STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	C 09/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(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 a complaint investigation on September 11-14, 2016.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the front door exit and the smoking area exits were equipped with a sounding device that activated when the doors were open resulting in 1 of 1 residents (#1) who was a known wanderer and constantly disoriented who exited the facility without staff knowledge. The findings are: Review of Resident #1's current FL-2 dated	D 067		

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D 067	Continued From page 1	D 067		

08/26/16 revealed:
-Diagnoses included hypotension, near syncope episode, hypertension, mild urinary tract infection, baseline dementia, history of carotid stenosis, history of cerebrovascular accident, history of congestive heart failure.
-Resident #1 was constantly disoriented.
-Resident #1 was ambulatory.

Review of the Resident Register revealed Resident #1 was admitted to the facility on 06/13/16.

Review of Resident #1's Care Plan (CP) dated 06/28/16 revealed:
-Resident #1 was constantly disoriented and had significant memory loss.
-Resident #1 must be constantly redirected.
-Resident #1 wanders a lot and goes outside to smoke with supervision.

Review of Nurses' Notes for Resident #1 dated 06/16/16 revealed:
-Resident #1 went out the 100 Hall exit door, started walking down the dirt driveway on the side of the facility, and staff brought him back inside the building.
-There was no documentation of door alarms sounding and no documentation of the time of the first incident.
-In the same Nurses's Note, a second incident reported Resident #1 went out another facility exit door and staff found him by the trash dump located behind the building.
-There was no documentation of door alarms sounding and no documentation of the time of the second incident.
-There were no times indicated on either of the two entries.
-There was no information on any alarm sounding

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D 067	Continued From page 2	D 067		

or other notification on the Nurses' Note entries.

Review of Psychiatrist Progress Note dated 06/24/16 revealed Resident #1 had a history of disorganized behaviors, disrobing, smearing feces, wandering, restless, and required constant redirection from staff on one on one basis.

Review of Resident #1's Incident Report dated from 08/24/16 revealed:
-Resident #1 was on the smoking porch but walked away from the around the facility.
-There was no documentation Resident #1 was supervised by staff while he was on the smoking porch on 08/24/16.

Interview of Resident #1 on 09/12/16 at 10:20 am revealed:
-Resident stated, "I am going to New York today".
-Resident #1 could not recall if he had ever wandered away from the facility since he was admitted.

Observation of Resident #1 on 09/12/16 at 10:20 am revealed:
-Resident #1 was sitting in a wheelchair in front of the employee break room.
-Resident #1 was alert and oriented to person only.

Observation of the facility during tour of the facility on 09/13/16 from 9:30am to 10:30am revealed:
-The front exit door of the facility that lead to the facility parking lot did not have a sounding alarm.
-The exit door from the residents' smoking area did not have a sounding alarm and opened a grassy area in the rear of the facility that was located approximately 400 feet from the main highway.

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D 067	Continued From page 3 Interview with a Personal Care Aide (PCA) on 09/11/16 at 6:00 pm revealed: -Resident #1 was a wanderer. -Staff had to watch Resident #1 because he tried to go out the exit doors a lot when he was up walking. -She could not remember the exact date but Resident #1 had gotten out the building, was found near the main highway, and staff had to bring him back to the facility in August 2016. Confidential Interview with a staff member revealed: -She knew Resident #1 was very disoriented and was a wanderer. -He would try to get out the facility if staff was not watching him closely. -It was hard to watch Resident #1 because sometimes there was not enough staff. -Resident #1 had a history of trying to leave the facility through the 100 Hall exit door. -Staff member could not recall how staff was notified of Resident #1's attempted elopements whether via door alarms, direct staff observation or by other residents. -He had wandered out various exit doors at least 5-6 times before staff could stop him. -The door alarms sounded off when Resident #1 tried to go out the exit doors on the 100 and 200 Halls. -The front door of the facility had never had an alarm on to let the staff know if a resident was attempting to leave the facility. -The smoking area door did not have an alarm on it. Interview with a Personal Care Aide (PCA) on 09/12/16 at 3:40 pm revealed: -Resident #1 was constantly disoriented.	D 067		

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-Resident #1 wandered a lot when he was ambulatory.
-Resident #1 had wandered outside the building several times but she could not verify how many times the resident had wandered outside without the staff 's knowledge.
-Resident #1 had gotten outside through the smoking area door which had no door alarm located in the back of the facility and walked around to the front side of the building before staff saw him.
-She could not recall any door alarms sounding off when Resident #1 wandered out the exit door by the smoking area or the front door exit.

Interview with a Medication Aide on 09/13/16 at 10:40am revealed:
-Resident #1 was constantly disoriented and he was a known wanderer.
-Staff needed to watch him frequently or he would leave the facility unsupervised.
-If she could catch him before he got to the exit door and call to him, Resident #1 would turn around and come back.
-Resident #1 had gotten out the alarmed exit door on the 100 Hall and was walking on the dirt path located approximately 20-30 feet from that exit.
-She heard the door alarm and went outside to bring Resident back in the building.
-She remembered on 08/22/16 when Resident #1 had gotten out of the facility and walked almost to the main highway.
-Staff looked outside and Resident #1 had made it to the fence by the main highway that lead to the driveway entrance for the facility.
-Resident #1 was brought back to the facility by staff.
-She was not sure how Resident #1 wandered out of the building or how long Resident #1 had been out of facility without staff being aware.

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D 067	Continued From page 5	D 067		

-She did not remember hearing any door alarms to warn staff that resident had wandered outside.
-The front door of the facility was not equipped with a door alarm and she did not remember if a door alarm had ever been on the smoker area exit door.
-Resident #1 had gotten out 3rd time but she could not recall the date.
-Resident #1 was seen through another resident's rear room window as Resident #1 was walking around the trash dump located behind the facility unsupervised.
-Staff had to strongly coerce Resident #1 to come back in the building.
-She did not know how Resident #1 got out the building on that occasion and she did not hear any door alarms going off.

Interview with a family member of Resident #1 on 09/13/16 at 11:18am revealed:
-Resident #1 was very disoriented and he could wander off sometimes.
-Staff had called and notified the family member when the Resident #1 was found at the trash dumpster and when Resident had wandered off from the facility and gotten almost to the road.
-She believed when Resident had wandered to the main highway that he thought he was going out to his mailbox like he did when he was at home.
-She did not know if the facility had door alarms on their exit doors.
-She believed the staff at the facility were doing the best they could to keep up with Resident #1 but Resident #1 liked to "stay busy".

