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
	HAL002007	A. BUILDING: _____ B. WING _____	C 08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted an annual survey and complaint investigation on August 2, 2016 and August 3, 2016. The county initiated the complaint investigation on August 1, 2016.	D 000	Baseboard Molding will be repaired and/or replaced. 11-30-2016	
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, interviews and record reviews, the facility failed to keep the three metal exit doors, door frames and doors to residents' rooms and bathrooms, and the main hallway, dining room and living room floors clean and in good repair. The findings are: Observation on 8/2/16 at 9:30am upon entering the facility revealed the main hallway and living room floors were tiled and had black streaks that were prevalent throughout the facility, including black marks from durable medical equipment (DME) devices, e.g., wheelchairs and walkers. Further observation on 8/2/16 from 9:45am to 11:15am during the initial tour and on 8/3/16 from 8:30am to 9:30am revealed: -A noticeable build-up of dirt and black staining on the floors along the baseboards and at the door	D 074	Areas where the floors and walls meet will be cleaned by the Housekeeping Staff on a Daily basis. This process will be monitored Weekly by the RCC and overseen as needed by the ADMINISTRATOR. Facility floors will be stripped and waxed by the Housekeeping Staff. This process will be monitored Weekly by the RCC and overseen as needed by the ADMINISTRATOR. Metal Doors will be repainted. Broken tiles will be repaired and/or replaced. Interior Doors will be repaired and/or replaced.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8-31-16

STATE FORM 6899 — VVCR11 — If continuation sheet 1 of 30

9-2016

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D 074	Continued From page 1 frames, where the tile floor met the concrete wall and door frames, throughout the main hallway and along all four walls in the dining room. -Black discoloration and black marks, from DME devices, on the floor at the exits located at each end of the main hallway and the main entrance to the facility. -Black marks, from DME devices, on the living room floor. -The tile floor, where it butted up to the threshholds at the exits located at each end of the main hallway and the main entrance to the facility, had cracks approximately 24 inches in length. -The rubber baseboard molding was pulling away from the wall near the exit on the men's hallway, and in the middle of the women's hallway, on both halls. -The metal exit doors and door frames, located at each end of the main hallway and the main entrance to the facility were scratched, had areas where the grey paint was missing and areas of rust. -14 of 16 resident's room doors and door frames were scratched, with markings from DME devices and had areas where paint was chipped/worn away. -The doors and door frames to the men's large and two small restrooms, the women's large and small restroom were scratched, with markings from DME devices and had areas where paint was chipped/worn away. -A semi-circular section missing from two floor tiles at the women's hall bathroom entrance approximately two inches in length and a crack approximately 24 inches in length along the wall, to the right, when entering the facility using the main entrance. -The floor tiles along the length of two walls in the dining room had ragged edges and were pulling away from the baseboard molding.	D 074		

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D 074	Continued From page 2	D 074		

Review of the local County Health Department building inspection form for the facility dated 6/14/16 revealed:
-A facility score of 92.5.
-In the comments section, replace loose baseboard molding; replace cracked floor tile at door to women's hall bathroom.

Review of the local County Health Department food service inspection form for the facility dated 6/14/16 revealed, in the food service comments section, clean floors in the dining room.

Interview on 8/3/16 at 9:40am with a Personal Care Aide (PCA) revealed:
-There was a maintenance request book kept in the Resident Care Coordinators (RCC) office
-When a maintenance issue was observed, staff completed a request form and slid it under the Administrator's door. Once the issue had been addressed, the Administrator would make comments to the form and place the form back into the log book.
-The housekeeper quit on 8/1/16. Until a new housekeeper was hired, night shift staff were mopping the floors.

Interview on 8/3/16 at 11:10am with the Administrator revealed:
-For maintenance issues, staff completed a request form and slid it under her door. She sent the request to the facility's owner. The owner sent a family member to complete the repairs. In cases of emergencies, a local company would be contacted to complete the repairs.
-The housekeeper "walked out" of the facility on 8/1/16.
-She was in the process of hiring a new housekeeper and hoped to hire someone by the

