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CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

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{D 000}	Initial Comments The Adult Care Licensure Section completed a follow-up survey on January 19, 20, 23, and 24, 2017.	{D 000}		
{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 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 record reviews, and interviews, the facility failed to assure Personal Care Aides (PCAs) and Medication Aides (MAs) were not performing assigned duties of washing, drying, folding, and delivering residents' laundry between 7am and 9pm. The findings are: Confidential staff interviews revealed: -The staff did residents' routine laundry on the days the residents were scheduled for bathing/showering. -The staff did laundry at the start of the shift. -Housekeeping staff did laundry on Tuesdays and Thursdays, but the personal care staff did laundry on the remaining days.	{D 206}		

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{D 206}	Continued From page 1 -Laundry duties included folding and returning resident laundry to their rooms. -Staff assigned to bathing the residents on first and second shifts were responsible for doing the residents' non-incidental laundry, except Tuesdays and Thursdays, when housekeeping staff did laundry. -A PCA would be assigned to laundry if there was an extra PCA on the schedule. -The staff wash, dry, fold or place on hangers and deliver the residents' clothes to their rooms. -Doing laundry for the residents took staff off the floor, and "anything could happen". -The staff did laundry on days when there was not a designated staff to do laundry. -When the staff could, the staff would "pop in" the laundry room and put a load of clothes in the wash or fold clothes. -There was not always a designated staff to do laundry. -The residents' laundry needs were heaviest on first shift. -There were times when the facility was short staffed and direct care staff would be responsible for the normal laundry needs of the residents. -The staff did residents personal laundry every day. -If the staff had four residents to shower, the staff did four loads of resident laundry. -It took about 30 minutes per load of laundry. -It was hard for the staff to keep up with residents when staff were in the laundry room. -The staff could not say that there had been any incidents to occur, to her knowledge, while laundry was being done. -Sometimes the staff did laundry between 3pm and 8pm. -The staff tried to keep the laundry caught up. -The staff believed that having direct care staff perform laundry duties had "the potential to	{D 206}		

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{D 206}	Continued From page 2	{D 206}		

hinder resident care".
-There were usually seven staff working the second shift and sometimes eight staff.
-When there were only four PCAs working, there would be one PCA on each hall, and one PCA assigned as a "floater".
-The "floater" PCA usually did laundry.
-When the staff worked as a "floater", the staff did laundry about 6pm or 7pm and did 8-10 loads of laundry.
-While clothes were washing and drying, the floater PCA helped provide resident care.
-The floater PCA was responsible for doing one resident shower on each of the three resident halls in the facility.
-The staff was able to complete all tasks when she worked as a floater.
-The PCAs did laundry on the weekend.
-Laundry would not get done if the PCAs did not do it.
-A PCA remembered doing laundry as recent as last week.
-The Executive Director (ED) and Resident Care Manager (RCM) knew direct care staff were doing the residents' laundry because the ED and RCM saw direct care staff going back and forth with laundry.

Review of the Memory Care Shower lists revealed:
-There were 13 showers scheduled for Mondays, Wednesdays, and Fridays for 1st shift.
-There were 12 showers scheduled for Tuesdays, Thursdays, and Saturdays for 1st shift.
-There were 11 showers scheduled for Mondays, Wednesdays, and Fridays for 2nd shift.
-There were 12 showers scheduled for Tuesdays, Thursdays, and Saturdays for 2nd shift.
-There were no showers scheduled for Sundays on 1st or 2nd shifts.

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{D 206}	Continued From page 3 Interview with the RCM on 01/24/2017 at 2:35pm revealed: -She was not aware direct care staff were doing resident non-incidental laundry. -As far as she knew, staff were not supposed to do laundry between the hours of 7am and 9pm. -She had not instructed staff to do resident non-incidental laundry when the staff are scheduled to provide resident personal care services. -She had not seen staff doing resident laundry unless there had been an emergency where the resident needed clothes to wear. -She had not given any staff permission to do laundry. -The ED assigned staff to do laundry if there were "extra staff". Interview with the ED on 01/24/2017 at 2:45pm revealed: -Laundry could not be done between the hours of "7am -7pm". -Staff were instructed after the survey in September 2016 that staff could not do resident laundry while doing personal care. -A housekeeping staff did laundry when there were three housekeepers. -He was not aware staff were doing resident non-incidental laundry when assigned to perform resident personal care services. -He had not seen or been told that direct care staff were doing laundry since the survey in September 2016. -A meeting was held informing staff about the laundry protocol, but the ED had not communicated to new employees the laundry protocol. -He would have expected the staff assigned to train the new staff to have communicated the	{D 206}		

