STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086002	A. BUILDING: _____ B. WING _____	C 10/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL LONG TERM CARE FACILITY	340 SNOWHILL DRIVE MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted an annual and follow-up survey on October 5-7, 2016.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure plumbing equipment was maintained in an operating condition. The findings are: Interview with the Administrator on 10/5/16 at 11:45am revealed: -The water had been turned ~~turned~~ off to the toilets on half of the main hallway affecting 12 residents. -There was a clog in the facility sewage pipes. -A plumbing contractor had been notified and would be onsite soon to repair the clogged pipe. Observations on 10/5/16 between 11:15pm and 4:15pm revealed: -In the common shower room beside resident room #21 the left stall toilet would not flush. -In the common bathroom across from resident room #11 the sink was slow to drain. Interview with a Housekeeper on 10/5/16 at	D 105	The facility had a contract plumber come in on 10/6/16 to fix all current plumbing issues. The administrator or his designee will do weekly checks for one month and then monthly thereafter, on all fire, safety, electrical, mechanical, and plumbing equipment to assure all equipment is maintained in an operating condition. All plumbing equipment as of 10/7/16 was fixed and back in a safe and operating condition. Amended date per telephone conversation with Jessica, Kyle, and Lisa on 11/8/16 at 3:44pm. CS	

Reviewed and Accepted with Revisions
Date: 11/8/16 CS

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D 105	Continued From page 1 12:03pm revealed: -A resident had broken the toilet "last night" in the common shower room beside resident room #21. -The Administrator had been made aware the toilet was not working that morning. Observation on 10/5/16 at 12:30pm revealed there was a plumbing contractor on site with various employees snaking the drains in the facility. Confidential interviews with two residents on 10/5/16 between 2:00pm and 2:30pm affected by the water shut-off revealed: -The plumbers had successfully snaked the sewage pipes. -The water had been turned back on to their toilets. Observations on 10/6/16 between 8:15am and 9:30am revealed: -In the shared bathroom between resident room #6 and #8, the toilet would not flush. -In the common bathroom to the left of the staff bathrooms, the shower was not draining. -The sink in the ladies staff bathroom was very slow to drain. -In the common bathroom across from room #13, there was an intermittent drip underneath the sink wetting the floor every time the sink was used. -In the common bathroom across from room #13, the bathtub was slow to drain. -In the common shower room beside room #23, water leaked around the shower head when it was turned on. Observation on 10/6/16 at 9:07am a plumbing contractor was in the facility beginning repairs on various plumbing issues in the building.	D 105		

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D 105	Continued From page 2 Review of the facility Sanitation Report dated 2/22/16 revealed "Unclog the drain in the shower in the main hall bathroom." Interview with the Administrator on 10/6/16 at 9:36am revealed: -The facility was on city sewer. -Clogs were occurring in the facility pipes, "but it's not all the time." -A clog in the sewage pipe "started on Tuesday of this week when somebody had flushed a lot of brown towels" down the toilet. -He had the plumber out on Tuesday to "snake the lines" and they also repaired "a couple of toilets" by securing toilet bases to the floor. -"That bathroom where the tub is we know was slow to drain. He was supposed to return on Wednesday to finish the repairs, but he called out sick." -He was aware there were multiple plumbing issues in the facility and the plumber was currently on site working on the issues to resolve them.	D 105		
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 living; (B) change in ability to walk or transfer;	D 255		

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D 255	Continued From page 3 (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 complete an assessment within 10 days for 1 of 5 residents (Resident #3) following a significant change related to a decline in condition.	D 255	The facility did immediately assess resident # 3 to assure any significant change in resident # 3's condition is addressed and properly taken care of in assistance with facility physician. Supervisor in charge and/or their designee will assure any change in any residents condition will be addressed immediately and will be properly assessed for their plan of care with facility physician. An in-service will be conducted with all facility staff in regards to any significant change and the proper procedure with re-assessing residents current needs, notification to physician, and documenting accordingly. The supervisor in charge will do weekly chart reviews for one month to assure all residents are currently assessed accordingly, then monthly thereafter. In-services and chart reviews on all residents shall be completed by 11/20/16.	