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D 074	Continued From page 3 end of this week. -The floors were being mopped by night staff during the hours of 9:00pm to 7:00am, and during the day as needed. -The main hallway floor had recently been stripped and waxed. The black streaks in the floors were caused by a staff mopping the floor using a product that had bleach in it. -The walls and ceilings in the facility had recently been painted by a volunteer from the community. This volunteer had agreed to sand and stain all of the doors in the facility. The administrator speculated this would be completed in the next six months.	D 074	RCC and ADMINISTRATOR reviewed Resident Rights and Mandated Reporting with all Staff. A Resident Rights Inservice and Sensitivity Training has been scheduled with the local Ombudsman for the Facility.	
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21 Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents were free from mental abuse by allowing Staff A to yell and curse Resident #1, and neglecting to properly maintain and repair durable medical equipment (wheelchairs) for three Residents (#4, #5 and #6). The findings are: 1. Review of Resident #1's current FL-2 dated 10/22/15 revealed:	D 338	The building will continue to follow Facility Policy in regards to Resident Abuse, Neglect, and Exploitation. Staff Members suspected of violating Resident Rights will be immediately suspended and not allowed to return to work while investigation is underway. Staff suspected of violating Resident Rights will be reported to the Healthcare Personnel Registry within 24 Hours. Reporting will be done using the 24 HR Initial Report Form and 5 Day Working Report Form. To assist in preventing future occurrences ongoing education for the Facility will be scheduled by the RCC. This process will be monitored Daily by the RCC and overseen as needed by the ADMINISTRATOR.	9.3.2016 and ongoing.

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D 338	Continued From page 4 -His diagnoses included mental retardation and schizophrenia. -He was constantly disoriented, identified as a wanderer and, at times, was aggressive towards others. -He required assistance with bathing, dressing, and feeding. -His speech was noted as "rarely speaks" and "non-verbal". -Medications included Risperdal Consta injectable 50mg every 2 weeks and risperidone 0.25mg oral tablets as needed for anxiety and agitation. (Both medications are used to treat schizophrenia). Review of Resident #1's record on 8/2/16 at 2:30pm revealed: -He had been to the emergency room or urgent care nine times between 6/3/16 and 7/29/16, seven times for behaviors, and twice for medical issues, a fall and a mouth ulcer. -Staff notes revealed a change and increase in Resident #1's behavior such as wandering, becoming physically aggressive, taking off his clothes, urinating in his bed, and screaming. -The facility doctor and facility psychiatrist made many medication changes during June and July 2016 (19 medication changes affecting medications such as buspirone, Lexapro, Ativan, Loxapine, Melatonin, Depakote, Wellbutrin, Klonopin, and Seroquel). These medications are used to treat depression, sleeplessness, agitation, and psychosis. -The Resident Care Coordinator (RCC) and several medication aides communicated with the facility's psychiatrist and the facility's primary care physician regularly via staff notes, Physician Treatment forms, and Physician Treatment/Recommendation Request forms. -These forms included information such as the	D 338		

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D 338	Continued From page 5 resident's symptoms and behaviors. Interview with a Medication Aide (MA) on 8/1/16 at 4:41pm revealed: -She had witnessed Staff A being verbally abusive towards Resident #1 on two occasions, no specific date was given. -She described the verbal abuse as Staff A yelling and saying curse words at Resident #1. -She believed that the Resident Care Coordinator (RCC) and the Administrator knew about the situation. -After the second occurrence, she said to Staff A, "You don't have to talk to him like that." Interview with a Personal Care Aide (PCA) on 8/1/16 at 4:23pm revealed: -She had witnessed Staff A yelling at and saying curse words toward Resident #1. -She gave examples of "I'm not dealing with your s**t today" and telling the resident what to, "sit down ", "be quiet". Interview with a second PCA on 8/2/16 at 4:15pm revealed: -She witnessed Staff A being verbally abusive towards Resident #1. -She gave examples of, "I' m not in the mood for your s**t", "Go to your room", "Go sit down", "you are not getting a cigarette". -She explained that Resident #1 had not smoked in 5 years or longer. However, Staff A gave Resident #1 cigarettes to smoke so he would get out of her area. -She reported that one of the MAs had taken a video of Staff A's behavior and shown the video to the RCC and Administrator. Interview with a third PCA on 8/3/16 at 9:00am revealed:	D 338		

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D 338	Continued From page 6 -She had witnessed Staff A being verbally abusive towards Resident #1. -She described the verbal abuse as yelling and cursing. -She reported the incident to the RCC and Administrator. She also gave a written statement. -She explained that she had worked with Staff A on the same shift and had tried to protect Resident #1 by removing him from the situation. She took him to the dining room or living room to separate him from Staff A. Interview with Resident #1's roommate on 8/2/16 at 4:30pm revealed his roommate heard Staff A yelling at Resident #1 "a little bit". Interview with a resident on 8/2/16 at 4:45pm revealed: -He heard Staff A yelling at Resident #1. -He did not remember the exact words. -Staff A yelled at Resident #1 a few nights in a row. -Resident #1 wouldn't go to bed and he walked around the facility naked when the yelling incidents occurred. -This resident did not report the incidents to anyone. Interview with Resident #1's Guardian on 8/2/16 at 3:41pm revealed: -Resident #1 had been at the facility for four years. -She voiced no complaints about his care, but felt that his needs would be better served in a group home setting. -She was working on moving the resident to a group home, but had to have approval from local mental health provider. -Resident #1 had behavioral changes in the past six months.	D 338		