Interview with Resident Care Coordinator on 09/13/16 at 4:00pm revealed:
-She did not know if any residents who currently resided at the facility were considered constantly

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D 067	Continued From page 6 disoriented. -She was not aware Resident #1 had been identified by the physician as constantly disoriented. -There had never been an alarm on the front exit door of the facility. -A door alarm had been on the exit door of the smoking area but it had been turned off because the residents at the facility thought it was annoying. -She did not know if Resident #1 wandered out the doors that did not have alarms. -She would have door alarms placed on the exit doors for the front door and the door to the smoking area. _____ The facility submitted a Plan of Protection dated 9/13/16 as follows: -Staff will monitor all doors without alarms on them to assure who comes in and out of door. -Supervisor will assure all CNA, PCA monitor doors every 20 minutes on all 3 shifts until alarms are placed on doors on 09/14/16. -Staff will be in serviced on all Resident that are disoriented to know who needs monitoring. -Facility will place alarm doors without alarms by 09/14/16. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 14, 2016.	D 067		
D 206	10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staff The following describes the nature of the aide's	D 206		

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D 206	Continued From page 7 duties, including allowances and limitations: (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure Personal Care Aides (PCA) and Medication Aides (MA) were not assigned housekeeping duties of washing, drying and folding/hanging residents' laundry between the 7am and 9pm. The findings are: A confidential staff interview revealed: -The staff on all shifts were responsible for doing the residents' laundry. -The staff washed, dried and folded the residents' comforters, sheets, pillowcases and any remaining personal clothing not completed by 1st shift housekeeping. -We tried to get it done in between taking care of the residents. A second confidential staff interview revealed: -The facility usually had 2 personal care aides and 2 medication aides on day shift Monday through Friday. -The facility had one less medication aide on the weekends. -Housekeeping staff try to complete all of the residents' personal clothing from 8am to 3pm. -The PCAs were responsible to keep the washer and drying going all day. A third confidential staff interview revealed:	D 206		

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D 206	Continued From page 8 -Loading the washer, transferring clothes to the dryer and folding clothing took at least 3 hours of PCA staff time for each shift. -Housekeeping staff who did laundry duty worked only first shift. -Second and third shift PCAs and MAs were responsible to continue the laundering responsibilities for the facility. A fourth confidential staff interview revealed: -All MAs and PCAs contributed to the laundry responsibilities. -The washer and dryer were kept running all day on all shifts. -MAs and PCAs would often remove the dirty bed linens from resident rooms and take them to the laundry room when they were not assisting residents. -The facility expected all staff to participate in the laundry responsibilities. A fifth confidential staff interview revealed: -The weekend laundry responsibilities were greater due to having less staff. -Housekeeping did not spend as many hours laundering clothing and linens on the weekends as they did during the weekdays. -Management expected the laundry needs to be met by all staff when not performing resident care. Observations on 9/13/16 at 10:45am revealed: -There were 2 large barrels in the common bathroom on the "200 hall". -One of the barrels contained the residents' soiled clothing; the other one contained soiled towels and linens. -A medication aide was placing a resident's dirty linens in one of the barrels.	D 206		

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A sixth confidential staff interview revealed:
-One of the barrels in the common bathroom is used for soiled linens and the other was used for the resident's soiled clothing.
-When the barrels are full, the MAs and PCAs on all shifts took them to the laundry room, sorted, and loaded it in the washer to be washed.
-The MAs and PCAs would go back to the laundry room, place the washed clothes in the dryer and load another load in the washer.

A seventh confidential staff interview revealed:
-Laundry duties were part of their normal work routine.
-The staff member had put dirty laundry in the washer, transferred wet laundry to the dryer, folded the dry laundry and taken the clean laundry back to the hall.

An eighth confidential staff interview revealed:
-Staff had to help with laundry duties since the laundry staff was only there part-time.
-There was no laundry staff on the weekends and existing staff had to do the laundry on the weekends.
-Laundry duties performed included putting dirty laundry in the washer, drying laundry and folding laundry.

Observations of the laundry room on 9/13/16 at 11:20am revealed:
-There were clothes in the washer and clothes in the dryer.
-A housekeeping staff member was folding clothes on a table by the door.

Interview with a housekeeping staff in the laundry room on 9/13/16 at 11:20am revealed:
-When the clothes were done drying, housekeeping, PCAs or MAs would fold or hang

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D 206	Continued From page 10 them and take them to the residents' rooms. -The washer and dryer ran throughout the day and night. -PCAs and MAs on second and third shifts continued the laundry responsibilities throughout the entire day to meet the residents' laundry needs. -The facility did not have a dedicated laundry person. Observation of facililty's PCA and MA job descriptions on 9/13/16 at 1:35pm revealed there were no laundry responsibilities listed among the job expectations. Interview with the Resident Care Coordinator (RCC) on 9/13/16 at 2:05pm revealed: -Housekeeping, PCAs and MAs contributed time to the residents' laundry needs. -PCAs and MAs assisted with laundry when they were not assisting residents. -All staff were expected to assist with laundry responsibilities when not assisting residents. -She was unaware that the laundering responsibilities took time away from resident care for the PCAs and MAs. -The facility did not have a dedicated laundry person. -PCAs and MAs had not voiced any concerns with having to perform laundry duties in addition to their regular job duties. -The PCAs and MAs were to assist with laundry only when they were not assisting residents. -She would hire staff dedicated to do laundry.	D 206		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart	D 219		

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10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter.

Bed Count	Position Type	First Shift	Second Shift	Third Shift
21 - 30	Aide	16	16	8
	Supervisor	Not Required	Not Required	Not Required
	Administrator/SIC	In the building, or within 500 feet and immediately available.		
31-40	Aide	16	16	16
	Supervisor	8*	8*	In the building, or within 500 feet and immediately available.**
	Administrator	On call		
41-50	Aide	20	20	16
	Supervisor	8*	8*	In the building, or within 500 feet and immediately available.**
	Administrator	On call		
51-60	Aide	24	24	16
	Supervisor	8*	8*	In the building, or within 500 feet and immediately available.**
	Administrator	On call		
61-70	Aide	28	28	24
	Supervisor	8*	8*	4 hours within the facility/4 hours within 500 feet and immediately available.**
	Administrator	On call		
71-80	Aide	32	32	24
	Supervisor	8	8	4 hours within the facility/4 hours within 500 feet and immediately available.**
	Administrator	On call		
81-90	Aide	36	36	24
	Supervisor	8	8	4 hours within the

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facility/4 hours within 500 feet and immediately available.**

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

91-100 Aide 40 40 32

Supervisor 8 8 8**

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

101-110 Aide 44 44 32

Supervisor 8 8 8**

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

111-120 Aide 48 48 32

Supervisor 8 8 8**

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

121-130 Aide 52 52 40

Supervisor 8 8 8

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

131-140 Aide 56 56 40

Supervisor 8 8 8

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call

141-150 Aide 60 60 40

Supervisor 8 8 8

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

151-160 Aide 64 64 48

Supervisor 16 16 8

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

161-170 Aide 68 68 48

Supervisor 16 16 8

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

171-180 Aide 72 72 48

Supervisor 16 16 8

Administrator 5 days/week: Minimum of 40

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hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure minimal staffing for Personal Care Aides (PCA) and Medication Aides (MA) on 1st and 2nd shifts was provided from 8/16/16 to 9/12/16 according to census.

The findings are:

Interview with the Resident Care Coordinator (RCC) on 9/12/16 at 1:45pm revealed the census range was 46-47 residents at the facility during the months of August 2016 and September 2016.