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D 255	Continued From page 4 The findings are: Review of Resident #3's current FL2 dated 2/22/16 revealed: -Diagnoses included dementia and symptomatic iron deficiency anemia (a deficiency in iron that limits the production of red blood cells, which hold hemoglobin, which carries oxygen to body tissues. Symptoms include fatigue, weakness, confusion, agitation, shortness of breath, dizziness and pallor). -The resident was documented as ambulatory (no assistive devices indicated), intermittently disoriented, displaying no inappropriate behaviors, and continent of bowel and bladder. Review Resident #3's Care Plan dated 12/7/15 revealed: -The resident required limited assistance with eating and bathing. -He was continent of bowel, occasionally incontinent of bladder and required limited assistance with toileting. -He was independent with ambulation and required verbal cueing with dressing. -He received medications for mental illness and had been discharged from mental health services on 11/4/15. -He was sometimes disoriented and forgetful, needing reminders. -Additional diagnoses of Alzheimer's Disease, anxiety disorder, depression and schizophrenia, bi-polar type. Observations on 10/5/16 at 11:10am, upon arrival at the facility, revealed: -Resident #3 was standing in his stocking feet, beside a busy road, attempting to pick up a newspaper. -The road was located at the top of the facility's	D 255		

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D 255	Continued From page 5 driveway which sloped from the road down toward the facility. -The resident was unsteady on his feet and holding onto an unlocked wheelchair that was beside, and parallel to, the road. -He was attempting to sit down and was assisted into his wheelchair by a local DSS staff member and returned to the facility. -He was not wearing oxygen. -There were two residents smoking on the front porch in view of the driveway. -There were no staff members outside the facility at the time the resident was found. -Inside the facility, a Personal Care Aide (PCA) was kneeling on the floor in the main hallway beside a resident who had just had a seizure, a Medication Aide carrying a plate of food entered the hallway and stood by the PCA and Resident, the Administrator was in his office approximately 5 feet to 7 feet away from the PCA with the Resident on the floor and one staff member (a PCA) was in the laundry room emptying the clothes dryer. -The driveway was not visible from where each of these staff members had been located. -No other staff were observed at that time. Review of Resident #3's Licensed Health Professional Support (LHPS) quarterly reviews revealed: -A review written 3/18/16, stated the resident had a fall with no apparent injury and had been sent to the Emergency Room (ER) due to weakness. He returned with continuous oxygen he refused to wear. He had been alert but confused, pleasant but "speaks inappropriately", ambulating with a wheelchair and working with physical therapy. He required help with transfers. -A review written 7/28/16, stated he had been ambulating independently, had fallen on 7/13/16	D 255		

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D 255	Continued From page 6 and lacerated his right forearm requiring sutures. It had become red and swollen. He had been self propelling short distances in a wheelchair and needed help with doorways and if going long distances. He had been alert but forgetful, made inappropriate remarks at times. He required help with transfers. -A review written 10/3/16, stated he had unwitnessed falls on 8/12/16 and 8/30/16 with no apparent injury. Due to his increased wandering, he had been referred to a skilled nursing facility (SNF) but that had been put on hold pending increased wandering. He required 1 person to assist with his transfers. He self propelled short distances in his wheelchair. Review on 10/6/16 at 9:05am of incident/accident reports related to Resident #3's falls revealed: -On 4/26/16 at 6:30am: He had gone out to get the newspaper at the top of driveway and had fallen on his bottom with no apparent injury. No corrective action had been taken. The fall was unwitnessed. -On 7/13/16 at 11:20am: He had been outside the facility and had wheeled his wheelchair off of the sidewalk. He had been found, in the wheelchair, up against the facility wall with a "deep hole to the bone" in his right forearm. He had been sent to the hospital. X-rays had been negative for a fracture and the laceration required sutures. No corrective action had been taken post fall. The fall was unwitnessed -On 8/12/16 at 6:00pm: The staff, alerted by another resident, found Resident #3 sitting in urine on a shower room floor with no apparent injury noted. No corrective action had been taken post fall. The fall was unwitnessed. -No report had been located regarding a fall on 8/30/16, outside the facility, unwitnessed, and no apparent injury.	D 255		