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D 338	Continued From page 7 -She felt that the facility was safe, clean and homelike and had made many improvements in the past six months. -Staff communicated well with her, had reviewed Resident #1's medication changes with her, and listened to her concerns. -She typically visited Resident #1 between 12:00 noon and 6:00pm. -She had never observed any staff yelling at Resident #1. -Resident #1 had not reported any staff member yelling at him or that he was afraid of any staff member. Interview with the Administrator on 8/3/16 at 9:00am revealed: -She had found out about the verbal abuse from Staff A towards Resident #1 this past weekend (July 30-31, 2016). -Staff reported the verbal abuse to her and she asked for a written statement. -She then asked other employees who worked with Staff A if they had witnessed any verbal abuse, then she asked them for written statements. -When she had all the written statements (currently still waiting on one), then she will suspend Staff A for three days or until the investigation is complete. -She had watched the video of Staff A yelling at Resident #1 as recorded by another employee. -In the video, she had not seen the act, but could hear Staff A's tone of voice, but could not make out the words. -A class on Resident Rights was held on 3/11/16, but Staff A did not attend. -In the class, the Ombudsman went over each Resident Right and gave examples of violations and what is not a violation. They also performed role plays.	D 338		

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D 338	Continued From page 8 -A class of " Managing Challenging Behaviors " was offered on 7/27/16. Staff A did not attend this class. -She reported that Staff A did not show any initiative in attending the Resident Rights Class or the Managing Challenging Behaviors class. -The Administrator had not made a report to the Healthcare Registry. She thought that her investigation had to be complete before making the report to the Healthcare Registry. Interview with the RCC on 8/3/16 at 9:30am revealed: -She had found out a few days ago about Staff A being verbally abusive towards Resident #1. -She and the Administrator are currently waiting on a statement from one of the MAs. -She viewed the recording that one of the medication aides had made, she couldn't tell what was said, but could hear a loud tone of voice; -She did not hear any curse words on the recording. -She had not made a report to the Healthcare Registry because she had not finished her investigation yet. Review of the facility's policy on investigation revealed: -"Any incident where abuse, neglect or exploitation of a client is suspected or reported shall be thoroughly investigated within 24 hours". -"All instances of suspected abuse, neglect, or exploitation of a client will be reported to the County Department of Social Services and to the Division of Facility Services within 24 hours." -"Any staff member who is alleged to have committed any of these infractions must be reported to the Healthcare Registry."	D 338		

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D 338	Continued From page 9 2. Review of Resident #4's current FL2 dated 10/22/15 revealed: -Diagnoses included delirium with tremors, anemia and seizure disorder. -Under the ambulatory status section, semi-ambulatory was checked with "w/c" handwritten in the box. Review of Resident #4's current personal care plan dated 10/7/15 revealed: -Resident #4 was assessed as ambulatory with an aide or device, with "walker and wheelchair" handwritten on comments line. -Under the activities of daily living (ADL) section, the number one (1) was written for the activity of ambulation/locomotion (a rating of one indicated the resident required supervision when completing the task). Observations of Resident #4 during the survey revealed he used his wheelchair to move throughout the facility. Observations of Resident #4's wheelchair during the survey revealed: -Both padded arm rests were torn, tattered and wrapped with clear tape. -The left arm rest was loose to the touch. Interview on 8/3/16 at 9:00am with Resident #4 revealed: -The padded arm rests have been torn and tattered for some time. -He had spoken with "the wheelchair man" (personnel from the contracted DME company) about getting it repaired or replaced the last time the DME personnel was at the facility. -The condition of the arm rests were not injuring his arms; they aggravated him.	D 338	Wheelchairs will be cleaned by the Nursing Staff on scheduled days according to existing Facility schedule. Wheelchairs will be inspected for repair needs during this time. Repair needs will be reported to the RCC by the Nursing Staff using Maintenance Request Forms. If repair needs are reported, RCC will contact resident's MD for new orders to replace or repair the DME equipment. This process will be monitored Weekly by the RCC and overseen as needed by the ADMINISTRATOR.	8.3.2016 and ongoing.

