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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on September 22-23, 2016 and September 26-27, 2016. The complaint investigation was initiated by the Sampson County Department of Social Services on August 17, 2016.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that the walls and floors were kept clean and in good repair on the 300 hall and on the 100 and 200 halls in the Special Care Unit (SCU). The findings are: Observation of room #315 on 9/22/16 at 11:57 a.m. revealed: -One of four walls had peeled paint and several indentions. -The white tiled floor in the private bathroom behind the toilet had green stains. Observation of the white tile floor in the private bathroom in room #308 on 9/22/16 at 12:02 p.m. revealed the floor had black stains throughout the floor. Interview with a resident on 9/22/16 at 12:07 p.m.	D 074		

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D 074	Continued From page 1 revealed staff cleaned the facility daily. Interview with second resident on 9/22/16 at 12:20 p.m. revealed staff cleaned the facility daily. Observation of the brown walls throughout the 300 hall on 9/22/16 at 12:45 p.m. revealed the lower section of the walls had black scuff marks. Interview with the Housekeeping Supervisor on 9/27/16 at 4:30 p.m. revealed: -The floors walls and bathrooms are cleaned daily. -She checked behind the housekeepers daily to make sure they cleaned the facility. -The peeled paint on the walls had been like that for a month. -Maintenance was in the process of finding someone to paint the areas which needed painted at the facility. Observation in room #101 on 09/22/16 at 11:30am revealed: -The bathroom sink was separating from the wall. -Several slats of the mini-blinds covering the window were broken in the middle. Observation in room #103 on 09/22/16 at 11:33am revealed grout behind the commode that was stained black Observations in room #104 on 09/22/16 at 11:35am revealed: -Three tiles, approximately 3 inches by 6 inches were detached from the base of the wall behind the commode in the bathroom. -The wall behind the resident's recliner had several irregularly shaped holes. Observation in room #108 09/22/16 at 11:37am	D 074		

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D 074	Continued From page 2 revealed the bathroom sink was separating from the wall. Observation in room #110 on 09/22/16 at 11:39am revealed a deep scrape approximately ¼ inch wide, ran the entire width of the exterior [facing the room] bathroom door. Observations in room #111 on 09/22/16 at 11:43am revealed crumbling sheetrock at the corner of the walls in the room's vestibule. Observations in room #112 on 09/22/16 at 11:47am revealed: -There were several irregularly holes in the sheetrock behind the resident's recliner. -The bathroom sink was separating from the wall. Observations in room #113 on 09/22/16 at 11:50am revealed: -The bathroom was behind the sink was missing an area of paint approximately 12 inches by 6 inches. -There were several irregularly shaped holes in the sheetrock behind the resident's recliner. Observations in room #114 on 09/22/16 at 11:55pm revealed, the seal around the base of the commode was cracking and stained brown. Observations in room #208 on 09/22/16 at 12:02pm revealed a large, approximately14 inches by 6 inches, area behind the sink in the bathroom was missing paint. Observations in room #210 on 09/22/16 at 12:50pm revealed: -The bathroom sink was separating from the wall. -A round hole, approximately 3 inches in diameter, was in the sheetrock behind the room	D 074		

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D 074	Continued From page 3 door. -A triangular area approximately 7 inches by 6 inches of the wall behind the sink had missing paint. Observations in room #212 on 09/22/16 at 12:05pm revealed tiles were missing from the baseboard behind the commode. Observations of the dinning area on 9/22/16 at 12:17pm revealed: -A deep scratch, approximately 24 inches long was in the wall behind the trash can. -A small, round hole, approximately ¼ inch in diameter was in the sheetrock under the electrical plug. -A black mark approximately 48 inches long, 4 inches above the molding, was along one wall. -The mini-blind covering the window had several damaged slats. Interview with the maintenance staff on 9/22/16 at 4:05p revealed: -He is scheduled to be at the facility one day a week. -He has been replacing damaged mini-blinds this week and last. Interview with a Personal Care Aide (PCA) on 9/27/16 at 5:36pm revealed: -The PCA was not aware of any housekeeping, repair or plumbing concerns. -If staff had a concern they were to complete a work order and give it to the Office Manager. -Work order slips were kept at the nurse's station. Interview with the Memory care Director (MCD) on 9/27/16 at 5:41pm revealed: -Monitoring of the environment on the Special Care Unit (SCU) was a group effort.	D 074		