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D 219	Continued From page 14 Review of PCA and MA staff hours on the time sheets for staffing from 8/16/16 to 9/12/16 for first shift revealed 16 of 28 first shifts were understaffed. (Staffing rules require 28 hours for the facility's census of 46-47 residents on 1st shift) -8/16/16: 22.50 hours for 1st shift. -8/17/16: 22.50 hours for 1st shift. -8/18/16: 19.50 hours for 1st shift. -8/19/16: 22.25 hours for 1st shift. -8/20/16: 23.00 hours for 1st shift. -8/21/16: 23.25 hours for 1st shift. -8/26/16: 21.25 hours for 1st shift. -8/27/16: 15.25 hours for 1st shift. -8/28/16: 22.75 hours for 1st shift. -8/30/16: 23.25 hours for 1st shift. -9/2/16: 23.00 hours for 1st shift. -9/3/16: 23.00 hours for 1st shift. -9/4/16: 23.00 hours for 1st shift. -9/5/16: 23.00 hours for 1st shift. -9/8/16: 21.00 hours for 1st shift. -9/10/16: 23.00 hours for 1st shift. -9/11/16: 23.00 hours for 1st shift. Review of PCA and MA staff hours on the time sheets for staffing from 8/16/16 to 9/12/16 for second shift revealed 14 of 28 second shifts were understaffed. (Staffing rules require 28 hours for the facility's census of 46-47 residents on 2nd shift) -8/19/16: 22.25 hours for 2nd shift. -8/20/16: 22.50 hours for 2nd shift. -8/21/16: 22.50 hours for 2nd shift. -8/22/16: 22.50 hours for 2nd shift. -8/26/16: 16.00 hours for 2nd shift. -8/28/16: 22.50 hours for 2nd shift. -8/29/16: 23.25 hours or 2nd shift. -9/2/16: 23.00 hours for 2nd shift. -9/3/16: 23.00 hours for 2nd shift. -9/4/16: 23.00 hours for 2nd shift.	D 219		

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D 219	Continued From page 15 -9/5/16: 23.00 hours for 2nd shift. -9/8/16: 23.00 hours for 2nd shift. -9/9/16: 23.00 hours for 2nd shift. -9/10/16: 23.00 hours for 2nd shift. -9/11/16: 23.00 hours for 2nd shift. Confidential interviews with 4 staff regarding staffing on 1st and 2nd shift revealed: -Both shifts were frequently understaffed. -There were not enough staff to bathe all the residents on posted schedules. -The week-ends "always" seemed to be short on staff. -The residents need a lot of care for only two Personal Care Aides (PCA) to handle on each shift. -If we had more staff, we could take better care of the residents. -There were staff members who called out of work for various reasons at the last minute where replacement staff could not be scheduled. -There were not any extra staff members to work in place of those who called out of work. -The facility staff quit recently and were in the process of hiring and training new staff. -When staff called out, they were supposed to find their own replacement, but sometimes they did not. -When there were staff call-outs, staff tried to look unsuccessfully for alternate staff to come in on several occasions. Confidential interviews with residents and resident's family members revealed: -The facility was frequently understaffed on the weekends. -Residents were not getting bathed according to schedule due to low staffing. -The RCC had been told on several occasions about the need for more staffing.	D 219		

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D 219	Continued From page 16 -Confidential interviewees could not give exact times or approximate dates of when they had informed the RCC. Interview with the RCC on 9/13/16 at 2:15pm revealed: -She was responsible for making the staffing schedule and ensuring minimum staff requirements. -When staff had quit she would try to replace them as soon as she could. -She was not aware of a staffing deficiency. -It was increasingly difficult to find staff. -Staff were expected to find replacements if they called in sick. -Some staff had to work over to compensate for staff occasional call outs. -She had been staffing according to an older census for under 40 residents and did not realize it. -She would ensure all staffing levels met the required minimum level. -First and second shift would immediately have an added staff member to meet the staffing requirement need.	D 219		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily	D 255		

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D 255	Continued From page 17 living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure an assessment was completed within 10 days following a change of condition for 1 of 1 resident	D 255		

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sampled (#1) with a significant change in the resident's ability to walk and transfer.

The findings are:

Review of Resident #1's current FL-2 dated 08/26/16 revealed:
-Diagnoses included hypotension, near syncopal episode, hypertension, mild urinary tract infection, baseline dementia, history of carotid stenosis, history of cerebrovascular accident, history of congestive heart failure.
-Resident #1 was constantly disoriented.
-Resident #1 was ambulatory.

Review of the Resident Register revealed Resident #1 was admitted to the facility on 06/13/16.

Review of Resident #1's Care Plan (CP) dated 06/28/16 revealed:
-Resident #1 had no problems with ambulation but required limited assistance.
-Resident #1 did not require the use of any assistive devices for ambulation.
-The CP was signed by the Assistant Resident Care Coordinator (ARCC) and dated 06/24/16.
-The CP was signed by the nurse practitioner on 06/28/16.

Review of Physician's Orders and Notes for Resident #1 revealed:
-A physician's order for a physical therapy referral dated 08/28/16 due to frequent falls.
-A physician's order dated 08/31/16 for no-weight bearing to Resident #1's right foot secondary to right ankle fracture diagnosis and resident required the use of a wheelchair.

Review of Physician's Notes for Resident #1

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revealed:
-A physician's note dated 08/30/16 revealed Resident #1 had fractured right ankle.
-A physician's note dated 09/06/16 revealed Resident #1 was homebound with dementia, non-weight bearing, wheelchair bound, and unable to walk due to right ankle fracture.

Observation of Resident #1 on 09/12/16 at 10:20 am revealed:
-Resident #1 was alert and was sitting in a wheelchair
-Resident #1 had a cast to his right lower leg and was wearing an orthopedic shoe to his right foot.

Interview with Resident #1 on 09/12/16 at 10:20 am revealed:
-Resident #1 was oriented to person but disoriented to place and time.
-Resident #1 said, "I want to stand up but I can't".
-Resident #1 did not understand his right ankle was fractured and he was not supposed to bear weight on his right ankle.

Interview with a Personal Care Aide on 09/12/16 at 10:30 am revealed:
-Resident #1 was disoriented.
-Resident #1 had broken his right foot around the end of August and he had been in a wheelchair since then.
-Resident #1 was to avoid bearing weight on his right foot.
-Resident #1 did not understand that he could not walk so he kept trying to get up from his wheelchair.
-The staff had to keep an eye on Resident #1 so he would not fall.