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D 338	Continued From page 10 A phone call on 8/3/16 at 12:30pm to the DME company personnel assigned to the facility was not returned by exit. Interview on 8/3/16 at 9:40am with a PCA revealed: -There was a maintenance request book kept in the Resident Care Coordinators (RCC) office -When a maintenance issue was observed, staff completed a request form and slid it under the Administrator's door. Once the issue had been addressed, the Administrator would make comments to the form and place the form back into the log book. -He was not aware of the condition of Residents #4, #5 and #6's wheelchairs or if they needed repairs. Review on 8/3/16 at 9:45am of the maintenance request book revealed there were no requests completed for Residents #4, #5 or #6's wheelchairs. Observation on 8/3/16 at 9:46am of the PCA completing a maintenance request for wheelchair repairs. Interview on 8/3/16 at 11:10am with the Administrator revealed: -For maintenance issues, staff completed a request form and slid it under her door. She sent the request to the facility's owner. The owner sent a family member to complete the repairs. In cases of emergencies, a local company would be contacted to complete the repairs. -When a DME repair issue was brought to her attention, she called the DME company. -She was aware of the wheelchair repairs needed for Residents #4 and #5.	D 338		

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D 338	Continued From page 11 -A representative from the DME company visited the facility on a monthly basis and was working on the wheelchair issues. -She was not aware that the facility was responsible for the repairs when special assistance did not cover the repair costs. Interview on 8/3/16 at 1:03pm with the Administrator revealed she had contacted the DME company and confirmed Residents #4, #5 or #6 were not eligible for wheelchair replacement. She indicated the DME company had agreed to come to the facility and repair the wheelchairs "free of charge". Observation on 8/3/16 at 2:27pm revealed a representative from the DME company repairing wheelchairs. 3. Review of Resident #5's current FL2 dated 9/25/15 revealed: -Diagnoses included seizure disorder and refractory seizures. -Under the ambulatory status section, semi-ambulatory was checked. Review of Resident #5's current personal care plan dated 10/7/15 revealed: -Resident #5 was assessed as limited ability with "uses wheelchair" handwritten on comments line. -Under the activities of daily living (ADL) section, the activity of ambulation/locomotion box was blank. Observations of Resident #5 during the survey revealed he used his wheelchair to move throughout the facility. Observations of Resident #5's wheelchair during the survey revealed both padded arm rests were	D 338		

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D 338	Continued From page 12 torn and tattered. Interview on 8/3/16 at 8:30am with Resident #5 revealed: -The padded arm rests had been torn and tattered "for some time". -He had spoken with the administrator "about two weeks ago". He indicated the administrator was working with the durable medical equipment (DME) company on obtaining a new wheelchair or getting this one repaired. -The condition of the arm rests were not injuring his arms. A phone call on 8/3/16 at 12:30pm to the DME company personnel assigned to the facility was not returned by exit. Interview on 8/3/16 at 9:40am with a PCA revealed: -There was a maintenance request book kept in the Resident Care Coordinators (RCC) office. -When a maintenance issue was observed, staff completed a request form and slid it under the Administrator's door. Once the issue had been addressed, the Administrator would make comments to the form and place the form back into the log book. -He was not aware of the condition of Residents #4, #5 and #6's wheelchairs or if they needed repairs. Review on 8/3/16 at 9:45am of the maintenance request book revealed there were no requests completed for Residents #4, #5 or #6's wheelchairs. Observation on 8/3/16 at 9:46am of the PCA completing a maintenance request for wheelchair repairs.	D 338		

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A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

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D 338	Continued From page 13 Interview on 8/3/16 at 11:10am with the Administrator revealed: -For maintenance issues, staff completed a request form and slid it under her door. She sent the request to the facility's owner. The owner sent a family member to complete the repairs. In cases of emergencies, a local company would be contacted to complete the repairs. -When a DME repair issue was brought to her attention, she called the DME company. -She was aware of the wheelchair repairs needed for Residents #4 and #5. -A representative from the DME company visited the facility on a monthly basis and was working on the wheelchair issues. -She was not aware that the facility was responsible for the repairs when special assistance did not cover the repair costs. Interview on 8/3/16 at 1:03pm with the Administrator revealed she had contacted the DME company and confirmed Residents #4, #5 or #6 were not eligible for wheelchair replacement. She indicated the DME company had agreed to come to the facility and repair the wheelchairs "free of charge". Observation on 8/3/16 at 2:27pm revealed a representative from the DME company repairing wheelchairs. 4. Review of Resident #6's current FL2 dated 10/22/15 revealed: -Diagnoses included hypertension, deaf and schizoaffective disorder. -Under the ambulatory status section, semi-ambulatory was checked with "w/c" handwritten in the box.	D 338		

