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
	HAL039009	A. BUILDING: _____ B. WING _____	C 08/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on August 9-12, 2016 and August 15, 2016.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 6 staff sampled had a criminal background check, completed prior to hire. (Staff A and D) The findings are: 1. Review of Staff A's personnel record revealed: -She was rehired as a medication aide on 12/13/13. Documentation of a criminal background check dated 06/17/10 was found in Staff A's record. Interview with the Business Office Manager (BOM) on 8/15/16 at 3:00 p.m. revealed: -The BOM was told that she did not need to complete another criminal background check on Staff A because Staff A was a rehire. -She did not want to say the name or title of the person who told her. -Another criminal background check for Staff A was completed on 8/15/16. Refer to interview with the Business Office Manager (BOM) on 8/15/16 at 3:00 p.m.	D 139	At the time of hire each employee will have a criminal background check completed. If employee is a rehire a new criminal background check will be completed. Criminal background checks to be completed by Business Office Manager. To be monitored quarterly by Administrator.	8/19/2016

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Director of Operations (X6) DATE 9/8/2016

9/12/16
PSDR
reviewed and accepted

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D 139	Continued From page 1 Refer to interview with the facility's Director on 8/15/16 at 3:30 p.m. 2. Review of Staff D's personnel record revealed: -She was hired as a Resident Care Coordinator/Special Care Unit (SCU/RCC) on 3/12/15. Documentation of a criminal background check dated 4/26/13 was found in Staff D's record. Interview with the Business Office Manager (BOM) on 8/15/16 at 3:00 p.m. revealed: -She was told that she did not need to complete another criminal background check on Staff D because Staff D was a rehire. -She did not want to say the name or title of the person who told her. -Another criminal background check for Staff D was completed on 8/15/16. Refer to interview with the Business Office Manager (BOM) on 8/15/16 at 3:00 p.m. Refer to interview with the facility's Director on 8/15/16 at 3:30 p.m. _____ Interview with the Business Office Manager (BOM) on 8/15/16 at 3:00 p.m. revealed: -She was told not to complete another criminal background check on staff rehired at the facility. -She was just following instructions. -"Now, I know I need to complete a criminal background check on staff rehire at the facility." -The facility's monitoring plan in place for criminal background checks for staff was the check should be completed, prior to hire. -She was responsible for the completion of a criminal background check on all staff, prior to hire	D 139		

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D 139	Continued From page 2 Interview with the facility's Director on 8/15/16 at 3:30 p.m. revealed: -He did not tell the BOM not to complete the criminal background checks on staff rehired at the facility. -The BOM was just following instructions. -The facility's monitoring plan in place for criminal background checks for staff was the check should be completed, prior to hire.	D 139		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 1 of 5 residents sampled (#5) who exhibited inappropriate behaviors. The findings are: Review of the current FL-2 for Resident #5 dated 06/08/16 revealed: -Diagnoses included Alzheimer's disease, hypertension, chronic kidney disease, and atrial fibrillation. -Resident #5 was constantly disoriented and a wanderer. Review of the Resident Register for Resident #5	D 273	The staff will contact physician when behaviurs are noted. MTISIC or RCC will follow up with MD recommendation. RCC will be for faxing MD office. Report will be sent by RCC to physician with in 24 hours of noted incident Training will be completed by RCC 8/19/2016. All staff will be trained.	8/19/2016