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D 074	Continued From page 4 -All staff was responsible to report any needed repairs or concerns they had. -Staff completed a work order sheet and it was given to the Office Manager. Interview with the Administrator, the Area Supervisor and the MCD on 9/27/16 at 4:16pm revealed: -Management has been discussing needed repairs. -The Administrator had been in on weekends puttying [repairing] holes in the sheetrock in preparation for painting. -The facility has contracted with a local repairman to complete the needed repairs.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that the furniture (dressers and bedside tables) in 9 of 25 resident rooms and 5 of 5 pieces of cloth upholstered furniture in a common area in the Special Care Unit (SCU) were clean and in good repair. The findings are: Observations in room #101 on 09/27/16 at 11:15am revealed: -The dresser's top layer of finish was missing in irregular patches, -The bedside tables were scratched and scraped	D 076		

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D 076	Continued From page 5 on both tops and edges. Observations in room #102 on 9/27/16 at 11:17am revealed the top layer of the dresser's finish was missing in irregular patches. Observations in room #104 on 09/27/16 at 11:17am revealed the top layer of the dresser's finish was missing in irregular patches. Observations in room #105 on 09/27/16 at 11:20am revealed the top layer of the dresser's finish was missing in irregular patches. Observations in room #106 on 09/27/16 at 11:21am revealed: -The dresser's top layer of finish was missing in irregular patches. -The bedside tables were scratched and scraped on both tops and edges. Observations in room #107 on 09/27/16 at 11:23am revealed the top layer of the dresser's finish was missing in irregular patches. Observations of room #111 on 09/27/16 at 11:27am revealed, the dresser top had a large, approximately 10 inches by 8 inches, raised area in the top layer of finish as if liquid had seeped underneath. Observations of room #115 on 09/27/16 at 11:29am revealed: -The dresser's top layer of finish was missing in irregular patches. -The bedside table were scratched and scraped on both on the top and edges. Observations in room #208 on 09/27/16 at 11:32am revealed the top layer of the dresser's	D 076		

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D 076	Continued From page 6 finish was missing in irregular patches. Five pieces of fabric covered furniture, including chairs and loveseats, were in the common area of the 200 hall: -The headrest area of all 5 were darkly discolored. -The cushions were very dirty and stained with reddish substance. -The armrests were stained dark and very dirty. Interview with a Personal Care Aide (PCA) on 9/27/16 at 7:24pm revealed: -The furniture on the Special Care Unit (SCU) had been stained and dirty for at least 3 of the last 4 months (July, August and September 2016). -The PCA had not reported the furniture as a concern. -The PCA had seen housekeeping attempt to clean the furniture with a solution and some cleaning rags a few times. Interview with the laundry person on 9/27/16 at 7:21pm revealed: -The housekeeping staff tried to clean the furniture in the common room on the Special Care Unit (SCU). -Approximately every 2 weeks housekeeping staff would use upholstery "stuff" to clean the furniture. -The furniture really needed to be cleaned with a steam cleaner. -Housekeeping had not requested a steam cleaner to clean the furniture. Interview with the Memory Care Director (MCD) on September 27, 2016 at 12:20pm revealed that all furniture was 2 years old.	D 076		

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D 076	Continued From page 7 Interview with the Administrator, the Area Supervisor and MCD on September 27, 2016 at 4:16pm revealed: -The Administrator was hired November 30, 2016. -The Administrator placed an order for new furniture soon after her hire date and "at least 2 other times." -The orders were sent to "Corporate" and then submitted to the owners who had to approve all large purchases. -The fabric furniture in the common area was steam cleaned every 2 weeks. -New non-fabric covered furniture was expected any day to replace the fabric covered furniture in the common area in the SCU.	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that the Special Care Unit was free from all obstructions and hazards as evidenced by exposed mirror frame, jagged metal on a baseboard heater and a lamp in a bathroom without a safety plug. The findings are:	D 079		