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D 338	Continued From page 14 Review of Resident #6's current personal car plan dated 10/12/15 revealed: -Resident #6 was assessed as ambulatory with an aide or device, with "wheelchair" handwritten on comments line. -Under the activities of daily living (ADL) section, the number three (3) was written for the activity of ambulation/locomotion (a rating of three indicated the resident required extensive assistance when completing the task). Observations of Resident #6 during the survey revealed she used her wheelchair to move throughout the facility. Observation on 8/3/16 at 10:15am of Resident #6's wheelchair revealed: -The right arm rest pad was completely gone -The cloth seat showed wear signs (discolored, thinning to material). -There was a dime sized hole in the cloth seat. Interview on 8/3/16 at 10:15am with Resident #6 revealed she was unsure how long her wheelchair had been in that condition. A phone call on 8/3/16 at 12:30pm to the DME company personnel assigned to the facility was not returned by exit. Interview on 8/3/16 at 9:40am with a PCA revealed: -There was a maintenance request book kept in the Resident Care Coordinators (RCC) office -When a maintenance issue was observed, staff completed a request form and slid it under the Administrator's door. Once the issue had been addressed, the Administrator would make comments to the form and place the form back into the log book.	D 338		

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D 338	Continued From page 15 -He was not aware of the condition of Residents #4, #5 and #6's wheelchairs or if they needed repairs. Review on 8/3/16 at 9:45am of the maintenance request book revealed there were no requests completed for Residents #4, #5 or #6's wheelchairs. Observation on 8/3/16 at 9:46am of the PCA completing a maintenance request for wheelchair repairs. Interview on 8/3/16 at 11:10am with the Administrator revealed: -For maintenance issues, staff completed a request form and slid it under her door. She sent the request to the facility's owner. The owner sent a family member to complete the repairs. In cases of emergencies, a local company would be contacted to complete the repairs. -When a DME repair issue was brought to her attention, she called the DME company. -She was aware of the wheelchair repairs needed for Residents #4 and #5. -A representative from the DME company visited the facility on a monthly basis and was working on the wheelchair issues. -She was not aware that the facility was responsible for the repairs when special assistance did not cover the repair costs. Interview on 8/3/16 at 1:03pm with the Administrator revealed she had contacted the DME company and confirmed Residents #4, #5 or #6 were not eligible for wheelchair replacement. She indicated the DME company had agreed to come to the facility and repair the wheelchairs "free of charge".	D 338		

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D 338	Continued From page 16 Observation on 8/3/16 at 2:27pm revealed a representative from the DME company repairing wheelchairs. On 8/2/16, the facility provided the following Plan of Protection which included: -Staff members suspected of violating Residents' Rights will be immediately suspended, and will not be allowed to return to work while investigation is underway. -The Declaration of Residents' Rights will be signed by all staff. -A Residents' Rights inservice will be scheduled as soon as possible. -Staff with substantiated findings will be terminated. -Residents' Rights will be reviewed with all staff. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2016.	D 338		
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 medication, 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:	D 358	Nursing Staff will be trained and counseled to question all eMAR changes that do not have supporting documentation in the Resident's Record or that require clarification. The RCC will verify all orders on the eMAR Dashboard with a copy of supporting documentation or the order in hand. Orders will not be verified on the eMAR Dashboard without this documentation in hand. Nursing Staff will be retrained in the proper ordering procedures for all medications, especially Narcotics. Staff will document all contact with the Resident's Physician related to ordering Narcotic Medications in the Nurse Notes in the Resident's Record.	9.3.2016 and ongoing

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D 358	Continued From page 17 TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a prescribing practitioner to 1 of 3 (#7) residents observed during a medication pass and 1 of 2 (#2) residents sampled. (Coreg and Percocet) The findings are: A. Review of Resident #7's current FL2 dated 6/28/16 revealed: -Diagnoses included chronic schizophrenia, hypertension, and emphysema. -A medication order for Coreg 25mg twice daily after meals. (Coreg is a medication used to treat hypertension and heart failure.) Observation of a morning medication pass on 8/3/16 at 8:45am revealed: -Resident #7 received 11 oral medications and 1 nasal spray, but no Coreg 25mg. -The Medication Aide (MA) pulled the bubble pack containing Resident #7's Coreg 25mg, but put it back into the medication cart because it was not on the electronic Medication Administration Record (eMAR.) Review of Resident #7's record revealed: -A prior medication order dated 11/12/15 for Coreg 12.5mg twice daily. -A signed physician's order sheet dated 1/7/15 for Coreg 12.5mg twice daily. Review of Resident #7's eMARs for August 2016 revealed: -No entry for Coreg 25mg. -No entry for routine blood pressures, only prn, and none were recorded.	D 358		