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{D 206}	Continued From page 4 information regarding resident laundry to the new staff. Review of the meeting minutes for 09/15/2016 revealed there was handwritten documentation that staff were told by the ED that the facility would be "hiring a housekeeping to do laundry from "7am - 7pm" then staff could start "7pm - 7am".	{D 206}		
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, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 4 of 4 sampled residents (#3, #4, #6, #7) with behaviors including wandering (#6, #7) and increased agitation and aggression (#3, #4) were adequately supervised according to assessed needs, resulting in injuries to residents including a hip fracture requiring surgical intervention (#6). The findings are: 1. Observations on 01/19/2017 at 2:05pm revealed: -Resident #6 was laying on the floor in front of Resident #3's room on his left side.	D 270		

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D 270	Continued From page 5 -A Personal Care Aide (PCA) was kneeled down beside Resident #6 who spoke to Resident #6 in Spanish. -The PCA was heard to say in English "his leg was twisted" when [the PCA] got to him and the PCA did not see what happened. -Resident #6 hollered when the resident's right leg was touched. Observation of Resident #6 on 01/19/2017 at 2:10pm revealed Emergency Medical Service (EMS) was present. Observation of Resident #6 on 01/19/2017 at 2:18pm revealed the resident left the facility on a stretcher with the EMS attendants. Interview with the Memory Care Manager (MCM) on 01/20/2017 at 2:40pm revealed: -Resident #6 had been admitted to the hospital. -Resident #6 had a fractured right hip. Interview with the bilingual PCA on 01/24/2017 at 2:05pm revealed: -The PCA heard a "holler". -The PCA looked down A-hall and saw Resident #6 "going toward the ground". -Resident #6's foot was in the doorway of Resident #3's room, and Resident #6's body was in the hallway. -Resident #6 screamed when his feet were moved. -The PCA asked Resident #6 in Spanish what happened. -Resident #6 said "that man just pushed me". -Resident #6 pointed to Resident #3. -Resident #3 was in his room. -"Everybody came running down". -One of the PCA's told the bilingual PCA that she had just changed Resident #6.	D 270		

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D 270	Continued From page 6 Confidential staff interview revealed: -The staff heard a noise in the hallway. -The staff saw Resident #6 on the floor. -The staff saw two PCA's running in A-hall from the direction of the area where the halls intersect. Interviews with the two PCA's assigned to work on A-hall on 01/19/2017 during the 7am - 3pm shift revealed: -Both PCA's had been employed at the facility since October 2016. -One PCA did not remember "exactly" where she was but thought she heard a "muffled noise", went to see what was going on, and did not see the incident occur. -The second PCA had gone up the hall to throw away trash when the maintenance person "motioned, and said hey hey hey come here, trying to get my attention to come". -The PCA thought Resident #3 and Resident #6 may have been arguing. -The PCA could not hear anything. -The PCA ran up the men's hall toward the employee lounge (in the direction of Resident #3's room). -When the PCA got to the TV/living room, the PCA saw Resident #6 fall backwards and "hit the floor". -The PCA did not see Resident #3 touch Resident #6. -The PCA stood there as the bilingual PCA talked to Resident #6 until Emergency Management Service (EMS arrived. -The PCA stated she had just provided incontinent care to Resident #6. -Resident #6 left the shower room on A-hall in front of the PCA. -The PCA went to the left and Resident #6 went to the right when leaving the shower room.	D 270		

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D 270	Continued From page 7 -Resident #6 was confused because the resident had been moved from room to room while maintenance repairs were being completed. Interview with a Personal Care Aide (PCA) on 01/19/2017 at 2:10pm revealed: -Resident #6 had gotten "confused". -Resident #3 pushed Resident #6 out of Resident #3's room. Interview with a second Personal Care Aide (PCA) on 01/19/2017 at 2:10pm revealed: -She did not see what happened to Resident #6. -She was told that Resident #3 had "pushed [Resident #6 named] out of his [Resident #3] room". -There had been prior confrontations with other people and Resident #3. -Resident #3 was bothered if someone went in his room. -Resident #3 could get aggressive. -The Memory Care Manager (MCM) and Executive Director (ED) knew Resident #3 was aggressive. -When Resident #3 became aggressive, staff "leave [the resident] alone, can't go in and mess with [the resident]". -Staff would tell management when a resident became aggressive. -Staff would monitor the resident when a resident became aggressive. -Monitoring the resident meant "might be 30 minute checks, redirect people" from going in the aggressor's room. Observation of Resident #3 on 01/19/2017 at 2:10pm revealed: -The resident was alone. -The resident was coming up B hall (women's hall).	D 270		