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D 079	Continued From page 8 Observation of the bathroom in room #110 on 9/22/16 at 3:55pm revealed: -The bathroom mirror was missing. -The mirror support frame remained on the wall. -The frame was strips of metal with sharp edges forming a capital "I" . Interview with the resident of room #110 on 9/22/16 4pm at revealed: -The mirror had been missing since she moved in about 2 weeks ago. -The resident had not spoken with anyone about the missing mirror. Interview with the Memory Care Coordinator (MCD) on 9/22/16 at 6:12pm revealed she thought replacement mirrors have been ordered. Observation of the outside of the dining area on 9/22/16 at 4:20pm revealed: -A baseboard heater was mounted on the molding in the hallway near the enterance to the dininng area. -One end of the heater had been damaged with sharp metal exposed and the end cap was not in place. Interview with the MCD on 9/22/16 at 5:15pm revealed: -The baseboard heater was no longer used. -She did not know how long it had been damaged. The damaged heater was removed from the wall by the maintenance staff to prevent injuries before the survey team left for the day. Observations on 9/23/16 between 7:45am and	D 079		

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D 079	Continued From page 9 8:00am revealed: -Loose, peeling and cracked paint and caulk around the sinks in the bathrooms in resident rooms #201, #208, #210 and #212 causing the sinks to be loosened from the wall. -A broken over the toilet shelf where one shelf was at an angle and the remaining two shelves had fallen down unto the toilet tank lid in the bathroom in resident room #204. -Missing toilet paper spindles leaving pertruding spindle holders on the wall in the bathrooms of resident rooms #203, #205 and #206. -Urine stains on the toilet and urine odor in the bathroom in resident room #208. -There was an accent lamp on the floor next to the toilet with the cord wrapped around the safety pull up bar. -The cord was just under the electrical outlet next to the sink in the bathroom in resident room #208. -There was no GFCI outlet in the bathroom in resident room #208. (Ground fault circuit interrupter used to prevent electrical shock in areas where there is water) Interview with the laundry person on 9/23/16 at 8:05am revealed: -The over the toilet shelf in the bathroom in resident room #204 belonged to a resident. -The resident must have pulled the shelves down. -The laundry person would report the shelves to the Memory Care Director (MCD). -The loose, peeling and cracked paint and caulk around the sinks in the resident bathrooms in the Memory Care Unit (MCU) had been reported to the office manager. -Housekeeping staff was responsible for cleaning toilets every day. -There were 2 housekeepers on duty every day. -The laundry person checked the housekeepers work each day.	D 079		

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D 079	Continued From page 10 -The Medication Aide (MA) walked around the Memory Care Unit each day to make sure things were clean and in good repair. Interview with a Personal Care Aide (PCA) on 9/27/16 at 5:36pm revealed: -The PCA was not aware of any housekeeping, repair or plumbing concerns. -If staff had a concern they were to complete a work order and give it to the Office Manager. -Work order slips were kept at the nurse's station. Interview with the MCD on 9/27/16 at 5:41pm revealed: -Monitoring of the environment on the Memory Care Unit (MCU) was a group effort. -Cleanliness on the MCU was all staffs responsibility. -Housekeeping also cleaned the MCU daily. -All staff was responsible to report any needed repairs or concerns they had. -Staff completed a work order sheet and it was given to the Office Manager. The Office Manager was not available for interview 9/27/16 11:00am through 7:30pm. Telephone interview with the Contract Maintenance Supervisor on 9/27/16 at 5:50pm revealed: -The maintenance company handled "pretty much" all maintenance for the facility. -The maintenance company did not repair major systems such as air conditioning, heating and kitchen equipment. -The maintenance company's technician was at the facility 1 day each week and if needed sometimes a second day. -The Maintenance Supervisor was available to assist technicians if needed at the facility.	D 079		