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D 358	Continued From page 18 Review of Resident #7's eMARs for July 201[illegible] revealed: -No entry for Coreg 25mg. -An entry for Coreg 12.5mg, 1 tablet twice da[illegible]ly, with no doses of Coreg documented as given[illegible] -The entry for Coreg 12.5mg was marked D/[illegible]'d (discontinued) with stop date of 6/29/16. -One dose of Coreg 12.5mg was documente[illegible], as administered at 9am on 7/1/16. -No entry for routine blood pressures on the [illegible]uly MARs, only a prn, and none were recorded. Review of Resident #7's eMARs for June 201[illegible]6 revealed: -An entry for Coreg 12.5mg, 1 tablet twice da[illegible]ly, with scheduled administration times of 9am a[illegible]nd 9pm. -The Coreg 12.5mg had been documented a[illegible] given twice daily except for 3 doses circled fr[illegible]m 6/25/16 through 6/28/16 when the resident w[illegible]s in the hospital. -Resident #7's documented blood pressures ranged from 101/79 to 190/89. Review of Resident #7's record revealed: -She was taken to the hospital on 6/25/16 for shortness of breath and abdominal pain. -Resident #7's blood pressure on admission [illegible]/as 199/115. (Per the National Institute of Health guidelines, a desirable normal blood pressur[illegible] would be 120/80 or below.) -Resident #7 was discharged back to the fac[illegible]ity on 6/28/16, with medication orders that inclu[illegible]ed increasing the Coreg to 25mg, twice daily aft[illegible]r meals. Interview with Resident #7 on 8/3/16 at 11:15 am revealed: -She was in the hospital recently.	D 358		

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D 358	Continued From page 19 -Her medications were changed, but she was not sure which medications were changed. -She had always had high blood pressure. -Staff check her blood pressure sometimes, but "I don't like to have it checked every day." Review of Resident #7's medications available to administer in the med cart revealed: -A bubble pack of Coreg 25mg, 1 twice daily before meals, with a dispense date of 6/29/16. -Forty-one tablets had been dispensed and 19 remained. Interview with the Medication Aide (MA) on 8/3/16 at 12:45pm revealed: -She didn't give Resident #7 her Coreg 25mg because it wasn't on the eMAR. -She could not explain the 22 missing tablets from the bubble pack of Coreg 25mg. -The Resident Care Coordinator (RCC) was the only one who can make entries into the eMAR. -The RCC and the MA on duty are responsible for checking the accuracy of the eMARs. Interview with a pharmacist at the facility's pharmacy provider on 8/3/16 at 2:35pm revealed: -The most recent order they had for Resident #7's Coreg 25mg was dispensed on 6/29/16 for 42 tablets. -They were not sure why the Coreg 25mg was not on the eMAR for July and August 2016. -Facility staff can add and delete medication orders from the eMAR. -Just because a medication was discontinued on the eMAR dosen't mean it was discontinued in the pharmacy's dispensing computer system. -She was not sure exactly who could make changes to the eMAR at this particular facility but believed the RCC, Administrator, and MA could all make changes to the eMAR.	D 358		

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D 358	Continued From page 20 Interview with the triage Registered Nurse at Resident #7's Nurse Practitioner's (NP) office on 8/3/16 at 3:37pm revealed: -The most recent order they have on file for Resident #7's Coreg was 12.5mg twice daily from 11/12/15. -The NP did not receive a copy of the 6/28/16 FL2 from the hospital. B. Review of Resident #2's current FL2 dated 11/19/15 revealed diagnoses of diabetes, hypertension, and chronic schizophrenia. Record review revealed medication orders dated 5/26/16, 7/5/16 and 7/14/16 for Percocet 5/325 #120 tablets, 1 tablet four times a day. (Percocet is a narcotic analgesic used to treat moderate to severe pain.) Review of Resident #2's electronic Medication Administration Record (eMAR) for June 2016 revealed: -An entry for oxycodone-acetami 5-325 (generic Percocet) 1 tablet four times a day with scheduled administration times of 7am, 12 noon, 5pm, and 10pm. -A circled initialed entry on 6/30/16 at 9pm with an explanation for the circled entry of "resident in hospital." Review of Resident #2's July 2016 eMAR revealed: -An entry for oxycodone-acetami 5-325 1 tablet four times a day with scheduled administration times of 9am, 1pm, 5pm, and 9pm. -Doses of oxycodone-acetami 5-325 were circled as not given on 7/2/16, 7/3/16, 7/4/16, 7/5/16 and 7/6/16. -The explanation given for the circled doses on	D 358		