Interview with the Resident Care Coordinator on 09/13/16 at 4:00 pm revealed:

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D 255	Continued From page 20 -She and the Supervisor were responsible for completing and updating the CPs for the residents. -It was an oversight that the CP had not been updated for Resident #1 yet regarding his change in ambulation. -She would be working to get the CP updated for Resident #1 and signed by the physician to reflect the change in Resident #1's ambulatory status.	D 255		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide personal care in accordance to the residents' assessed needs for 1 of 3 sampled resident's (#6) who was determined to require total staff assistance with dressing,grooming, and had on clothing that was stained with dried food particles. The findings are: Review of Resident #6's current FL-2 dated 5/8/16 revealed the resident was totally dependent on staff for dressing, bathing and feeding. Diagnosis included cerebral vascular accident, hypertension, Gastroesophogeal reflux	D 269		

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D 269	Continued From page 21 disease, benign prostrate atrophy. Review of Resident #6's current care plan dated 11/4/15 revealed the resident was totally dependent on staff for dressing and grooming and limited assistance with assistive devices for ambulation. Observation during the initial tour on Sunday 9/11/16 at 6:00pm revealed: -The resident was rolling his wheelchair to the dining room without staff. -The resident had on a dark colored hat and coat, blue thermal shirt and red jogging pants. -The shirt was stained with brown food particles and a white smeared substance. -The resident was served dinner by staff. -While eating, the resident spilled food on his clothing. -Staff did not assist the resident with cleaning the food off of the resident. -The resident left the dining room without staff assistance. Observation of Resident #6 on Monday 9/12/16 at 10:20am revealed: - The resident was sitting in a recliner in his room. -The resident was wearing the same clothing he was wearing on 9/11/16 at 6:00pm. -The coat, shirt and pants had food particles on them. -The blue shirt had the stained brown food particles and a white smeared substance. Observation of Resident #6 on 9/12/16 at 12:20 pm revealed the resident had on the same clothing he was wearing on 9/11/16 and 9/12/16 at 10:20am. Observation of Resident #6 on Tuesday 9/13/16	D 269		

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at 8:30am revealed:
-The resident had on the same clothing was wearing on 9/11/16 and 9/12/16.
-The resident was eating breakfast in the dining room.

Observation on 9/13/16 at 10:39 am revealed Resident #6 sitting in his recliner in his room with clean clothing. The resident was dressing in grey jogging pants, blue thermal shirt, a dark colored jacket and hat.

Interview with Resident #6 at 10:40am on 9/13/16 revealed [PCA name] shave me good, "I have on clean underwear, clothes, and socks. "I feel good".

Interview with the personal care aide (PCA)on 9/13/16 at 11:00am revealed:
- The resident clothing was "dirty" with food, and food stains.
-Staff should have changed his clothes.
- The male resident bath days are Tuesday, Thursday and Saturday.
-When staff perform baths they are suppose to complete a Bath and Shin report sheet and give it to the medication aide.
-The resident refused to shower the last time I worked on 9/8/16 (Thursday.
- I documented the refusal it the bath shower report form.
-The resident is very particular and staff sometimes had to encourage him and he will comply.
-He likes things done his way.
-I have not been trained on how to complete the personal care log for the resident.
- I think the supervisor completes the log.

Interview with another PCA on 9/13/16 at

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D 269	Continued From page 23 11:10am revealed: -Male residents bath days are Tuesday, Thursday and Saturdays on first shift. -The resident was shaved and showered on Saturday(9/10/16). -The staff are suppose to complete the bath and skin report sheet and give it to the medication aide. -The resident was dressed in red jogging pants, and blue shirt. -Staff should changed the resident if his clothing gets soiled between shower days. Interview with a third PCA on 9/12/16 at 1:12pm revealed: -Male resident are given showers on First shift on Tuesday, Thursdays and Saturdays. -Resident #6's name requires help with dressing, grooming and mobility to the dining room for meals. -Staff are supposed to make sure resident who need help are cleaned before going to meals. -Staff are supposed to change residents clothing if needed between shower days. Interview with a fourth PCA on 9/13/16 at 3:15pm revealed: -First staff are responsible for providing showers to male residents on Tuesday, Thursdays, and Saturdays. -Residents are checked every two hours to make sure they are living and breathing and everything is alright with the resident. -Staff are supposed to change resident clothing if needed on days that showers are not given. Review of Resident #6's Bath and Skin report revealed: -On 9/3/16 (Saturday)the resident was assesed	D 269		

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D 269	Continued From page 24 and given a bath. -On 9/6/16 (Tuesday)the resident was assess and given a bath. -On 9/8/16 (Thursday) the resident refused to shower/bath. -On 9/10/16 (Saturday) the resident was assesed and given a bath.. -On 9/13/16 (Tuesday) the resident was assesed and given a bath. Review of Resident #6's personal care logs for September 2016 revealed: -Did not have any documentation that a Tub bath or Shower, shave, mouth or oral care, skin care or nail care had been given from 9/1/16-9/12/16. Interview with the Resident Care Coordinator (RCC) on 9/13/16 revealed: -Male residents are showered on Tuesday, Thursdays and Saturdays. -Staff are supposed to complete the bath and skin report sheet when baths/showers are given and give the sheet to the supervisor. -The PCA are supposed to complete the personal care logs when tasked are performed. -If a resident request more bath/showers than the scheduled times staff should accommodate the request. -Staff are supposed to change resident when the clothing is dirty. -Staff should have changed Resident #6's clothing. -The supervisor or the RCC is responsible for assuring the PCA attend to the resident personal care needs.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 25 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 observations, interviews, and record review, the facility failed to provide the necessary supervision of 2 of 8 sampled residents (#1, #8) to prevent the resident from exiting the building and frequents falls with injuries (#1) and who exhibited erratic, aggressive behaviors (#8). The findings are: 1. Review of Resident #1's current FL-2 dated 08/26/16 revealed: -Diagnoses included hypotension, near syncopal episode, hypertension, mild urinary tract infection, baseline dementia, history of carotid stenosis, history of cerebrovascular accident, history of congestive heart failure. -Resident #1 was constantly disoriented. -Resident #1 was ambulatory. Review of the Resident Register revealed Resident #1 was admitted to the facility on 06/13/16. Review of Resident #1's Care Plan (CP) dated 06/28/16 revealed: -Resident #1 was constantly disoriented and had significant memory loss. -Resident #1 must be constantly redirected. -Resident #1 wanders a lot and goes outside to	D 270		

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smoke with supervision.

Review of Nurses' Notes for Resident #1 dated 06/16/16 revealed:
-Resident #1 went out the 100 Hall exit door, started walking down the dirt driveway on the side of the facility, and staff brought him back inside the building.
-Resident #1 went out another exit door and staff found him by the trash dump located behind the building.
-No times were documented in the Nurse's Notes for when these two separate incidents occurred.

Review of 72 Hour Monitoring Reports for Resident #1 for June 2016 revealed:
-On 06/13/16, Resident #1 was agitated and told staff he wanted to kill himself.
-On 06/13/16, Resident #1 wandered into several residents ' rooms, rambled, tore up beds, and spat in residents ' dressers drawers.
-On 06/17/16, Resident #1 went out the 100 Hall exit door and staff had to go get him.
-On 06/18/16, Resident #1 continued go out the facility exit doors several times, was very agitated and got physical with staff.

Review of a Psychiatrist Progress Note dated 06/24/16 revealed Resident #1 had a history of disorganized behaviors, disrobing, smearing feces, wandering, restlessness, and required constant redirection from staff on a one on one basis.

Review of Nurses' Notes for Resident #1 revealed:
-There was no documentation in the Nurses' Notes from 06/17/16 through 08/26/16.
-Documentation was noted on 08/27/16 by a home health nurse for Resident #1's admission to

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be evaluated for physical therapy services.

Review of a Psychiatrist Progress Note dated 08/26/16 revealed:
-The chief complaints were delusional agitation, insomnia, and dementia.
-Facility staff reported Resident #1 was very paranoid and delusional at night and sometimes became aggressive.
-Resident #1 had a lot of daytime sedation and then was awake and wandered at night.
-Mental status examiniation revealed Resident #1 was pleasantly confused, oriented to person only, had poor judgement, and had short-term and long-term memory.