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D 255	Continued From page 7 Based on observations and record review on 10/5/16, it was determined Resident #3 was not interviewable. Interviews from 10/5/16 through 10/7/16 with 5 staff regarding Resident #3 revealed: -He had become more confused/disoriented and increasingly more agitated. -He spoke inappropriately, making "gross" or sexually orientated comments. -He sat in soiled undergarments refusing to change them and refused baths on a regular basis. -He had been urinating on his floor and in his sink. -He had fallen multiple times since the first of the year in his room, in the driveway, on the porch and in the hallway. -He was not able to walk safely and is now in a wheelchair. -He had driven his wheelchair off of the sidewalk and had been found laying in the grass. -He had "really" declined since falling and hurting his arm in July 2016. -He can't do his own Activities of Daily Living (ADLs) anymore. -He had sustained multiple skin tears as a result of the falls. -He is mostly in the wheelchair and is a falls risk. -They are concerned he will get in the road and be run because he likes to get the newspaper. -The facility had used wanderguards in the past and should "at least try it" with this resident. -The wanderguard does not lock the door. It alarms when the resident is going through the doorway. -They can't watch him all the time because "he is all over the place." -They had talked about the wanderguard among	D 255		

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D 255	Continued From page 8 themselves but had not talked to the Supervisor or Administrator. -Some of them check on him every half hour and/or take him with them as they work. -There had not been any meetings to talk about changes in his care as a result of his falls, wandering and continued decline -His doctor had written an order for him to go to a nursing home but then changed her mind. Interview on 10/7/16 at 11:55am with Resident #3's physician revealed: -After the first of the year (2016), she began to get reports from the staff regarding a decrease in the residents ability to walk safely and to take care of himself. -They reported he had been found sitting in soiled undergarment, refusing to change them. -He had been refusing to bathe on a regular basis and urinating in inappropriate places. -He had been found outside of the facility and up by the main road getting the paper. -She really noticed a decline after he fell and lacerated his right arm in July 2016 and had been treated for a subsequent infection. -The staff observed "he didn't act like himself." -Falls were a big concern for her. No interventions had been put in place to safeguard the resident and she suggested the facility look at a other placement. -In August 2016, the staff informed her the resident had been experiencing progressive debility, a decline in condition, periods of increased wandering, and required total assistance with everything but eating. -She had been concerned the resident could exit the facility and the staff would not know that he had left. -He had been in a wheelchair and getting up unattended resulting in falls. and she had been	D 255		

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D 255	Continued From page 9 concerned he might fall into the road. -On 8/17/16, she had written an order for the facility to obtain a level of care assessment and to send her the results when available. -On 8/24/16, based on the assessment (his decline in gait stability, his wandering, his inability to perform activities of daily living and progressive dementia) she had recommended a skilled nursing facility (SNF) with a locked unit, completed an FL2 and requested he be transferred to [name of facility] for SNF. -The end of September 2016, the facility staff had asked her to re-evaluate the resident's condition and need for the SNF. -The staff had reported he had been wandering less, had been more active and was more like himself and the staff requested he remain at the facility. -On 9/28/16, she had written an order the resident could stay at the ALF (Assisted Living Facility) at this time, she would re-evaluate level of care as needed and for staff to please monitor his wandering. -Her plan had been for the Resident to remain in the facility, to monitor closely for decline in condition, an increase in wandering behaviors and if that occurred, he would need a higher level of care. -The facility had not notified her the resident had been found on 10/5/16 out near the road. -She stated, "He really needs a higher level of care". Interview on 10/7/16 at 12:15pm with the Administrator revealed: -The facility policy stated the staff would notify the care provider of resident wandering and falls and the resident would be monitored more closely. -He was aware Resident #3 had fallen one time when reaching over from his wheelchair to	D 255		