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D 270	Continued From page 8 -The resident walked toward the section of the facility where all the halls intersected. -The resident walked in a moderately fast pace. Observation of Resident #3 on 01/19/2017 at 2:20pm revealed Resident #3 was entering his room. Observation of Resident #3 on 01/19/2017 at 4:10pm revealed: -The resident was in the "Quiet Room" on C-hall. -The resident walked out of the Quiet Room and went toward the nursing station, an area of the facility where all the halls intersected. -There was no staff in attendance with Resident #3 when the resident left the Quiet Room on C-hall. Observation of Resident #3 on 01/19/2017 at 4:15pm revealed: -Resident #3 went outside in the enclosed area and smoked a cigarette. -A PCA stood in the doorway of the facility while Resident #3 and 4 other residents went outside to smoke. -Resident #3 paced back and forth while smoking a cigarette in the outside enclosed area. Review of the Increased Supervision and Accountability Checklist dated 01/19/2017 for Resident #3 revealed: -There was documentation for monitoring the whereabouts of Resident #3 every 15 minutes from 2:00pm - 7:15pm. -Staff documented Resident #3 was smoking at 2:00pm and 2:15pm. -Staff documented Resident #3 was in the end living room at 4:00pm, 4:15pm, 4:30pm, 5:00pm, and 5:15pm.	D 270		

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D 270	Continued From page 9 a. Review of the current FL-2 dated 10/05/2016 for Resident #6 revealed: -Diagnoses included Alzheimer's dementia, hypertension, and pacemaker. -The resident was intermittently disoriented. -The resident was ambulatory with a walker. -The resident was a wanderer at times. Review of Resident #6's Resident Register dated 03/07/2012 revealed: -Resident #6 was admitted to the facility on 03/07/2012. -Personal information included the resident required assistance with orientation to time and place. Review of the Resident Service Plan dated 09/05/2016 for Resident #6 revealed: -The Memory Care Manager (MCM) completed the assessment of the resident needs. -The resident was assessed to be a wanderer. -The resident was assessed to make poor decisions regarding his safety and needed to be in a secure unit. -The resident was sometimes disoriented and forgetful, needing reminders. Review of a hospital discharge summary dated 01/23/2017 for Resident #6 revealed: -Resident #6 was admitted to the hospital on 01/19/2017 from the facility. -Resident #6 was assessed and found to have sustained an acute fracture of the right femur after an unwitnessed fall. -Surgical intervention with right hip nailing was completed. -Resident #6 was discharged on 01/23/2017 to an inpatient rehabilitation facility. Confidential interviews with staff revealed:	D 270		

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-Resident #6 was considered a wanderer.
-Resident #6 was not an "everyday wanderer".
-Staff did not know that there was documentation on the FL-2 that Resident #6 had wandering behavior.
-Resident #6 would forget where his room was.
-Resident #6 would open doors.
-Resident #6 had been found in another resident's bed on another hall.
-Resident #6 had to be "guided".
-Staff recently hired at the facility had never been told Resident #6 had wandering behavior.
-A recently hired was not sure if there were steps to supervise a wanderer, but ths staff would guide them in the right direction by taking the resident by their hand and walking with the resident, and would have a conversation with the wandering resident to refocus the resident's wandering behavior.
-There was no written policy on supervision of wandering residents.
-The PCA's were supposed to supervise wandering residents.