Review of the Facility Incident Reports dated from 08/22/16 through 09/02/16 revealed:
-On 08/22/16, Resident #1 was found on the floor of his room with large cut to his right elbow (Emergency Medical Services (EMS) were called for first aid but no hospital transport).
-On 08/24/16, Resident #1 was on the smoking porch and walked away around the facility.
-On 08/24/16, Resident #1 was walking with the aide and fell (No injuries but Resident #1 was sent to the Emergency Room (ER)).
-On 08/27/16, Resident #1 was up walking in lunchroom, stumbled, fell, and hit head, nose, and chin on desk top (Resident #1 had injuries to his nose, left hand, and chin. Resident sent out to ER).
-On 09/02/16, Resident #1 was in wheelchair, tried to stand up and fell (Resident #1 sent out to ER for complaint of left hip pain).

Interview with a Personal Care Aide (PCA) on 09/11/16 at 6:00 pm revealed:
-Resident #1 wandered.
-Staff had to watch Resident #1 because he tried

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to go out the exit doors a lot when he was up walking.
-Sometime between 08/23/16 and 08/24/16, Resident #1 had gotten out the building, was found near the main highway, and was brought back to the facility by staff.
-Resident #1 had several falls.
-Resident #1 had slipped and fallen in urine in his room one night but she could not recall what night that was.
-Resident #1 had fallen around the end of August and broke his right foot.
-She checked on all the residents every 2 hours.
-She did not think Resident #1 needed any increased supervision.
-She was aware Resident #1 had attempted to stand and walk on his own since he had broken his foot and was in a wheelchair.
-Resident #1 needed assistance when transferring and was not supposed to bear weight on his right foot.
-Resident #1 used a wheelchair because he was not supposed to bear weight on his right foot. .
-Resident #1 could not call for help because of his cognitive status.
-She did not know if the facility had any policies for supervision of residents who had frequent falls or wandering tendencies.

Confidential Interview with a staff member revealed:
-Staff were required to perform 2 hour checks on all residents in the facility.
-She thought Resident #1 needed 1:1 supervision because he was so disoriented.
-Staff had to supervise Resident #1 when he wanted to go outside to smoke in the smoking area.
-She tried to check on Resident #1 every 30-45 minutes when she worked because Resident had

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a history of frequent falls and he would try to get out the facility if staff was not watching him closely.
-It was hard to watch Resident #1 because sometimes there was not enough staff.
-Resident #1 had a history of trying to leave the facility through the 100 Hall exit door.
-He had wandered out various exit doors at least 5-6 times before staff could stop him.

Observation and interview of Resident #1 on 09/12/16 at 10:20 am revealed:
-Resident #1 was sitting alone in a wheelchair in front of the employee break room.
-Resident #1 had a cast to his right lower leg and was wearing an orthopedic shoe to his right foot.
-Resident #1 was alert and oriented to person only.
-Resident #1 said, " I am going to New York today".
-Resident #1 tried repeatedly to stand up from his wheelchair but was unsuccessful.
-Resident #1 said, "I want to stand up but I can' t".
-Resident #1 did not understand his right ankle was fractured and he was not supposed to bear weight on his right ankle.
-Staff was at the opposite end of the hallway at the nurse's station.

Interview with a second Personal Care Aide (PCA) on 09/12/16 at 3:40 pm revealed:
-Resident #1 was constantly disoriented.
-She was aware the resident had fallen several times in the last month but she could not verify how many falls.
-Resident #1's last fall was earlier this month when he tried to get out of his wheelchair without assistance.
-Resident #1 did not understand he needed to call for help to get out his wheelchair.

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-Resident still tried to get out his wheelchair without assistance.
-Staff had to keep telling Resident #1 not to get up out his wheelchair without assistance.
-Resident #1 would stop momentarily as long as staff stand close to him.
-When staff turned to perform other duties, Resident #1 would try to get out of wheelchair again.
-Resident #1 wandered a lot when he was walking.
-Resident #1 had wandered outside the building several times but she could not verify how many times the resident had wandered outside without the staff ' s knowledge.
-Resident #1 had gotten outside through the smoking area door in the back of the facility and walked around to the front side of the building before staff saw him.
-Resident #1 was supposed to be supervised when he went out to smoke because he would wander off.
-She did not know who was supervising Resident #1 when he wandered away from the smoking area door.
-Staff were required to perform 2 hour checks on all residents.
-She tried to check Resident #1 about every hour because she knew Resident #1 had often tried often to get out of his wheelchair and she was afraid he could fall.
-She was not asked to monitor Resident #1 more often than every two hours even though he had frequent falls, wandering tendencies, and tried to get out of his wheelchair unassisted.
-She did not know if the facility had any policies for supervision of residents who had frequent falls or wandering tendencies.

Observation on 09/12/16 from 4:00pm - 5:00pm

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D 270	Continued From page 31 revealed: -Resident #1 was in his bed with eyes closed in Room 200 with room door half opened at 4:00pm. -No accessible call bell system was available for Resident #1. -The Supervisor was observed at the nurse's station located approximately 15-20 feet from Room 200. -The PCA assigned to 200 Hall was down the opposite end of the hall from Room 200 from 4:00pm to 4:20pm in other residents' room. -The Medication Aide (MA) was observed down the opposite end of the hall from Room 200 administering medications to other residents from 4:00pm to approximately 4:20pm. -The PCA assigned to the 200 Hall went in the shower room at 4:40pm to give another resident a shower, MA was off the floor, and Supervisor was still at the nurse's station. -At 4:49pm, the MA was on the 100 Hall administering medications and the PCA for the 200 Hall was still in the shower room on the 200 Hall. -No staff came and checked Resident #1 from 4:00pm to 5:00pm. Interview with a Medication Aide on 09/13/16 at 10:40am revealed: -It was hard for her to administer medications and monitor residents at the same time. -Resident #1 was constantly disoriented and he was a known wanderer. -Resident #1 had to be supervised when he went outside. -Staff needed to watch him frequently or he would leave the facility unsupervised. -If the PCAs were busy, she would keep Resident #1 with her down the halls as she administered medications to other residents to make sure he did not wander out the facility.	D 270		

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D 270	Continued From page 32 -If she could catch him before he got to the exit door and call to him, Resident #1 would turn around and come back. -She heard a door alarm on one occasion when Resident #1 had gotten out the 100 Hall exit door, walked down the dirt path located about 50 feet from the door exit, and she had to go outside to bring Resident #1 back in the building. -She remembered an incident in August 2016 when Resident #1 had gotten out of the facility and walked almost to the main highway. -She did not remember any of the door alarms going off on that day and staff did not know Resident #1 had wandered outside of the facility until a visitor told the staff. -Resident #1 was brought back to the facility by staff on that day and he appeared fine, laughing, and called her pretty. -She did not know how Resident #1 wandered out of the building without staff being aware. -Another incident occurred on that day when Resident #1 was walking down the hall fell on the floor by the beauty salon. -Resident #1 was taken to the emergency room by EMS because his blood pressure was low when she checked it after he fell on that day. -Resident #1 had gotten out another time but she was not sure of the date when a staff member saw through the window of another resident's room that Resident #1 was walking around the trash dump located behind the facility. -Staff had to go and coerce Resident #1 to come back in the building because Resident #1 did not want to come inside the facility. -She did not know how Resident #1 got out the building on that occasion. -No staff had seen Resident #1 leave the building and she did not remember -Resident #1 had fallen several times before he broke his foot.	D 270		