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D 079	Continued From page 11 Interview with the laundry person on 9/23/16 at 8:05am revealed: -The laundry person had taken the lamp out of the bathroom and placed it on the bedside stand in resident room #208 on 9/22/16. -The resident must have put the lamp back in the bathroom. -The laundry person thought the resident would listen to her instructions to keep the lamp on the bedside stand and out of the bathroom. -The resident must have forgotten her instructions and just put the lamp back in the bathroom. -The laundry person had not reported the lamp in the bathroom to anyone. Interview with the resident in resident room #208 on 9/26/16 at 4:39pm revealed: -He was unable to state why he put the lamp in the bathroom. Interview with a Personal Care Aide (PCA) on 9/23/16 at 3:42pm revealed: -The PCA did not know how long the lamp had been in the bathroom. -She had seen it in the bathroom at least one time before. -Staff would take the lamp out of the bathroom because he plugged it in next to the sink and set it on the floor beside the toilet. -The resident would just put the lamp back in the bathroom. Interview with the MCD on 9/23/16 at 6:25pm revealed: -The MCD was made aware of the lamp in the bathroom in resident room #208 on 9/23/16 by the MA. -The lamp was removed from the bathroom and	D 079		

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D 079	Continued From page 12 placed in the MCD office. -The resident's family was notified and was going to pick up the lamp.	D 079		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure milk was served at least twice daily to residents in the Special Care Unit (SCU) at the facility. The findings are: Review of the menu dated 9/23/16 revealed residents were to be served milk for breakfast and dinner. Observation of the breakfast meal on 9/24/16 at 7:50 a.m. revealed: -One resident received nectar thickened milk. -Thirty three residents were not served or offered milk. Interview with a Personal Care Aide (PCA) on	D 299		

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D 299	Continued From page 13 9/23/16 at 8:00 a.m. revealed: -The aide worked in the SCU. -The kitchen determined if the residents were served milk during the meal. -If a resident wanted milk, staff would get the resident milk from the kitchen. Interview with a second PCA on 9/23/16 at 8:54 a.m. revealed: -The aide worked in the SCU. -Residents received milk as needed or requested. -If a resident wanted milk, staff would get the resident milk from the kitchen. -She did not know why the residents did not receive milk for breakfast on 9/23/16. Interview with a Cook on 9/23/16 at 11:50 a.m. revealed: -Milk was served to the residents, based upon the menu (breakfast, dinner). -Dietary staff used to send a pitcher of milk to the SCU to serve with the meals, but dietary staff stopped sending the pitcher of milk, because the staff in the unit did not serve the residents the milk. -Dietary staff stopped sending the milk to the SCU one week ago. Observation on 9/23/16 at 5:40 p.m. revealed Dietary staff had taken a pitcher of milk to the SCU. Interview with a PCA and a Medication Aide (MA) on 9/23/16 at 6:00 p.m. revealed: -Milk was optional. -The residents received milk if they requested it. Observation on 9/23/16 at 6:30 p.m. revealed none of the residents was served or offered milk.	D 299		

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D 299	Continued From page 14 Review of the menu dated 9/26/16 revealed residents were to be served milk for breakfast and dinner. Observations of the dinner meal on 9/26/16 at 5:20 p.m. revealed: -Thirty five residents were in the dining room. -The residents were served one cup of water and one cup of tea on the dinner tray. -There was a gallon container in a bowl of ice on top of the food cart. Observation on 9/26/16 at 5:28 p.m. revealed: -The MA began serving a thick white liquid from what looked like a gallon milk container she got from on top of the food cart. -The MA served 8 residents the thick white liquid. -There were no other milk containers on the food cart brought to the SCU. -No milk was served during the dinner meal. Interview with the MA on 9/26/16 at 5:28 p.m. revealed the thick white liquid in the gallon milk container was "Mighty Shakes" a nutritional supplement. Interview with the Memory Care Director (MCD) on 9/27/16 at 9:32 a.m. revealed for the dinner meal on 9/26/16, the residents were served milk and not mighty shakes. Interview with a Nurse Aide (NA) on 9/26/16 at 1:30 p.m. revealed: -The NA worked in the SCU. -Dietary staff sent the milk from the kitchen. -Residents received milk at breakfast and snacks. -She had not seen milk being offered "that much at dinner."	D 299		