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D 358	Continued From page 21 the exception sheet of the eMAR was "on order/waiting on Pharmacy." Review of Resident #2's August 2016 eMAR revealed -An entry for oxycodone-acetami 5-325, 1 tablet four times a day, with scheduled administration times of 9am, 1pm, 5pm, and 9pm. -All doses had been initialed as administered Interview with Resident #2 on 8/3/16 at 11:12 am revealed: -She normally gets her medications as ordered by her physician. -She ran out of her pain medication (Percocet) "for about 3 days, a month ago." -"I had some Motrin to take, but it's not as good." -She believed the staff had forgotten to order her Percocet and let her run out. -She had a lot of pain in her legs, "I have restless leg syndrome." Interview with the Resident Care Coordinator (RCC) on 8/3/16 at 2:15pm revealed: -Staff (Medication Aides) are supposed to reorder medications when they get down to the blue trip on the end of the bubble pack, signifying the last few days doses. -When a hard script was required, "we called the doctor and had them fax it in to the pharmacy." -"Sometimes it took awhile for the doctor to get back to us on the hard script, and we have to call again." -"We are planning on changing doctors for that very reason." -She was sure Resident #2's Percocet had been ordered before she ran out. Interview with the Pharmacist at the pharmacy provider on 8/3/16 at 2:35pm revealed:	D 358		

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D 358	Continued From page 22 -They had refilled Resident #2's Percocet on 6/1/16 for 120 tablets, 7/6/16 for 120 tablets, and had a hard script dated 7/14/16 on hold. -The pharmacy normally cycle fills most routine medications. -Narcotics like Percocet required a hard script and it is the facility's responsibility to call the doctor to obtain the hard script. Interview with the triage RN at prescriber's office on 8/3/16 at 3:37pm revealed: -The facility called the prescriber's office to obtain hard scripts for narcotics not the pharmacy. -The facility did not call for a hard script for Resident #2's Percocet until 7/5/16. On 8/3/16, the facility provided the following Plan of Protection which included: -The facility contacted Resident #7's primary care provider to restart the Coreg order. -Staff were counseled to question eMAR changes that do not have supporting documentation in the resident's record. -The RCC will verify all orders on the eMAR dashboard with a copy of supporting documentation or order in hand. -Orders will not be verified without this documentation in hand. -Staff will be retrained in proper ordering procedures for medications especially narcotics. -Staff will document all contact with residents physician related to ordering narcotic medications. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2016.	D 358		

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D 438	Continued From page 23	D 438		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to report Staff A to the Health Care Personnel Registry who had allegedly verbally abused Resident #1. The findings are: Review of Staff A's employee file revealed: -She was originally hired by the facility on 12/15/15. -She was hired in the position of Supervisor and Medication Aide (MA). -A criminal background check was completed on 12/10/15. -A Healthcare Registry check was completed on 1/4/16. Interview with a Medication Aide (MA) on 8/1/16 at 4:41pm revealed: -She had witnessed Staff A being verbally abusive towards Resident #1 on two occasions, no specific date was given. -She described the verbal abuse of Staff A yelling and saying curse words to Resident #1 (no specific time given.)	D 438	The building will continue to follow Facility Policy in regards to Resident Abuse, Neglect, and Exploitation. Staff Members suspected of violating Resident Rights will be immediately suspended and not allowed to return to work while investigation is underway. Staff suspected of violating Resident Rights will be reported to the Healthcare Personnel Registry within 24 Hours. Reporting will be done using the 24 HR Initial Report Form and 5 Day Working Report Form.	9.3.2016 and ongoing.

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D 438	Continued From page 24 -She believed that the Resident Care Coordinator (RCC) and the Administrator knew about the situation. -After the second occurrence, she said to Staff A, "You don't have to talk to him like that." Interviews with three Personal Care Aides (PCA) on 8/1/16 at 4:23pm. and 8/2/16 at 9:00am revealed: -One PCA had witnessed Staff A yelling at and saying curse words toward Resident #1. -She gave examples of "I m not dealing with your s**t today" and telling the resident what to "sit down", "be quiet ". -The second PCA gave examples of, "I'm not in the mood for your s**t ", "go to your room", " go sit down", "you are not getting a cigarette". -The second PCA explained that Resident #1 had not smoked in 5 years or longer. However, Staff A gave Resident #1 cigarettes to smoke so he would get out of her area. -Resident #1 smoked the cigarettes given to him by Staff A. -The second PCA reported that one of the MAs had taken a video on her cell phone as evidence of Staff A's behavior and shown the video to the RCC and Administrator. -The third PCA had witnessed Staff A being verbally abusive towards Resident #1. -The third reported the incident to the RCC and Administrator. She also gave a written statement. -The third explained that she had worked with Staff A on the same shift and had tried to protect Resident #1 by removing him from the situation. -The third PCA took him to the dining room or living room to separate him from Staff A. Interview with a resident on 8/2/16 at 4:45pm revealed: -He heard Staff A yelling at Resident #1.	D 438		