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D 270	Continued From page 33 -Resident #1 had fallen by the nurse's station and hit his face on the desk of the nurse's station and at least 2 other times she could remember (Unable to give exact dates). -Since Resident #1 had broken his foot, he had to use a wheelchair and he would try to get up unassisted if staff was not there to watch him. -Staff tried to keep Resident #1 up front by the nurse's station so he could be monitored more frequently in his wheelchair. -No increased monitoring or supervision had been put in place even though Resident #1 had left the building at least 2 different times and he had least 3 falls to her knowledge. -Staff did not document the frequency of supervision for any residents. -Staff checked Resident #1 when they had chance and when they were not working with other residents. -Staff did document on the 72 hour monitoring sheet once a shift when they had a new resident, when a resident had fallen, or when residents returned back to the facility from the ER or the hospital. -Staff were supposed to complete incident reports on all residents who had falls and elopements. -Staff were supposed to notify the resident's contact whenever incidents reports were filed on a resident. -A resident's physician was only notified of an incident if the resident had to go the hospital and the hospital discharge recommended to follow-up with the primary care physician. -Physicians were notified of resident elopement. -Completed incident reports were given to the RCC or put under her office door if she was not present at the facility. -The facility did not have any policies for "Falls" or "Residents who Wandered" for its residents.	D 270		

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D 270	Continued From page 34 Observation on 09/13/16 at 10:55am revealed: -There was a parking lot that led from the front of the facility and there was low cut grass on the right, left, and rear sides of the facility. -The right side of the facility was approximately 50 feet of a grassy area that extended between the facility and the adjacent lot. -The left side of the facility was approximately 200 feet of a grassy area that extended between the facility and the secondary road. -The rear of the facility was approximately 400 feet of a grassy area that extended between the facility and the main highway. -The parking lot was approximately 100-150 feet and opened into the facility driveway and was located on the front side of the facility. -The facility driveway opened to a secondary road and six single level apartment buildings were located directly across the other side of the secondary road. -The secondary road formed an L-shape from the facility parking lot around the left side of the facility and measures approximately 200 feet to its curve. -A ditch that measured approximately 5-7 feet wide was midway the grassy area on the left side of the facility and contained dark brown sludge. -This length of ditch extended from the secondary road back to the main high and its depth varied from appropriately 2-4 feet. -The distance from the curve of the secondary road to the main highway was approximately 500 - 600 feet. -At the end of the secondary road was a white fence located on the right side and it was approximately 20-30 feet from the main highway. -There were no speed bumps, no posted speed limit signs, or stop signs that led from the main highway down the secondary road to the facility.	D 270		

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D 270	Continued From page 35 Interview with a family member regarding Resident #1 on 09/13/16 at 11:18am revealed: -The family member was aware the resident had "frequent falls". -Resident #1 was used to be being active and she thought when he tried to move too fast sometimes it caused him to fall. -She believed low blood pressure may have caused one his falls last month because she found out Resident #1 had low blood pressure and was dehydrated after he sent to the emergency room. -Resident #1 was up and walking until he fell sometimes around 08/27/16. -She found out Resident #1 had a broken right foot on 08/30/16 because he was not able to participate in his physical therapy because Resident #1 could not walk right. -Resident #1's physician had ordered the wheelchair after Resident #1 was diagnosed with a broken right foot. -Resident #1 still tried to get up and walk on his own often and he had fallen at least once this month but he was not hurt. -Due to Resident #1's age and cognitive ability, he was not able to understand that he needed staff to help him if he wanted to get out of his wheelchair. -The facility had contacted her after all of Resident #1's falls and she knew about two times Resident #1 had eloped from the facility. -She had been notified by staff when they found Resident #1 by the main highway and when Resident #1 had gone outside to the trash dump. -She visited often and felt staff were taking care of Resident #1well. -The family member had no issues or concerns regarding his quality of care at the facility. Interview with the RCC on 09/13/16 at 4:00pm at	D 270		

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D 270	Continued From page 36 3:55pm revealed: -There were no residents in the facility who were identified as constantly disoriented. -She did not of any residents in the facility who had wandering tendencies. -The facility only monitored residents every 2 hours. -The facility did not have a fall policy, a wandering policy -The facility did not have a policy to deal with agitated residents or residents with erratic behaviors. Interview with a Supervisor on 09/14/16 at 9:25am revealed: -Resident #1 was constantly disoriented meaning he did not realize what was going on around him. -Resident #1 was known to wander and to have exit seeking behaviors. -She thought Resident #1 had gotten out of the facility either by walking out the front exit or from the smoking area. -She had told the other staff to monitor Resident #1 more frequently and to keep him close to monitor for safety. Interview with the Nurse Practitioner (NP) for Resident #1 on 09/14/16 at 12:25pm revealed: -The facility contacted her regarding all falls with and without injury for the resident. -The Resident #1 had a lot of falls but she was not sure of the cause of all his falls were. -The facility staff had not made her aware that Resident #1 had eloped from the facility or had exhibited exiting seeking behaviors. -Resident #1 needed "increased supervision" more than the 2 hour facility checks to ensure his safety. -She saw Resident #1 on 08/08/16 during an onsite visit at the facility and she has noted a	D 270		

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decline in Resident #1's mental status.
-Resident #1 had increased agitation and confusion when she saw him in August.
-Exit seeking behaviors did concern her for the safety of Resident #1.
-It was her expectation for to monitor Resident #1 at least every 2 hours while in bed asleep.
-When Resident #1 was awake or out of bed, staff should make sure Resident #1 was in a populated area and Resident #1 was monitored every 30 minutes by staff for his personal safety.

Interview with the RCC on 09/14/16 at 2:35pm revealed:
-She was not aware Resident #1 had eloped from the facility or had exit seeking behaviors because staff did not tell her.
-She was working with staff to improve the supervision of Resident #1.
-She had assigned a PCA on 09/14/16 to supervise Resident #1 on a one on basis.
-If she had known Resident #1 had exit seeking behaviors she would have told the staff to supervise him more often.
-She would not give a frequency for her expectation for the staff to supervise Resident #1 but she expected staff to check the resident more frequently like about every 30-45 minutes.
-She would contact the NP for Resident #1 to see if he needed a higher level of care.