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D 255	Continued From page 10 pick-up a soda can. -He was aware Resident #3 had gone to the road in the past, when he was walking, but since he had been in the wheelchair the behavior had stopped. -He had noticed a decline in the Resident over the last couple of months. -The Medication Aide/Supervisor was responsible for completing the Care Plans. -The facility had a wanderguard system in place but this had not been discussed for this resident until "just lately". -He was not aware the physician had assessed the Resident for a higher level of care until after after the FL2 had been completed and the order to move the Resident had been written on 8/24/16. -He thought it might have been the transportation person, who makes rounds with the physician, who had asked for the change in the Resident's level of care. -The facility tried to move the Resident to the locked unit but the SNF would not take him without a guardian. -The Resident's current responsible person no longer came to the facility due to debility and what appeared to be cognitive issues. -The Administrator had not yet contacted anyone regarding guardianship. -He stated he thought the facility would move the Resident to a higher level of care.	D 255		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs,	D 270		

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D 270	Continued From page 11 care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 1 of 5 sampled residents (Resident # 3) related to falls, wandering and a decline in activities of daily living. The findings are: Review of Resident #3's current FL2 dated 2/22/16 revealed: -Diagnoses included dementia and symptomatic iron deficiency anemia (a deficiency in iron that limits the production of red blood cells, which hold hemoglobin, which carries oxygen to body tissues. Symptoms include fatigue, weakness, confusion, agitation, shortness of breath, dizziness and pallor). Review of Resident #2's record revealed: -Additional diagnoses of Alzheimer's Disease, anxiety disorder, depression and schizophrenia, bi-polar type. Review of Resident #3's Care Plan dated 12/7/15 revealed: -The resident required limited assistance with eating and bathing. -He was continent of bowel, occasionally incontinent of bladder and required limited assistance with toileting. -He was independent with ambulation and	D 270	The facility immediately updated resident # 3's care plan and current symptoms in accordance with facility physician. The supervisor in charge will assure all resident charts are reviewed and currently up to date. Chart reviews will be done monthly to assure all residents have up to date careplans. An in-service will be done with all staff members who are in residents charts on the importance of up to date careplans and the process of updating careplans and physician notification. Any changes in condition that are outside the scope of care for ALF will be assessed for alternate placement. This shall be completed on or before 11/20/16.	

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D 270	Continued From page 12 required verbal cueing with dressing. -He received medications for mental illness and had been discharged from mental health services on 11/4/15. -He was sometimes disorientated and forgetful, needing reminders. -Additional diagnoses of Alzheimer's Disease, anxiety disorder, depression and schizophrenia, bi-polar type. Observations on 10/5/16 at 11:10am, upon arrival at the facility, revealed: -Resident #3 was standing in his stocking feet, beside a busy road, attempting to pick up a newspaper. -The road was located at the top of the facility's driveway which sloped from the road down toward the facility. -The resident was unsteady on his feet and holding onto an unlocked wheelchair that was beside, and parallel to, the road. -He was attempting to sit down and was assisted into his wheelchair by a local DSS staff member and returned to the facility. -He was not wearing oxygen. -There were two residents smoking on the front porch in view of the driveway. -There were no staff members outside the facility at the time the resident was found. -Inside the facility, a Personal Care Aide (PCA) was kneeling on the floor in the main hallway beside a resident who had just had a seizure, a Medication Aide carrying a plate of food entered the hallway and stood by the PCA and Resident, the Administrator was in his office approximately 5 feet to 7 feet away from the PCA with the Resident on the floor and one staff member (a PCA) was in the laundry room emptying the clothes dryer. -The driveway was not visible from where each of	D 270		