Interview with the Maintenance Person on 01/23/2017 at 10:45am revealed:
-On 01/19/2017, he was working in Resident #3's room.
-When he had stepped out of the resident's room, Resident #6 was standing outside Resident #3's door.
-As soon as the he stepped out of Resident #3's room, Resident #6 started stepping in Resident #3's room.
-He did not see when Resident #6 stepped into Resident #3's room because he had his back to the residents.
-When he turned around, Resident #6 was in Resident #3's room.
-Resident #3 had his hands up with the palms of

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his hands facing Resident #6 and was yelling and cursing at Resident #6.
-He did not see any staff with the residents and stated before he could get the attention of staff to come to the room, Resident #3 had "shoved" Resident #6 with "everything he had, like a young guy, like he flipped a switch and went crazy".
-He estimated that a staff person was about 50 to 75 feet away from Resident #3's room.
-He saw Resident #3 start to tumble out the door to Resident #3's room.
-Resident #3's arms were stretched out with the palms of his hands still facing toward Resident #6.
-Resident #6 fell out of the room backwards.
-Resident #6 "went down hard, went down like a tree".
-He was unsure exactly what time the incident occurred but thought it was mid-morning.
-As soon as Resident #6 "went down", there were staff around the resident, including the RCM and ED.
-Resident #6 was hollering.
-When Resident #6 "went down", the resident landed on his hip.
-He thought Resident #6 landed on his right hip.

Interview with the ED on 01/20/2017 at 9:30am revealed:
-The MCM had heard from the hospital and Resident #6 had a fracture.
-He thought staff had seen what happened when Resident #6 was injured on 01/19/2017.
-He knew the maintenance man had seen what happened when Resident #6 was injured on 01/19/2017.
-He was on his way in his office and heard Resident #6 scream.
-He ran to see what was going on.
-Resident #6's leg was on the floor in the doorway

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of Resident #3's room.
-Another staff immediately called EMS while a staff who spoke Spanish remained on the floor beside Resident #6.

Interview with the ED on 01/24/2017 at 9:30am revealed:
-In talking with staff, the ED thought Resident #6 came out of the shower room on A-hall after two staff had provided personal care. The PCA's were still in the shower room cleaning up when Resident #6 walked out. Staff heard Resident #6 fall and went to see what happened. The Activity Director was in the TV room (next to Resident #3's room) doing activities when the incident occurred.
-Staff were present and supervising the residents when the incident occurred.
-The ED was not aware of any triggers that indicated Resident #3 was going to have an outburst.
-There was no written supervision policy or procedure.
-"It was not like staff had to guard each resident".
-There was no set frequency or time for staff to see each resident.
-Staff were expected to "lay eyes on each resident and make sure they're in the building".
-Staff were required to redirect residents when they were seen about to enter another resident's room.

b. Review of Resident #3's current FL-2 dated 07/13/2016 revealed:
-Diagnoses included vascular dementia, middle cerebral anomaly, head trauma, and amnesia.
-The resident was intermittently disoriented.
-The resident was verbally abusive.

Review of Resident #3's Resident Register dated

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D 270	Continued From page 13 07/01/2015 revealed Resident #3 was admitted to the facility on 07/01/2015. Review of the Resident Service Plan dated 10/05/2016 for Resident #3 revealed: -The Memory Care Manager (MCM) completed the care plan on 09/28/2016 with Resident #3. -The resident was assessed to be a wanderer. -The resident was verbally abusive. -The resident was assessed to make poor decisions regarding his safety and needed to be in a secure unit. -The resident was sometimes disoriented and forgetful, needing reminders. -The resident had a history of mental illness. -The resident was currently receiving medications for mental illness/behavior. -The resident was currently receiving mental health services. Confidential interviews with staff revealed: -Resident #3 was polite, sweet, and stayed in his room. -Resident #3 had been seen verbally agitated, and heard cursing and fussing. -Resident #3 would curse and fuss when someone "got in his space". -Resident #3 would "lash out" if he felt someone was messing with him. -Resident #3 would "act out" if someone walked in his room. -Resident #3 had been seen pushing another resident. -Resident #3 had been seen slapping another resident 5-6 months ago. -Resident #3 did not like other residents entering his room. -When Resident #3 acted out, "most of the time", the resident would curse and tell whoever entered the resident's room to leave.	D 270		