2. Review of Resident #8's current FL-2 dated 02/09/16 revealed:
-Diagnoses were schizo-effective disorder
-bipolar type and mild mental retardation.
-Resident #8 was semi-ambulatory.
-Resident #8 was prescribed Cogentin 2mg -1 tablet by mouth once daily, Thorazine 100mg - 1.5 tablets by mouth twice daily, Valium 5mg - 1 tablet by mouth once daily, and Lithium

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D 270	Continued From page 38 Carbonate 300mg by mouth twice daily (Congentin and Valium are medications used to treat bipolar disorders. Thorazine and Lithium Carbonate are medications used to treat schizophrenia). Review of the Resident Register revealed Resident #8 was admitted to the facility on 01/21/16. Review of Resident #8's Care Plan (CP) dated 02/04/16 revealed: -Resident #8 was always disoriented and had significant memory loss. -Resident #8 could become very agitated and aggressive at times. Review of a Physician's Order for Resident #8 revealed an order dated 03/10/16 for Ativan 2mg/ml injection to be administered 1mg = 0.5ml intramusularly every 12 hours as needed (PRN) for agitation (Ativan is a medicatio used to treat agitation and anxiety). Review of a Physician's Order for Resident #8 revealed an order dated 06/15/16 for Clonazepam (Klonopin) 0.25mg dissolvable tablet - 1 tablet dissolve under tongue every 12 hours as needed for anxiety and agitaion (Clonazepam (Klonopin) is a medication used to treat anxiety). Review of Nurses' Notes for Resident #8 for June 2016 revealed: -Resident #8 was in her room and banged on doors and walls, ripped down the window blinds, pulled out and broke 2 dresser drawers, broke her radio, stripped of all her clothes, urinated on her room floor, came out in the hallway unclothed, and knocked all the books off the counter at the nurse's station on 06/29/16.	D 270		

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-There was no documentation Resident #8's primary care physician or psychiatrist were notifed of her behaviors on 06/29/16.

Review of Nurses' Notes for Resident #8 dated 07/24/16 revealed Resident #8 was agitated, cursing at staff, and was given 1mg of Ativan PRN intramuscularly due to agitation by the home health nurse.

Review of the Progress Notes from the Psychiatry Provider for Resident #8 dated 07/29/16 revealed:
-Staff reported Resident #8 urgently needed a follow-up because of increased behaviors.
-Resident #8 had refused to take her Lithium.
-Staff had reported Resident #8 had a few periods when she was crawling on floors, walked bent over, and cried excessively for no reason.
-Resident #8 had stolen items from other residents' rooms.
-Behaviors were consistent with mania.
-Care plan recommendations included an an physician order to discontinue Lithium due to Resident #8's refusals and start Depakote sprinkles 125mg three times a day with meals for mood disorder (Depakote is a medicatio used to treat bipolar disorder.

Review of the Progress Notes from the Psychiatry Provider for Resident #8 dated 08/26/16 revealed:
-Facility staff had reported Resident #8 had frequently refused to take her medications and continued to have unpredictable aggressive behaviors.
-Resident #8 wandered in the facility, went in other residents' rooms, stole their belongings, and broke things in the facility.
-On 08/26/16, Resident #8 had ripped a

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telephone off the wall and threw it across a room without apparent provocation.
-Lithium 150mg, 1 tablet by mouth daily at bedtime had been restarted on 08/19/16 but Resident #8's lithium level continued to be sub-therapeutic.
-Care plan for 08/26/16 included a physician's order to increase Lithium 150mg from once daily to twice daily.
-Staff to contact the provider if Resident #8's aggressive behavior continues.

Review of Nurses' Notes for Resident #8 for August 2016 revealed:
-Resident #8 was agitated, cursing, hitting and spitting at staff, flipped her dinner plate, accused staff to have pushed her down, and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 08/01/16.
-Resident #8 spat, cursed, and refused to take her night time medications on 08/07/16.
-Resident #8 was agitated and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 08/13/16.
Resident #8 was agitated and spitted at staff and was given 1mg of Ativan PRN intramuscularly due to agitation by the home health nurse on 08/22/16.
-Resident #8 was agitated, poured drink on the floor, and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 08/24/16. /
-Resident #8 dragged her/ nightstand up and down the hallway, cursed, spat, and hit staff on 08/25/16 and refused her PRN medication for agitation.
-Resident #8 was agitated and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 08/26/16.
-Resident #8 was naked, threw all cups off the

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medication cart, and staff notified the psychiatrist for Resident #8 on 08/29/16.
-Resident #8 was agitated and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 08/31/16.

Review of the Progress Notes from the Psychiatry Provider for Resident #8 dated 09/09/16 revealed:
-Staff had contacted the psychiatry provider on 09/09/16 because Resident #8 had demonstrated escalating behaviors consistent with mania and was very difficult to redirect.
-Facility nursing staff had contacted her on 09/06/16 because Resident #8 had become more violent and aggressive.
-Care plan for 09/09/16 a physician's order to increase Lithium 150 mg to 1 tablet by mouth three times a day, decrease Risperdal 0.5mg to 1 tablet by mouth twice a day, and to increase Klonopin to 0.5mg to 1 tablet by mouth once a day (Risperdal is a medication used to treat schizophrenia and bipolar disorder).

Review of a Physician's Order for Resident #8 dated 09/12/16 revealed:
-An order to discontinue Ativan 2mg/ml injection - 0.5ml dose.
-An order for Ativan 2mg/ml injection to be administered 1ml intramusularly every 12 hours as needed for severe agitation.

Review of Nurses' Notes for Resident #8 for September 2016 revealed:
-Resident #8 was agitated and spat at staff and was given 1mg of Ativan PRN intramuscularly, due to agitation, by the home health nurse on 09/01/16.
-Resident #8 was very agitated, hit another resident, and was given 1mg of Ativan PRN

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intramuscularly due to agitation by the home health nurse on 09/04/16.
-Resident #8 was agitated, combative, hit a resident and staff, and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 09/05/16.
-The psychiatrist on call for Resident #8 was notified on her aggressive behaviors on 09/05/16 and the psychiatrist on call said because of Resident #8's altered mental status there was not anything he could do and he would talk with Resident #8's regular psychiatrist about adjusting her psychiatric medications.
-Resident #8 was spitting, hitting staff and other residents, threw her shoes, cursed and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 09/09/16 and her pscyhiatrist was notified.
-Resident #8 was agitated, hitting and spitting at other residents, stripped out her clothes, screamed and used her teeth to rip her shirt, and was given 1mg of Ativan PRN intramuscularly by the home health nurse on 09/12/16.

Observation of Resident #8 on 09/11/16 at 6:20pm revealed:
-Resident #8 was lying in her bed with a sheet wrapped around her head.
-The blanket on her bed hung halfway off the bed onto the floor.
-The contents of the room were in disarray and several clothing items and incontinence diapers were scattered on the floor.
-There was a double sided 8 drawer dresser in the room.
-The top 2 drawers were missing.