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COLONIAL LONG TERM CARE FACILITY	340 SNOWHILL DRIVE MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 these staff members had been located. -No other staff were observed at that time. Review of Resident #3's Licensed Health Professional Support (LHPS) quarterly reviews revealed: -On review dated 3/18/16, documented the resident had a fall with no apparent injury and had been sent to the Emergency Room (ER) due to weakness. He returned with continuous oxygen he refused to wear. He had been alert but confused, pleasant but "speaks inappropriately", ambulating with a wheelchair and working with physical therapy. He required help with transfers. -On review dated 7/28/16, documented he had been ambulating independently, had fallen on 7/13/16 and lacerated his right forearm requiring sutures. It had become red and swollen. He had been self propelling short distances in a wheelchair and needed help with doorways and if going long distances. He had been alert but forgetful, made inappropriate remarks at times. He required help with transfers. -On review dated 10/3/16, documented he had unwitnessed falls on 8/12/16 and 8/30/16 with no apparent injury. Due to his increased wandering, he had been referred to a skilled nursing facility (SNF) but that had been put on hold pending increased wandering. He required 1 person to assist with his transfers. He self propelled short distances in his wheelchair. Review on 10/6/16 at 9:05am of incident/accident reports related to Resident #3's falls revealed: -On 4/26/16 at 6:30am: He had gone out to get the newspaper at the top of driveway and had fallen on his bottom with no apparent injury. No corrective action had been taken. The fall was unwitnessed. -On 7/13/16 at 11:20am: He had been outside the	D 270		

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D 270	Continued From page 14 facility and had wheeled his wheelchair off of the sidewalk. He had been found, in the wheelchair, up against the facility wall with a "deep hole to the bone" in his right forearm. He had been sent to the hospital. X-rays had been negative for a fracture and the laceration required sutures. No corrective action had been taken post fall. The fall was unwitnessed -On 8/12/16 at 6:00pm: The staff, alerted by another resident, found Resident #3 sitting in urine on a shower room floor with no apparent injury noted. No corrective action had been taken post fall. The fall was unwitnessed. -No report had been located regarding a fall on 8/30/16, outside the facility, unwitnessed, and no apparent injury. Based on observations and record review on 10/5/16, it was determined Resident #3 was not interviewable. Interviews from 10/5/16 through 10/7/16 with 5 staff regarding Resident #3 revealed: -He had become more confused/disoriented and increasingly more agitated. -He spoke inappropriately, making "gross" or sexually orientated comments. -He sat in soiled undergarments refusing to change them and refused baths on a regular basis. -He had been urinating on his floor and in his sink. -He had fallen multiple times since the first of the year in his room, in the driveway, on the porch and in the hallway. -He was not able to walk safely and is now in a wheelchair. -He had driven his wheelchair off of the sidewalk and had been found laying in the grass. -He had "really" declined since falling and hurting	D 270		

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D 270	Continued From page 15 his arm in July 2016. -He can't do his own Activities of Daily Living (ADLs) anymore. -He had sustained multiple skin tears as a result of the falls. -He is mostly in the wheelchair and is a falls risk. -They are concerned he will get in the road and be run because he likes to get the newspaper. -The facility had used wanderguards in the past and should "at least try it" with this resident. -The wanderguard does not lock the door. It alarms when the resident is going through the doorway. -They can't watch him all the time because "he is all over the place." -They had talked about the wanderguard among themselves but had not talked to the Supervisor or Administrator. -Some of them check on him every half hour and/or take him with them as they work. -There had not been any meetings to talk about changes in his care as a result of his falls, wandering and continued decline -His doctor had written an order for him to go to a nursing home but then changed her mind. Interview on 10/7/16 at 11:55am with Resident #3's physician revealed: -After the first of the year (2016), she began to get reports from the staff regarding a decrease in the residents ability to walk safely and to take care of himself. -They reported he had been found sitting in soiled undergarment, refusing to change them. -He had been refusing to bathe on a regular basis and urinating in inappropriate places. -He had been found outside of the facility and up by the main road getting the paper. -She really noticed a decline after he fell and lacerated his right arm in July 2016 and had been	D 270		

