family member/ guardian and to document in the nurses notes. -She stated "I called Resident #13's guardian on 4/15/16 but she appeared to be sleeping." -She said, she did not have time during her shift to document calling the guardian of Resident #13. Interview on 5/12/16 at 12:40 pm with the Administrator in Training revealed: -He was aware Resident #13 was sent to the ER on 4/15/16. -He relied on the MAs to contact the guardian for changes in resident's behaviors, hospitalizations, or ER visits. -Documentation should be completed, and he was unsure why it was not for Resident #13. -Education and training staff on documentation had been stressed numerous times to MAs and PCAs. -He had never spoken to the guardian concerning the ER visit or the discharge of Resident #13.	D 454		
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, interview, and record	D912		

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review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, health care, and medication administration.

The findings are:

A. Based on interviews, record reviews, and observations, the facility failed to provide supervision and monitoring for 2 of 6 sampled residents related to a resident drinking rubbing alcohol resulting in a fall with injury (Resident #10) and failing to secure the whereabouts of a resident with dementia which resulted in the resident missing for several hours (Resident #11). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A2 Violation)].

B. Based on observations, interviews, and record reviews the facility failed to assure physician notification for 2 of 7 sampled residents with regards to low blood pressures (BP) (Resident #7) and refusal of medications and meals (Resident #13). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]

C. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #7 and #8) regarding administering blood pressure medications that had been discontinued (Resident #7) and administering anti-anxiety medication without a physician's order (Resident #8). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]