Observation of Resident #8 on 09/12/16 at 10:35am revealed:
-Resident #8 was naked sitting in her wheelchair

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D 270	Continued From page 43 on the 200 Hall. -Resident #8 made growling noises and her teeth were clenched. -Staff came and took Resident #8 back to her room and closed the door. -Resident #8 was naked in her room started to rip the sheets and blankets from her bed. Interview with a Personal Care Aide on 09/12/16 at 10:40am revealed: -Resident #8 was known to show aggressive behaviors and stripped naked often. -She thought Resident #8 was trying to get attention from the staff. -Staff normally just took the resident back to her room and closed the door when she got agitated. -Resident #8 had hit and cursed staff and other residents on several occasions. -Resident #8 had thrown things in her room and at staff in an attempt to hit them. -If Resident #8 got too agitated, then staff called for the Home Health nurse to come out and give an injection for agitation. -She did not know what the medication was that was given by the Home Health nurse. -Staff had contacted Resident #8's physician about her aggressiveness. -She had never been given any instructions or training on dealing with Resident #8's agitation or aggressiveness. -She just tried to stay away from Resident #8 when she was agitated and tried to keep Resident #8 from hurting other residents when she got agitated. -The facility did not have a policy for how staff was supposed to handle residents who exhibited aggressive behaviors. Observation of Resident #8 on 09/12/16 at 12:15pm revealed:	D 270		

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D 270	Continued From page 44 -Resident #8 was naked in her wheelchair sitting in front of the nurse's station with the Resident Care Coordinator, a Medication Aide, and a Personal Care Aide present. -Resident #8 cursed and yelled at staff through clenched teeth. -Resident #8 swung to hit staff when they tried to approach her. -The Resident Care Coordinator, Medication Aide, and a Personal Care Aide wrapped a sheet around Resident #8. -The Personal Care Aide took the Resident #8 back to her room and closed the door. Interview with the Medication Aide on 09/12/16 at 12:20pm revealed: -Resident #8 was known to display aggressive behaviors. -Her aggressiveness had gotten worse in the last month when her psychiatric medications were changed. -Staff did not know how to manage Resident #8 except to try to keep her from hurting herself or other residents. -The staff normally just took Resident #8 and put her in her room and closed the door. -Staff normally checked Resident #8 every 2 hours even when Resident #8 was aggressive. -The facility did not have policy for dealing with residents who displayed aggressive or agitated behaviors. -Resident #8's physician was aware of the resident's aggressive behaviors and agitation. -If Resident #8 acted out really bad, staff would call for the home health nurse to come and give the PRN medication for agitation. Observation of Resident #8 on 09/12/16 at 2:45pm revealed: -Resident #8 was fully dressed, in her room alone	D 270		

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with the door closed.
-Resident #8 ripped down the blinds from her room window which caused a loud noise.
-No staff came to investigate the noise.
-A PCA was informed that Resident #8 had ripped the blinds from her window.

Interview with the Resident Care Coordinator on 09/12/16 at 3:00pm revealed:
-Resident #8 had really acted out today.
-She would get the Supervisor or the Medication Aide to call Resident #8's physician.
-Staff had already called the Home Health nurse to come out and give Resident #8 her medication for agitation.
-Resident #8 was known to be agitated and could be very aggressive.
-Resident #8 had been really acting out since her Lithium had been restarted in August 2016 after the Lithium had been discontinued in July 2016.
-There was not much the staff could do except try to keep Resident #8 from hurting herself and other residents by putting her in her room and closing the door.
-There wasn't much else the staff could do to when Resident #8 became agitated.
-Staff checked on Resident #8 every 2 hours to make sure she was safe.

Interview with Home Health Nurse on 09/12/16 at 4:20pm revealed:
-He was not sure why Resident #8's aggressive behaviors had increased.
-Staff normally tried to keep Resident #8 from hurting herself or other residents at the facility.
-Staff normally took Resident #8 back to her room when she got aggressive or agitated and called him to come administer her PRN medications that were ordered for her agitation.
-He was not sure how frequently staff monitored

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Resident #8 when she displayed aggressive or agitated behaviors.
-He had called and left a message for Resident #8's physician because her agitation and aggressive behaviors had gotten worse this week.

Observation of Resident #8 on 09/12/16 at 4:35pm revealed Resident #8 was transported by EMS to the ER to be evaluated for increased aggressive and erratic behaviors.

Observation of Resident #8 on 09/13/16 at 8:45am revealed:
-Resident #8 was sitting in her wheelchair on the 200 Hall fully dressed.
-Resident talked with her teeth tightly clenched and said "I'm okay" repeatedly.

Interview with the Medication Aide on 09/13/16 at 8:50am revealed:
-Resident #8 was sent back from the ER last night and the Psychiatrist was supposed to follow up with Resident #8 post-ER visit.
-Resident #8 had already agitated and cursed at staff this morning.
-Staff had not been advised to monitor Resident #8 more frequently since her ER visit.
-She would try to check on her when she could.

Interview with a Personal Care Aid eon 09/13/16 at 9:00am revealed:
-She had not been given any new instructions on supervision of Resident #8 since she came back from the hospital.
-Resident #8 was still agitated this morning so she would try to keep an eye on her today.
-She planned to check Resident #8 about every 30-45 minutes today to make sure she was okay.
-If Resident #8 got really agitated she would take

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her down to her room.

Interview with a family member of Resident #8 on 09/13/16 at 11:49am revealed:
-Resident #8 had a history of aggressive behaviors and staff had called him yesterday to let him know that Resident #8 was being sent out by rescue squad to be evaluated.
-Resident #8 seems to be irritated and angry all the time and he thought it was because of her medications.
-The facility staff made all the arrangements for Resident #8's psychiatric visits.
-He felt like the staff looked after Resident #8 well and he had no concerns with the care the facility provided.
-Resident #8 could be difficult and was easily agitated for no reason.
-He was not sure how often staff monitored Resident #8 when she displayed aggressive or agitated behaviors.

Survey staff was unsuccessfully with 3 attempts to contact the Psychiatric Provider for Resident #8 for telephone interview.

Refer to interview with RCC on 09/13/16 at 4:00pm at 3:55pm.

Observation of Resident #8 on 09/14/16 at 2:05pm revealed:
-Resident #8 was sitting alone in her wheelchair in the main sitting room by the front door.
-Resident was spinning the back left wheel of her wheelchair.

Interview with RCC on 09/14/16 at 2:35pm revealed:
-She had instructed the staff earlier that morning to be provide 1:1 supervision when Resident #8.

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D 270	Continued From page 48 -One on one supervision had not been provided prior to 09/14/16. -Staff had been instructed to try to calm the resident down and to notify the physician. -She would contact Resident #8's physician to see what other strategies could the staff use when the resident was agitated and/or aggressive. _____ The facility submitted a Plan of Protection dated 9/13/16 as follows: -Facility will immediately have one staff member to monitor any resident with behavior, falls to ensure safety. -Staff will be in-serviced on fall risks and difficult behaviors to ensure resident safety. -Staff will contact necessary agency to ensure safety of resident(s). CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 14, 2016.	D 270		
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 observations, interviews and record review, the facility failed to assure residents received care and services which were adequate,	D912		

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D912	Continued From page 49 appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and physical environment. The findings are: 1. Based on observations, interviews, and record review, the facility failed to ensure the level of supervision for the residents were modified for 2 of 8 sampled residents (#1, #8) who eloped and had frequents falls with injuries (#1), and a resident who exhibited erratic, aggressive behaviors (#8). [Refer to Tag D270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)] 2. Based on observations, interviews and record reviews, the facility failed to assure the front door exit and the smoking area exits were equipped with a sounding device that activated when the doors were open resulting in 1 of 1 residents (#1) who exited the facility without staff awareness. [Refer to Tag D067, 10A NCAC 13F .0305 (h)(4) Physical Environment (Type A2 Violation)]	D912		