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D 299	Continued From page 15 Telephone interview with the Dietary Supervisor on 9/27/16 at 5:06 p.m. revealed: -Three months ago, dietary staff had sent milk to the SCU unit for all three meals, but staff were not giving it to the residents. -The staff in the SCU would send the milk back, because they said they offered the milk and the residents did not want the milk. Interview with the MCD on 9/27/16 at 9:32 a.m. revealed: -Resident are supposed to receive milk at least two meals daily. -All of the residents should have received milk during the dinner meal on 9/26/16. Interview with the Administrator on 9/23/16 at 6:00 p.m. revealed: -Her expectation was for the residents in the SCU to be served and not offered milk twice daily with meals. -She was not aware the residents in the SCU were not served milk twice daily with meals. -If she would have known, she would have made sure the residents received milk twice daily. Interview with the Administrator on 9/27/16 at 10:00 a.m. revealed when she became aware milk was not served to the residents in the SCU twice daily on 9/23/16, she had a meeting with her managers on 9/23/16 and told them to make sure residents was served milk twice daily in the SCU.	D 299		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,	D 338		

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D 338	Continued From page 16 Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure 1 of 7 residents (#6), who was dependent on staff to assist with feeding, was fed in a timely manner in the Special Care Unit (SCU) and 10 of 23 resident's bathrooms were supplied with paper or cloth towels, soap and toilet tissue. The findings are: 1. Interview with a Personal Care Aide (PCA) on 9/23/16 at 8:39 a.m. revealed Resident #6 was 1 of 7 feeders in the SCU. Observations on 9/26/16 from 5:20 p.m. until 5:54 p.m. revealed: -There were 35 residents in the SCU dining room. -Staff started serving residents their dinner trays at 5:20 p.m. -The front center table, which was known as the feeding table, had 6 residents seated at the table. -Two staff served trays to 2 of the residents at the feeding table at 5:35 p.m. and assisted with feeding the residents. -Two additional staff served 2 more residents at the feeding table at 5:39 p.m. and assisted with feeding the residents. -A fifth staff served a fifth resident at the feeding table at 5:40 p.m. and assisted with feeding the resident. -There were no more staff available to assist Resident #6 at the feeding table. -There was not enough room for staff and residents at the front center table. -Resident #6 was sitting at the dining room table watching all of the other residents eat.	D 338		

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D 338	Continued From page 17 -Resident #6's plate was covered with a lid and remained in the food cart until the resident was served her dinner meal. -Resident #6 was not served dinner until 5:54 p.m. Observation on 9/26/16 at 5:50 p.m. revealed a PCA was cleaning the tables in the dining room and Resident #6 was still sitting at the feeding table and no one had set up the resident's plate to eat. Interview with the MCD on 9/26/16 at 5:52 p.m. revealed staff should have fed Resident #6 during the same time the other residents were eating their meal. Observation on 9/26/16 at 5:56 p.m. revealed Resident #6 was feeding herself during the dinner meal and a PCA was feeding and prompting Resident #6 with her meal. Observation on 9/26/16 at 6:16 p.m. revealed Resident #6 had eaten all of her meal. Interview with the PCA, who assisted Resident #6 with her meal and who cleaned the tables in the dining room during the dinner meal, on 9/26/16 at 6:21 p.m. revealed Resident #6 had eaten a late lunch, because staff was feeding other residents and there was no room in the dining room to feed Resident #6. Interview with a second PCA on 9/26/16 at 6:19 p.m. revealed: -Resident #6 had eaten a late dinner on 9/26/16, because staff was supposed to feed one resident at a time. -He had just started working at the facility two days ago and was told to feed one resident at a	D 338		