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D 273	Continued From page 3 revealed she was admitted to the facility Special Care Unit on 06/16/16. Review of a "Special Care Unit Quarterly Review" for Resident #5 dated 06/16/16 revealed: -Resident #5 exhibited the following behavior patterns: wandering, hallucinations, sundowning, following other people, and exit seeking. -Resident #5 did exit seeking especially in the afternoon during sundowning hours. -Resident #5 often thought other males were her boyfriend/husband. Review of the Nurse's Notes for Resident #5 revealed: -Resident #5 asked fellow male residents on several different occasions to go to bed with her on 07/01/16 during the 7-3 shift and was redirected by staff. -Resident #5 was rubbing the legs of another male resident on 07/06/16 during the 3-11 shift and she was redirected by staff. -Resident #5 repeatedly asked a fellow resident "do you know who I am" and she was asked by the fellow resident to leave him alone on 07/08/16 at 12:15 p.m. -Resident #5 told the 7-3 shift Supervisor on 07/08/16 that she knew the fellow resident because she had met him through her family member and she and fellow resident use to mess around. -The 7-3 staff on 07/08/16 redirected Resident #5, documented her behaviors, and notified the lead Resident Care Coordinator (RCC). -The Director of Operations (DOO) contacted Power of Attorney (POA) for Resident #5 on 07/08/16 at 1:30 p.m. and made him aware of the behaviors observed and the POA said he would call the physician for Resident #5 and see if the physician could "give her something".	D 273		

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D 273	Continued From page 4 -The Supervisor observed Resident #5 rubbing and touching on a fellow resident on 07/08/16 and had to be redirected from 3:30 p.m - 5:00 p.m. -The Supervisor documented on 07/08/16 during the 3-11 shift when she redirected Resident #5 to leave the other male resident alone, Resident #5 said she did not have to leave "her husband" alone and she was going to touch him if she wanted to. -Resident #5 became combative on 07/08/16 at 8:45 p.m. when she returned from activities in the Assisted Living Unit and it took 2 staff members to get her back in the Special Care Unit (SCU). -Resident #5 was observed during the 7-3 shift on 08/11/16 touching a male resident and Resident #5 got upset when she was redirected to stop by the Supervisor. -Resident #5 continued to "pursue" male resident on the 3-11 shift on 08/11/16. Review of a facility Accident/Incident Report dated 07/04/16 revealed: -The Supervisor on 07/03/16 at 2 p.m. found Resident #5 nude from the waist down in the bed of Resident #1 and Resident #1 was observed with his boxers pulled down. -The Supervisor notified the RCC. Interview with the Director of Operation (DOO) on 08/10/16 at 5:00 p.m. revealed: -Staff in the SCU had observed Resident #5 touching and asking the male residents to go bed with her several times since she was admitted. -Staff in the SCU had redirected Resident #5 to stop touching and asking male residents to go to bed with her. -Resident #5 had fixation on Resident #1 because her family member had told the DOO that Resident #1 resembled Resident #5's deceased husband.	D 273		

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D 273	Continued From page 5 -Resident #1 was removed from the SCU after the incident with Resident #5 on 07/03/16. -Staff noted that Resident #5 had started rubbing and called another male resident "her husband" after the incident on 07/03/16. -He and the lead RCC observed Resident #5 on 07/08/16 rubbing the legs of the male resident and referred to the resident as "her husband". -He called and spoke to both POAs for Resident #5 on 07/08/16 about the observed behaviors. -Resident #5's family member said he would call Resident #5's physician on 07/08/16 to see if anything could be done. -He did not know if the family member had notified Resident #5's physician of the behaviors. -He was not sure if the lead RCC had notified the Resident #5's physician about the behaviors. -The lead RCC had instructed the staff in the SCU to monitor Resident #5 more frequently and to document Resident #5's behaviors. Interview with the lead RCC on 08/10/16 at 5:15 p.m. revealed: -The staff in SCU had reported Resident #5 had touched and referred to male residents as her husband or boyfriend. -She really had not thought anything about the behaviors until after the incident on 07/03/16. -After 07/03/16, she instructed the staff to monitor Resident #5's interactions with male residents and document any inappropriate behaviors. -She did not call the physician for Resident #5 about the incident on 07/03/16 or for any incidents documented since then. -She thought the DOO had called Resident #5's physician since he was investigating the incident from 07/03/16 but she was not sure. -She and the DOO had observed Resident #5 on 07/08/16 and Resident #5 touching and calling a male resident her husband.	D 273		