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D 270	Continued From page 16 treated for a subsequent infection. -The staff observed "he didn't act like himself." -Falls were a big concern for her. No interventions had been put in place to safeguard the resident and she suggested the facility look at a other placement. -In August 2016, the staff informed her the resident had been experiencing progressive debility, a decline in condition, periods of increased wandering, and required total assistance with everything but eating. -She had been concerned the resident could exit the facility and the staff would not know that he had left. -He had been in a wheelchair and getting up unattended resulting in falls. and she had been concerned he might fall into the road. -On 8/17/16, she had written an order for the facility to obtain a level of care assessment and to send her the results when available. -On 8/24/16, based on the assessment (his decline in gait stability, his wandering, his inability to perform activities of daily living and progressive dementia) she had recommended a skilled nursing facility (SNF) with a locked unit, completed an FL2 and requested he be transferred to [name of facility] for SNF. -The end of September 2016, the facility staff had asked her to re-evaluate the resident's condition and need for the SNF. -The staff had reported he had been wandering less, had been more active and was more like himself and the staff requested he remain at the facility. -On 9/28/16, she had written an order the resident could stay at the ALF (Assisted Living Facility) at this time, she would re-evaluate level of care as needed and for staff to please monitor his wandering. -Her plan had been for the Resident to remain in	D 270		

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D 270	Continued From page 17	D 270		

the facility, to monitor him closely for decline in condition, an increase in wandering behaviors and if that occurred, he would need a higher level of care.
-She was not aware the Resident had been non-compliant with his oxygen.
-The facility had not notified her the resident had been found on 10/5/16 out near the road.
-She stated, "He really needs a higher level of care".

Interview on 10/7/16 at 12:15pm with the Administrator revealed:
-The facility policy stated the staff would notify the care provider of resident wandering and falls and the resident would be monitored more closely.
-He was aware Resident #3 had fallen one time when reaching over from his wheelchair to pick-up a soda can.
-He was aware Resident #3 had gone to the road in the past, when he was walking, but since he had been in the wheelchair the behavior had stopped.
-He had noticed a decline in the Resident over the last couple of months.
-The Medication Aide/Supervisor was responsible for completing the Care Plans.
-The facility had a wanderguard system in place but this had not been discussed for this resident until "just lately".
-He was not aware the physician had assessed the Resident for a higher level of care until after after the FL2 had been completed and the order to move the Resident had been written on 8/24/16.
-He thought it might have been the transportation person, who makes rounds with the physician, who had asked for the change in the Resident's level of care.
-The facility tried to move the Resident to the

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D 270	Continued From page 18 locked unit but the SNF would not take him without a guardian. -The Resident's current responsible person no longer came to the facility due to debility and what appeared to be cognitive issues. -The Administrator had not yet contacted anyone regarding guardianship. -He stated he thought the facility would move the Resident to a higher level of care. _____ A Plan of Protection was provided by the facility on September 7, 2016 as follows: -The Resident will be fitted with a wanderguard bracelet so as to alert staff if the Resident approaches the doors. -The facility will review all resident charts to possibly identify any other residents that may need referral and follow-up. -The facility will contact the nurse practitioner about the Resident's falls and changes in his condition CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2016.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record	D 273		