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D 338	Continued From page 18 time during his training. Observation during the lunch meal on 9/27/16 at 12:15 p.m. revealed: -Three staff were feeding three residents in the "feeders" dining room. -Resident #6 was eating her lunch meal and staff was feeding the resident with her meal. Observation on 9/27/16 at 12:25 p.m. revealed Resident #6 had eaten all of her meal. Observations during the breakfast meal on 9/23/16 at 7:50 a.m. and during the dinner meal on 9/23/16 at 5:40 p.m. revealed all 7 feeders in the dining room were being fed at the same time. Interview with the MCD on 9/27/16 at 9:32 a.m. revealed: -She was responsible for the SCU. -Yesterday (9/26/16) during dinner was the first time a resident, who was a feeder, had not been fed while the other residents, who were feeders, were being fed. Interview with the Administrator on 9/27/16 at 10:00 a.m. revealed: -The residents needing feeding assistance has increased in the SCU within the past month. -Last night (9/26/16) she discussed with the MCD about opening the feeding dining room so they can have more space to feed the feeders. -All of the feeders should have been eating at the same time. -All the feeders not being fed at the same time on last night (9/26/16) was the first time that had happened at the facility.	D 338		

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D 338	Continued From page 19 2. Observations of the bathroom in room #101 on 09/22/16 at 4:20pm revealed that the toilet paper dispenser was missing the spindle (the cylinder that keeps the roll in place). Observation of the bathroom in room #104 on 09/22/16 at 4:22pm revealed: -The toilet paper dispenser was missing its spindle. -The soap dispenser was missing. -There was no soap in the bathroom. Observation of the bathroom in room #105 on 09/22/16 at 4:26pm revealed: -The paper towel dispenser was missing. -There was not a roll of paper towels abvailable. Observation of the bathroom in room #106 on 9/22/16 at 4:29pm revealed that the toilet paper dispenser was missing its spindle. Observation of the bathroom in room # 108 on 09/22/16 at 4:30pm revealed there were no paper towels abvailable for use. Observation of the bathroom in room #109 on 09/22/16 at 4:33pm revealed: -The paper towel dispenser was missing. -There were no paper towels available for use. Observation of the bathroom in room #112 on 09/22/16 at 4:35pm revealed there was no toilet paper available. Observation of the bathroom in room #113 on 09/2216 at 4:39pm revealed there was no paper towel dispenser. Interview with a resident, who was missing a	D 338		

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D 338	Continued From page 20	D 338		

paper towel dispenser in his bathroom, on 09/22/16 at 4:22pm revealed that he did not know what had happened to the paper towel dispenser in his bathroom.

Interview with a Personal Care Aide (PCA) on 09/22/16 at 4:40pm revealed that the housekeeping staff was responsible for supplying the resident's bathrooms with paper towels, toilet tissue and bath soap.

Interview with the Housekeeping Supervisor on September 27, 2016 at 4:50pm revealed:
-She checked all aspects of the resident's rooms "at least once a day".
-The office manager ordered 30 toilet tissue dispenser spindles last week.
-The facility is planning to purchase a different type of toilet tissue and paper towel dispenser that will be sturdier.
-Rooms that are missing a paper towel dispenser should have a roll of paper towels.

Interview with the maintenance staff on 09/22/16 at 4:05pm revealed:
-He was scheduled to be at the facility one day a week.
-Work orders are generated by the Office Manager or Administrator are sent to his mobile phone.
-He did not received a work order about the missing or damaged paper towel dispensers and soap dispensers.
-Housekeeping was responsible for replacing the toilet tissue spindles.