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D 273	Continued From page 6 -The DOO notified Resident #5's family member of what they observed on 07/08/16 but she did not call the physician about their observation or the 07/03/16 incident. -She didn't call the physician because she thought the DOO was handling this situation. Interview with the Supervisor on 08/11/16 at 3:40 p.m. revealed: -She had seen Resident #5 and Resident #1 sitting together and holding hands several times. -Resident #5 often followed Resident #1 around the SCU and referred to him as her "husband". -Resident #5 would rub the legs of Resident #1 and sit with her hands in his lap. -Resident #5 would get upset if staff tried to separate them and stated "he is my husband". -She heard members of Resident #5's family comment that Resident #1 looked like their father. -On 07/03/16, she found Resident #5 nude from the waist down in Resident #1's bed and Resident #1 had his boxers down. -She called the lead RCC and the lead RCC told her to call the DOO. -She called the DOO and he stated to monitor both residents and keep them separated. -The SCU staff had been watching Resident #5 more closely since 07/03/16 and the staff tried to keep Resident #5 away from the male residents. -The SCU staff usually checked Resident #5 every 15-20 minutes. -Resident #5 was out of the facility with family until 08/12/16 or 08/13/16. Interview with the SCU RCC on 08/12/16 and 10:50a.m. revealed: -She completed the assessment on the Special Care Unit Quarterly Review dated 06/16/16. -She completed the Special Care Unit Quarterly Review and put in Resident #5's record but she	D 273		

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D 273	Continued From page 7 did not report anything to the lead RCC. -She completed the quarterly reviews but the lead RCC developed any care plans or strategies to deal with residents' behaviors. -She was not sure if the lead RCC had reviewed the Special Care Unit Quarterly Review for Resident #5. -A male family member of Resident #5 told her during Resident #5's admission that Resident #5 had made sexual advances toward him but he didn't know how to handle it. -She did not tell the lead RCC about this conversation with the male family member. -SCU staff had reported to her Resident #5 had referred to other males residents as her "boyfriend/husband". -Staff had reported to the lead RCC that Resident #5 rubbed male residents and referred to them as her "boyfriend/husband" but she was not sure if it was before or after the incident on 07/03/16. -Resident #5 had pursued another male resident in the SCU since the incident on 07/03/16. -The lead RCC and the DOO were dealing with managing Resident #5's behaviors. -She did not call the physician about Resident #5's behaviors because the lead RCC was responsible to contact the physician. Interview with the lead RCC on 08/12/16 at 11:05a.m. revealed: -She was not aware of the behaviors documented on Special Care Unit Quarterly Review for Resident #5. -She did not know a male family member of Resident #5 had reported that Resident #5 had made sexually advances towards him. -If she had known about the Quarterly Review and the conversation with the male family member of Resident #5, she would have put	D 273		

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D 273	Continued From page 8 interventions in place to help manage those behaviors. -She did normally review the SCU Quarterly Review but the SCU RCC should have reported this to her. -She had told the staff in SCU to monitor Resident #5 every 20 minutes and redirect Resident #5 if she exhibited any inappropriate behaviors with male residents after the 07/03/16 incident. -Staff in the SCU had told her and the DOO that Resident #5 had started touching another male resident after the incident on 07/03/16. -She and the DOO observed Resident #5 touching and referring to another male resident as her husband on 07/08/16. -The DOO notified Resident #5's family about their observation on 07/08/16. -She and the DOO did not call the Resident #5's physician because Resident #5's family said they wanted to call the doctor. -She still had not contacted Resident #5's physician about Resident #5's behaviors and with another male resident in the SCU. -She would revise the SCU Quarterly Review to make sure that she reviewed and signed off on the SCU Quarterly Reviews. Interview with POA/family member of Resident #5 on 08/12/16 at 3:10p.m revealed: -He knew that the resident referred to other males as her "boyfriend/husband". -The resident had referred to him as her "boyfriend/husband" and made sexual advances toward him. -These sexual advances by Resident #5 were upsetting to him and he wasn't sure how to handle it. -He understood that inappropriate sexual behaviors could be part of the Alzheimer's	D 273		