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D 270	Continued From page 14 -When Resident #3 was heard yelling, that was a sign to get to the resident and intervene. -There had been a few incidents when Resident #3 had hit another resident. -An incident had occurred around the end of November 2016 or early December 2016 when Resident #3 pushed another resident who walked into the bathroom while Resident #3 was in the bathroom, and the staff intervened by separating the residents. -Smoking outside in the gazebo calmed Resident #3 down. -A verbal altercation had occurred between Resident #3 and another resident about 6 - 8 months ago and staff had to break it up. -If a verbal altercation involving Resident #3 was not diffused, Resident #3 would get aggressive. -Probably in March 2016, a resident had blood all over his face, from an altercation with Resident #3. -Staff did not really have to provide close supervision for Resident #3, because Resident #3 only came out of his room to eat or smoke. -Some staff provided 30 minute walk-throughs on "everybody" to "lay eyes on them". -Staff had either not participated in or did not remember when there had been an inservice on behaviors. -Staff had access to online training all the time. -A training memo had been posted on 01/19/2017 about a mandatory inservice scheduled for 01/26/2017. -A recently hired staff had not really been given any instructions on how to supervise Resident #3. -Resident #3 was very quick to act when he got aggressive. Review of the Mood/Behavior Monitoring and Communication Form for Resident #3 revealed: -On 09/24/2016, Resident #3 "became angry	D 270		

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when he returned from dinner and found another resident in his room. Resident attempted to hit the other resident. Staff intervened and removed the other resident".
-On 11/28/2016, Resident #3 was "yelling, shouting, hitting others. Moved other resident".

Review of an Accident /Injury Report dated 04/06/2016 revealed:
-Resident #3 started yelling and cursing.
-Resident #3 started hitting another resident in the face and head and dragged the resident out of his room.
-Staff separated the two residents.
-First aid was provided to the other resident and that resident was transported to a local hospital emergency room by EMS.
-Resident #3 was involuntarily committed to a hospital.

Review of an Accident/Injury Report dated 04/28/2016 revealed:
-Resident #3 was trying to use the bathroom and became agitated.
-Resident #3 started hitting another resident.
-Staff immediately went to see what was going on.
-Staff separated the residents.

Review of an Accident/Injury Report dated 11/28/2016 revealed:
-Resident #3 was yelling, shouting, and hitting another resident.
-Staff directed Resident #3 to the smoking area to cool down.
-An additional note revealed Resident #3 was hit by the other resident and Resident #3 hit the other resident back.

Review of Charting Notes for Resident #3 for

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D 270	Continued From page 16 November 28, 2016 revealed the resident was verbally and physically aggression with another resident when the other resident hit Resident #3. Interview with the ED on 01/20/2017 at 9:30am revealed: -Resident #3 had been involuntarily committed (IVC'd) to a hospital on the evening of 01/19/2017 around 7:30pm. -The facility did not have plans to readmit Resident #3 back to the facility. -Resident #3 started having "anger issues" back in April 2016. -Anger issues meant cursing, going off on staff and residents. -Resident #3 was involuntarily committed to a hospital in April 2016 and medications were adjusted. -When Resident #3 returned to the facility, the resident interventions were 72 hours of monitoring the resident to observe to see if behavior had adjusted. -He did not know if anything had been developed specifically for Resident #3 beside the 72 monitoring and behavior charting. -The ED and MCM would have discussed interventions for Resident #3, but the ED could not recall if that had happened. -There was an inservice scheduled for 01/26/2017 on behaviors. -If the resident had an outburst, it was written down. -Resident #3 was receiving psychiatric services, but the ED did not know when Resident #3 was last seen. -The Psychiatrist was aware of Resident #3's outbursts. -The MCM had notified the Psychiatrist. -The ED was not aware of any other residents that had been injured due to Resident #3's	D 270		

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behavior.
-Resident #3 had pushed other residents and hit a resident before but nothing like yesterday (01/19/2017).
-It had been "months" since Resident #3 had hit a resident.

Interview with the Memory Care Manager (MCM) on 01/20/2017 at 10:20am revealed:
-Resident #3 had been at the facility since 07/2015.
-If someone walked in Resident #3's room without knocking, Resident #3 "would probably curse you out".
-The cursing would only last for a few minutes.
-If the other resident started to curse back at Resident #3, he [Resident #3] would get more aggravated and continue to curse.
-Staff would "hurry and get to him, take him outside, redirect, let him smoke, talk to him".
-Most of the time staff could get to Resident #3 and redirect the resident by taking him outside to smoke, which settled the resident down.
-Resident #3 did not mess with or bother people otherwise.
-The last altercation she was aware of was on 11/28/2016 when another resident walked in on Resident #3 while the resident was using the shared bathroom between the two resident rooms. The MCM heard the two residents in the hallway cursing, got up and came out. The MCM did not remember which staff were present. The MCM stepped between the two residents. Resident #3 was hit on the arm by the other resident. Resident #3 hit the other resident back. The MCM yelled out for staff to take the other resident away from the scene. The MCM went outside with Resident #3 to smoke.
-The only other time the MCM could recall a behavior issue with Resident #3 was when the