Interview with the Administrator, the Area Supervisor and the Memory Care Director on September 27, 2016 at 4:16pm revealed:
-She expected that all resident's bathrooms are

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D 338	Continued From page 21 supplied with paper towels, soap and toilet tissue. -If a paper towel dispenser was missing or damaged, a roll of paper towels should still be in the bathroom. -"The residents in the SCU tend to be rougher on the papertowel dispensers." -The facility will purchase a different type of paper towel dispenser that will be sturdier and will assure that they are mounted securely on the walls. Observations in the Special Care Unit on 09/27/16 at 4:45pm revealed: -Paper towels were missing from rooms #109, #113, #205 and #208. -Bath soap was missing from rooms #104 and #112. -Toilet tissue was missing from room #111.	D 338		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of	D 468		

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D 468	Continued From page 22 orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 4 of 5 sampled Memory Care Unit staff (A, B, D, E) met the training requirement for 20 hours special care unit training within 6 months of hire. The findings are: 1. Review of Staff A's employee record revealed: -Staff A was hired on 10/27/15. -There was no job description in Staff A's employee record. -There was a certificate for 6 hours orientation training with no date for Staff A. -There was a certificate of completion for 7 hours training on Best Care for Dementia dated 10/27/15 for Staff A. -There was a certificate of completion for 3 hours training on Bathing without a Battle dated 10/27/15 for Staff A. -There was a certificate of completion for 3 hours training on Understanding Your Resident dated 10/27/15 for Staff A.	D 468		

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D 468	Continued From page 23 -There was a certificate of completion for 1 hour of training on Residents' Rights dated 11/6/15 for Staff A. -There was a certificate of completion for 1 hour of training on Bathing & Incontinence dated 2/8/16 for Staff A. -There was a certificate of completion for 1 hour of training on What is Abuse dated 3/7/16 for Staff A. -There was a certificate of completion for 1 hour of training on Wandering Behavior dated 3/22/16 for Staff A. -There were 17 total hours of training documented and dated in Staff A's employee record for the first 6 months after hire. Interview with Staff A on 9/26/16 at 4:22pm revealed: -Staff A was trained as a Nurse's Assistant (NA). -She had worked at the facility in 2014, left and returned in 2015. -Staff A worked on the Memory Care Unit (MCU) on all shifts. Review of facility staff schedule for 9/22/16 through 9/27/16 revealed: -Staff A worked 1st and 2nd shift on 9/22/16. -Staff A worked 1st and 2nd shift on 9/25/16. -Staff A worked 1st and 2nd shift on 9/26/16. -Staff A worked 1st shift on 9/27/16. Staff A was not available for interview regarding training on 9/27/16 after 3pm and did not have a working contact number. The Office Manager was not available for interview on 9/27/16 from 11:00am through 7:30pm. Refer to interview with the Memory Care Director	D 468		

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D 468	Continued From page 24 (MCD) on 9/26/16 at 5:00pm and on 9/27/16 at 7:20pm. Refer to interview with the Administrator on 9/27/16 at 5:00pm. 2. Review of Staff B's employee record revealed: -Staff B was hired on 4/15/10. -Staff B was hired as a Personal Care Assistant (PCA). -There was no certificate for 6 hours orientation training for Staff B. -There was a certificate of completion for 7 hours training on Best Care for Dementia dated 4/15/10 for Staff B. -There was a certificate of completion for 3 hours training on Bathing without a Battle dated 5/19/10 for Staff B. -There was a certificate of completion for 1 hour of training on Aphasia dated 5/5/10 for Staff B. -There was a certificate of completion for 1 hour of training on Fall Reduction dated 6/17/10 for Staff B. -There were 12 total hours of training documented and dated in Staff B's employee record for the first 6 months after hire. Interview with Staff B on 9/23/16 at 3:42pm revealed: -Staff B had worked at the facility for 6 years as a PCA. -Staff B worked on the Memory Care Unit (MCU) on 1st and 2nd shifts. Review of facility staff schedule for 9/22/16 through 9/27/16 revealed: -Staff B worked 1st shift on 9/22/16. -Staff B worked 1st and 2nd shift on 9/23/16. -Staff B worked 1st and 2nd shift on 9/24/16. -Staff B worked 1st and 2nd shift on 9/25/16.	D 468		