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D 273	Continued From page 9 disease process and the resident exhibited these behaviors. -He told the DOO that he was going to call Resident #5's physician but he did not do it because he didn't want the resident on any medication for her behaviors. -The facility just needed to do their job and watch the resident more closely. Interview with a Personal Care Aide on 08/15/16 at 2:00 p.m. revealed: -Resident #5 had sat and talked with Resident #1 a lot when he was in SCU. -Resident #5 had referred to Resident #1 as her husband. -She saw Resident #5 hold hands with Resident #1 and rubbed his legs several times. -She did not remember being given any instructions to keep Resident #5 or Resident #1 separated prior to 07/03/16. -The SCU staff was shocked to find Resident #5 in Resident #1's bed on 07/03/16. -The SCU staff monitored both residents every 15 minutes after this incident and kept them separated after the incident on 07/03/16. Interview with the same Supervisor on 08/15/16 at 2:45 p.m revealed: -She noticed Resident #5 started rubbing Resident #1's legs and holding his hands about a week after she was admitted to the facility. -Resident #5 always wanted to sit close to Resident #1 and she followed Resident #1 around sometimes in the SCU. -She observed Resident #5 would sometimes hover over other residents. -The staff had been instructed by the lead RCC not to let Resident #5 hover over other residents. -Resident #5 had been calling another male resident in the SCU her husband about week	D 273		

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D 273	Continued From page 10 after the 07/03/16 incident. -Resident #5 had started trying to hold hands and rub the leg of another male resident after the 07/03/16 incident but the staff redirected Resident #5 with other activities. -Resident #5 told her that staff could not keep her from the other male resident because that was her husband. -Staff tried to keep Resident #5 separated from the other male resident since the incident on 07/03/16. -She had reported Resident #5 had referred to the male resident as her husband and Resident #5 was holding hands, and rubbing the leg of the male resident to the SCU RCC and the lead RCC on 07/08/16. Interview with a second Personal Care Aide on 08/15/16 at 3:05 p.m. revealed: -Resident #5 acted like she was familiar with Resident #1. -She was told in shift report about two weeks after Resident #5 was admitted to the facility to keep Resident #5 separated from Resident #1 because of inappropriate behavior. -She could not remember who gave that information during the shift report. -Resident #5 got upset when staff separated her from Resident #1 and kept saying "he's my husband". -The SCU staff were given instructions to closely monitor Resident #5 every 20 minutes after the incident on 07/03/16. -The SCU staff was instructed to keep Resident #5 away from other male residents after 07/03/16. -Resident #5 had started rubbing and calling another male resident her husband since Resident #1 moved from the SCU on 07/04/16. Interview with the SCU RCC on 08/15/16 at 3:35	D 273		

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D 273	Continued From page 11 p.m revealed: -Resident #5 sought out male residents before female residents. -Resident #5 liked to touch male residents, put her hands in their laps, and rub the legs of the male residents. -Resident #5 thought all males in general were her "husband/boyfriend". -She did not tell the lead RCC about the male family member's observations or the observations she documented on the SCU quarterly review. -No system was put in place to dealing with possible inappropriate behaviors for Resident #5 when she was admitted. -There was a new system that had been put in place 08/13/16 to address those behaviors from Resident #5 and should be posted at the nurse's station in SCU. -Staff were supposed to keep Resident #5 away from the male resident at all times. -Resident #5's physician had not been notified of her behaviors that she knew of. Review of the Protocol for Resident #5 dated 08/13/16 revealed: -"The protocol applied to all gentlemen". -"Staff were to complete 20 minute checks and document any types of behaviors". -"Staff was to contact the physician and POA each time the resident had a behavior". -"Staff would redirect the Resident #5 each time she had a behavior". -"Staff would fill out an incident report and contact the RCC each time Resident had a behavior". Survey team attempts to contact Resident #5's Physician by telephone on 08/11/16, 08/12/16, and 08/15/16 for interview were unsuccessful. Review of the Plan of Protection dated 08/15/16	D 273		