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D 273	Continued From page 19 review, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 1 of 5 sampled residents (Resident #2) related to a vagus nerve stimulator (VNS). The findings are: Observations on 10/5/16 at 11:15am upon entrance to the facility revealed a female resident (Resident #2), laying on the hallway floor with a staff member kneeling beside her. Interview on 10/5/16 at 11:16am with the Personal Care Aide (PCA) kneeling beside the Resident revealed Resident #2 had experienced a seizure. Review of Resident #2's current FL2 dated 8/1/16 revealed: -A diagnosis of epilepsy, recurrent seizures. -For orientation: Disorientation, postictal (the altered state of consciousness after an epileptic seizure usually lasting between 5 to 30 minutes). -For neurological: Grand mal seizures (seizures that involve a loss of consciousness and violent muscle contractions) several times daily. -For skin: Indicated other with thigh, hip and lower abdomen listed. -Depakote ER 500mg, two tablets, twice a day (treats seizures and mood disorders). -Buspar 10mg three times a day (for anxiety). -Lamictal XR 100mg twice a day (decreases the intensity and the amount of seizures). -An admission date of 8/2/16. Review on 10/6/16 at 3:20pm of a letter in Resident #2's record revealed: -The letter was from the Resident's neurologist. -It was dated 7/15/16.	D 273	The facility contacted the Medical Director immediately for guidance and education on the management of the VNS in regards to the resident in question. Staff educated on proper procedure to assure safety and proper follow up of all diagnosis, treatment, and medical regimen. Upon admission or when a resident verbally reports a diagnosis and/or treatment the facility will contact the Medical Doctor or LHPS Nurse for guidance, management instructions, education, and confirmation. The supervisor in charge will do monthly chart audits to assure referral and follow-up to meet the routine and acute health care needs for all residents. Facility completed Plan of Protection on resident # 3 as of 10/25/16. Facility will complete chart reviews by 11/20/16.	

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D 273	Continued From page 20 -It was directed "To Whom It May Concern" -It stated the Resident had been under his care for a number of neurological conditions including constant seizures and was being moved to an assisted living facility. -She was being treated with VNS therapy for the seizures (Vagus Nerve Stimulation is designed to prevent seizures by sending regular, mild pulses of electrical energy to the brain via the vagus nerve in the left neck. It is often referred to as the "pacemaker of the brain"). -The VNS is adjusted by the neurologist according to seizure activity. -The letter stated, "Please do not hesitate to contact us should further information be required regarding this matter." Telephone interview on 10/6/16 at 3:38pm with the Licensed Health Professional Support (LHPS) nurse revealed: -Last week, while at the facility, she had been asked by the Medication Aide (MA)/Supervisor to see Resident #2 regarding the VNS. -She was concerned the facility hadn't notified her when the Resident was admitted and she could have provided staff training at that time. -On 10/13/16, she was scheduled to provide diabetic training at the facility and would train about VNS at that time. Review on 10/6/16 at 3:50pm of a progress note written by Resident #2's primary care physician on 8/10/16 revealed: -Resident #2 had been admitted with a history of severe epilepsy with a VNS in place. -The neurologist saw Resident #2 monthly for increases. -Resident #2 had multiple seizures per day. Interview on 10/6/16 at 4:00pm with Resident #2	D 273		

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D 273	Continued From page 21 revealed: -In April 2016, the VNS had been implanted in her upper left chest. -She wears the magnet around her wrist at all times. -When the magnet is brought near the stimulator, it generates an immediate electrical current to stop or reduce the severity of the seizure. -"It's kind of like a pacemaker. It turns on every 5 minutes, for 30 seconds, and stimulates a nerve in my neck." -"It also will turn on if my heart rate goes above 120. It thinks I having a seizure." -Upon admission, she had shared information about the VNS with the three staff on duty and showed them how to use the magnet. -She stated 2 or 3 weeks after she arrived at the facility, during an appointment with the neurologist, she had asked him if there was someone who could train the staff about the VNS and he said there was. -She had given the Administrator the neurologist's contact information in August. -She had been told, by the neurologist, the facility had not contacted him. Interview on 10/6/16 at 4:50pm with the facility transportation person revealed: -When Resident #2 was admitted to the facility, they knew nothing about her having the VNS. -The Resident was the one who told her what to do with the magnet if she had a seizure. -She also said she had been having 60 to 100 seizures a day before she got the VNS and the seizures were less now but not quite controlled. -The resident had her first seizure while the transportation person was away from the facility and before she had been able to share what she knew with the Medication Aide (MA) on duty. -The MA had swiped the magnet but nothing	D 273		