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D 438	Continued From page 25 -He did not remember the exact words. -Staff A yelled at Resident #1 a few nights in a row. -Resident #1 wouldn't go to bed and he was walking around the facility naked when the yelling occurred. -The resident had not told anyone about the yelling. Review of Resident #1's record revealed Staff A had reported the resident's behaviors of wandering, aggression, taking off his clothing and urinating in the bed to Resident #1's physician. Interview with Resident #1's Guardian on 8/2/16 at 3:41pm revealed: -She reported that Resident #1 had behavior changes in the past six months. -She felt that the facility is safe, clean and homelike and had made many improvements in the past six months. -She had never observed any staff yelling at Resident #1. -Resident #1 had not reported any staff member yelling at him or that he was afraid of any staff member. Interview with the Administrator on 8/3/16 at 9:00am revealed: -She had found out about the verbal abuse from Staff A towards Resident #1 this past weekend (July 30-31, 2016). -Staff reported the verbal abuse to her and she asked for a written statement. -She then asked other employees who worked with Staff A if they had witnessed any verbal abuse, then she asked them for written statements. -She had all the written statements (currently still	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002007	A. BUILDING: _____ B. WING _____	C 08/03/2016

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D 438	Continued From page 26 waiting on one), then she will suspend Staff A for three days or until the investigation was complete. -She had watched the video of Staff A yelling at Resident #1 as recorded by another employee. -In the video, she had not seen the act, but could hear Staff A's tone of voice, but could not make out the words. -She thought she had to finish her investigation before reporting this incident to the Health Care Personnel Registry. -A class on Resident Rights was held on 3/11/16, but Staff A did not attend. -In the class, the Ombudsman went over each Resident Right and gave examples of violations and what is not a violation. They also performed role plays. -A class on "Managing Challenging Behaviors" was offered on 7/27/16. Staff A did not attend this class. -She reported that Staff A did not show any initiative in attending the Resident Rights Class or the Managing Challenging Behaviors class. -The Administrator had not made a report to the Healthcare Registry. -She thought that her investigation had to be complete before making the report to the Healthcare Registry. Interview with the RCC on 8/3/16 at 9:30am revealed: -She had found out a few days ago about Staff A being verbally abusive towards Resident #1. -She and the Administrator are currently waiting on a statement from one of the medication aides who witnessed Staff A being verbally abusive towards Resident #1. -She viewed the video recording that one of the medication aides had made, she couldn't tell what was said, but could hear a loud tone of voice. -She did not hear any curse words on the	D 438		

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D 438	Continued From page 27 recording. -She had not made a report to the Healthcare Registry because she had not finished her investigation yet. Review of the facility's policy on investigation revealed: -"Any incident where abuse, neglect or exploitation of a client is suspected or reported shall be thoroughly investigated within 24 hours". -"All instances of suspected abuse, neglect, or exploitation of a client will be reported to the County Department of Social Services and to the Division of Facility Services within 24 hours. -"Any staff member who is alleged to have committed any of these infractions must be reported to the Healthcare Registry." On 8/2/16, the facility provided the following Plan of Protection which included: -Staff members suspected of violating Residents' Rights will be immediately suspended, and will not be allowed to return to work while investigation is underway. -Staff suspected of violating Residents' Rights will be immediately reported to the HCPR. -Reporting will be done using the 24 hour initial report and the 5 day working report form. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2016.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 28 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 observations, interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations in the areas of medication administration, and failure to report an allegation of abuse against a staff member to the Health Care Personnel Registry. The findings are: A. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a prescribing practitioner to 1 of 3 (#7) residents observed during a medication pass and 1 of 2 (#2) residents sampled. (Coreg and Percocet) [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation.) B. Based on observations, record reviews, and interviews, the facility failed to report Staff A to the Health Care Personnel Registry who had allegedly verbally abused Resident #1. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry, (Type B Violation.)]	D912		

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D914	Continued From page 29	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were free from mental abuse by allow a staff member to yell and curse a resident, and neglecting to maintain residents durable medical equipment (wheelchairs.) The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents were free from mental abuse by allowing Staff A to yell and curse Resident #1, and neglecting to properly maintain and repair durable medical equipment (wheelchairs) for three Residents (#4, #5 and #6). [Refer to tag D338, NCAC 13F .0909 Resident Rights (Type B violation.)]	D914		