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D 273	Continued From page 12 revealed: -The staff will contact the physician when resident behaviors are noted. -The Medication Aides, Supervisor, or Resident Care Coordinator will follow up with the physician's recommendation. -The Resident Care Coordinator would be responsible to fax the physician's office the documented behaviors. -Report will be sent by the Resident Care Coordinator to the physician within 24 hours of noted incidents. -Training for all staff on the incident reporting and review of policy will be done by the RCC by 08/19/16. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2016.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a physician's order was implemented for 1 of 1 sampled resident with multiples falls who had an order for physical	D 276	RCC will document each call made to believe orders date, time, who they spoke with. If order not recvd within 3 days RCC will contact doctor office again for order If RCC is not in building on vacation sick etc then RCC in special care unit will follow protocol.	8/16/2016 8/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039009	A. BUILDING: _____ B. WING _____	C 08/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

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D 276	Continued From page 13 therapy (PT). The findings are: Review of Resident #2's current FL-2 dated 1/20/16 revealed: -Resident #2 had diagnoses of unstable gait and recurrent falls. -Resident #2's ambulatory status was not documented. -Resident #2 was intermittently disoriented. Resident Registry revealed Resident #2 was admitted to the facility on 2/01/16. Review of Resident #2's care plan dated 3/08/16 revealed Resident #2 was documented as being ambulatory with the aid of a walker. Interview with Resident #2 on 8/11/16 at 3:15 p.m. revealed he had (PT) but did not remember the last time he had PT. Telephone interview with Resident #2's physician's nurse on 8/12/16 at 12:12 p.m. revealed: -Resident #2's physician had been made aware of resident's multiple falls. -The physician's expectation was that Resident #2 should be receiving physical therapy due to unsteady gait and multiples falls. -An order for Physical Therapy was faxed to the facility on 7/01/16. Review of a physician's fax dated 8/12/16 for Resident #2 revealed: -A verbal order for Physical Therapy (PT) and Occupational Therapy (OT) had been documented by the facility's Lead Resident Care Coordinator (LRCC) with no date. -The order had been signed and dated by the	D 276		

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D 276	Continued From page 14 physician on 6/28/16. -The order dated 6/28/16 had been hand stamped as faxed on 7/1/16, 7/13/16, 8/10/16 and 8/12/16. Interview with the Lead Resident Care Coordinator (LRCC) on 8/12/16 at 3:45 p.m. revealed: -She had requested a referral for PT for Resident #2. -She did not remember the exact date that she requested a referral for PT for Resident #2. -The physician's nurse had not responded to her request. -She had not received a referral for PT for Resident #2 until 8/12/16. If she had received the referral for PT for Resident #2 she would have faxed the information to the PT office within 24 hours of receiving the referral. Interview with the facility's Director on 8/15/16 at 4:35 p.m. revealed: -The LRCC had requested a referral for PT for Resident #2. -The LRCC had not received a referral for PT until 8/12/16. -The referral was sent to the PT office on 8/12/16. -A referral or order should be faxed to the appropriate agency within 24 hours.	D 276	The staff will contact physician when behaviors are noted. MT/SLC or RCC will follow up with MD recommendation. RCC will be responsible for faxing MD office	8/19/2016
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.	D912		

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D912	Continued From page 15 This Rule is not met as evidenced by: Based on observations, interviews and record review, 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 related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 1 of 5 residents sampled (#5) who exhibited inappropriate behaviors. [Refer to Tag D 273, 10A NCAC 13F .0902(b). (Type B Violation)]	D912		