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D 273	Continued From page 22 happened and she didn't know if she could swipe it more than once. -The Resident had turned blue, 911 had been called and the Resident had been taken to the hospital. -When the transportation person returned to the facility, she told the MA what the Resident had said to do when she had a seizure and there were "no cautions with the device, you can't swipe it too much." -The magnet is swiped across the VNS when a seizure is coming on, during, after and until the Resident coughs. -The Resident had been upset upon return from the hospital and told the staff to swipe the magnet if she is having a seizure and to keep swiping it until she coughs. -She also told the staff if she turns blue during the process "to wait 5 minutes before calling 911." -Two to three weeks after admission, she had taken the Resident to a neurology appointment and the neurologist told her what to do and she shared the information with the direct care staff. -The Administrator knew about the VNS and how to use the magnet. -Several staff had said they wanted someone to come to the facility and teach them about the VNS. Confidential interviews from 10/6/16 and 10/7/10 with direct care staff related to Resident #2 revealed: -The Resident had told them if she sat on the floor they should run the magnet slowly across her chest and when she coughs she is ok. -There were staff who weren't comfortable around the VNS, they wanted "real training, not something word of mouth." -They had questions related to the VNS and wanted them answered by someone other than a	D 273		

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D 273	Continued From page 23 coworker and/or the resident. -Two stated they were afraid they might do something wrong " because we don't really understand how it works." Interview on 10/7/16 at 12:15pm with the Administrator revealed: -The facility policy/procedure regarding admitting a resident with a treatment or device the staff is not familiar with is to contact the physician and find out about it. -The pharmacy can sometimes provide training the staff may need. -Resident #2's information (the FL) did not mention her device (the VNS). -"We found out about it from the Resident when she was admitted and she told the staff what to do." -The facility did not contact Resident #2's neurologist or her primary care physician within 24 hours of admission to obtain orders and/or clarify what needed to be done related to the VNS. -"Two to three weeks after the Resident was admitted, our transportation person went with the Resident to a neurology appointment and the doctor explained for her what needed to be done." -The transportation person then shared that information with the rest of the direct care givers. -He was not aware there were staff who were uncomfortable dealing with the VNS and the magnet. -"It's simple. You just wave it (the magnet) over the resident." -He would contact the pharmacy and have the LHPS nurse train the staff about the device. A Plan of Protection was provided by the facility on October 25, 2016 and included the following:	D 273		

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D 273	Continued From page 24 -The facility had contacted the medical doctor immediately for guidance and education on the management of the VNS in regards to the resident in question (Resident #2). -The staff were educated on the proper procedure to assure safety and proper follow-up of all diagnoses, treatments and medical regimen. -Upon admission, or when a resident verbally reports a diagnosis and/or treatment, the facility will contact the medical doctor and/or LHPS nurse for guidance, management instructions, education and confirmation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 6, 2016.	D 273	The facility contacted the Medical Director immediately for guidance and education on the management of the VNS in regards to the resident in question. Staff educated on proper procedure to assure safety and proper follow up of all diagnosis, treatment, and medical regimen. Upon admission or when a resident verbally reports a diagnosis and/or treatment the facility will contact the Medical Doctor or LHPS Nurse for guidance, management instructions, education, and confirmation. Supervisor in charge will audit each resident chart to assure all residents have the Declaration of Residents Rights., which assures each resident receives care and services which are adequate, appropriate, and incompliance with relevant federal and state laws and rules and regulations. Staff educated on all Resident Rights, emphasis given to the right to receive care and services appropriate to their change in condition. This shall be completed by 11/20/16.	
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, record reviews, and interviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care and personal care and supervision. The findings are:	D912		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL LONG TERM CARE FACILITY	340 SNOWHILL DRIVE MOUNT AIRY, NC 27030

(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
D912	Continued From page 25 1. Based on observations, interviews and record review, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 1 of 5 sampled residents (Resident #2) related to a vagus nerve stimulator (VNS). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 2. Based on observations, interviews and record reviews, the facility failed to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 1 of 5 sampled residents (Resident # 3) related to falls, wandering and a decline in activities of daily living. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).]	D912		