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D 468	Continued From page 25 Staff B was not available for interview regarding training despite attempts to contact by phone on 9/27/16. The Office Manager was not available for interview on 9/27/16 from 11:00am through 7:30pm. Refer to interview with the Memory Care Director (MCD) on 9/26/16 at 5:00pm and on 9/27/16 at 7:20pm. Refer to interview with the Administrator on 9/27/16 at 5:00pm. 3. Review of Staff D's, Medication Aide (MA), personnel file revealed: -Staff D was hired to work at the facility as a Personal Care Aide (PCA) on 3/25/16. -Staff D passed MA testing on 7/11/16 and began working as a MA. -From 3/25/16 to 9/6/16, Staff D had completed 10 hours of Special Care Unit (SCU) Training. -There was no documentation of the required 20 hours of SCU training. Observation on 9/27/16 at 3:55 p.m. revealed Staff D was working in the SCU. Interview with Staff D on 9/27/16 at 3:55 p.m. revealed: -She worked as a second shift and sometimes third shift MA in the SCU. -She had completed training in dementia and other related training, since she was hired (3/25/16), but she was unsure of the training she had completed. The Business Office Manager was not available	D 468		

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D 468	Continued From page 26 for interview on 9/27/16 from 11:00 a.m. through 7:30 p.m. Refer to interview with the Memory Care Director (MCD) on 9/26/16 at 5:00 p.m. and on 9/27/16 at 7:20 p.m. Refer to interview with the Administrator on 9/27/16 at 5:00 p.m.. 4. Review of Staff E's, MA/PCA, personnel file revealed: -Staff E was hired to work at the facility as a PCA on 5/1/15. -Staff E passed the MA testing on 7/22/16 and began working as a MA. -From 5/1/16 to 11/1/15, Staff E had completed 18.5 hours of SCU Training. -There was no documentation of the required 20 hours of SCU training. Telephone interview with Staff E on 9/27/16 at 7:29 p.m. revealed: -She was hired to work at the facility 5/1/15 as a PCA. -Sometimes she worked in the SCU. -She mainly worked in the assisted living side of the facility. -She had received at least 20 hours of SCU training since she had been working at the facility. -Most of her SCU training had been on the facility's computer system. -She had not had any SCU training in 2016. The Office Manager was not available for interview on 9/27/16 from 11:00 a.m. through 7:30 p.m. Refer to interview with the Memory Care Director (MCD) on 9/26/16 at 5:00 p.m. and on 9/27/16 at	D 468		

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D 468	Continued From page 27 7:20 p.m. Refer to interview with the Administrator on 9/27/16 at 5:00 p.m. _____ Interview with the Memory Care Director (MCD) on 9/26/16 at 5:00pm revealed the MCD was responsible for making sure staff had completed all CE trainings for orientation and annually. Interview with the MCD on 9/27/16 at 7:20 p.m. revealed: -When staff are hired to work in the Special Care Unit (SCU), she would tell the Office Manager so the Business Office Manager can set the staff up for training. -If staff had not received the training, the Business Office Manager would tell the MCD so she can make sure staff had received the training. Interview with the Administrator on 9/27/16 at 5:00 p.m. revealed: -The facility offered online CE trainings via a computer located in the main office in the facility. -There was a provider that scheduled additional trainings at the facility throughout the year. -The schedule for the provider's trainings was posted next to staff's work schedule. -The Office Manager was responsible for setting up new hires with initial orientation trainings which consisted of approximately 8 hours of online material. -The Office Manager was responsible for assuring each new staff completed all orientation trainings including the 6 hour and 20 hour special care unit training. -There was a new hire checklist the Office Manager was responsible for completing.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082022	A. BUILDING: _____ B. WING _____	09/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAGNOLIA	213 FOREST TRAIL CLINTON, NC 28328

(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 468	Continued From page 28 -There was a Business Office Manager who used to audit employee records for assure all documentation was in their record. -The Business Office Manager position was taken away approximately 3 months ago. -The Administrator and Regional Director were in the process of auditing staff records and found missing documentation. -The Office Manager was sent home the morning of 9/27/16 related to missing staff records and documentation of trainings.	D 468		