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resident was involuntarily committed at the beginning of the year.
-All staff were aware of what to do when Resident #3 got agitated.
She was not sure if there had been an in-service training for staff about interventions to use when Resident #3 became agitated, but staff knew what to do.
-When a resident was placed on 1:1 supervision, staff did not have to walk beside the resident, but staff needed to be where they could see the resident. Staff were to be 4 or 5 steps behind the resident when the resident was placed on 1:1 supervision.
-Resident #3 was placed on 1:1 supervision on 01/19/2017 around 2:00pm, and remained on 1:1 supervision until around 7:15pm on 01/19/2017 when Resident #3 left the facility with a police officer.
-New hire staff had seen a video as part of their orientation on managing behavior.

Interview with the ED on 01/20/2017 at 10:55am revealed:
-To diffuse aggressive behavior, in general staff were supposed to remove the resident from the environment.
-He "guess new staff would know what works for [Resident #3] if other staff tell them".
-The Medication Aides should tell them.
-The ED nor the MCM had discussed with new staff what interventions worked when Resident #3 became agitated or aggressive.

Interview with the Mental Health Provider Representative for Resident #3 at 12:00pm on 01/23/2017 revealed:
-Psychiatric services were started 02/02/2016 because Resident #3 became agitated when other residents bothered him.

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-The resident was provided psychotherapy sessions from 02/05/2016 - 09/16/2016, but was stopped at the request of the resident.
-Psychiatric services were provided every 4 - 5 weeks for medication management.
-The current mental health provider had visited the facility in 12/2016 and Resident #3 did not want to be seen.
-The current mental health provider last saw Resident #6 face to face on 10/06/2016 for medication management.

Review of a physician visit summary from a previous Primary Care Provider (PCP) dated 04/13/2016 for Resident #3 revealed:
-The physician documented "depression/anxiety/violent anger outbursts".
-The resident "remains a risks for other residents, so staff attempting to monitor him and other residents near him closely and avoid further situations where another resident wanders into his room".

Interview with the MCM at 12:45pm on 01/23/2017 revealed she was not aware the PCP had noted in Resident #3's record that the resident remained a risk for other residents.

Interview with the Primary Care Provider (PCP) on 01/23/2017 at 4:25pm revealed:
-She had seen Resident #3 two times at the facility.
-Resident #3 was described as "very, very anxious, extremely anxious, very agitated".
-She had not observed Resident #3 to be violent or hurt anyone, but extremely anxious by nature.
-She could not recall if she had heard of Resident #3 harming or striking a resident.
-Resident #3 refused the visit.
-Resident #3 would not allow the PCP to examine

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him.
-She would base her decision on the appropriateness of placement for Resident #3 on what the MCM and staff thought.

Telephone interview with a Power Of Attorney (POA) for Resident #3 on 01/24/2017 at 12:45pm revealed:
-Resident #3 was no longer at the facility.
-Resident #3 was a "gentle, low-key person".
-It was not the nature of Resident #3 to be aggressive.
-He was aware of the incident that occurred on 01/19/2017 when Resident #3 pushed another resident causing injury to the resident.
-He understood Resident #3 would not be returning to the facility because the facility had to be concerned about the safety of all residents.
-He suspected the 01/19/2017 incident was caused because Resident #3 was "startled".
-If Resident #3 was startled or provoked, the resident was strong enough to hurt someone.
-If Resident #3 hurt someone, the POA thought it would be unintentional.
-He did not consider Resident #3 to be a safety risk.

2. Review of Resident #4's current FL-2 dated 08/31/2016 revealed:
-Diagnoses included dementia, Alzheimer's and psychosis.
-The resident was constantly disoriented
-The resident was a wanderer.

Review of Resident #4's Resident Register revealed an admission date of 06/24/14.

Review of Resident #4's Resident Service Plan dated 06/16/2016 revealed:
-The Memory Care Manager (MCM) completed

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the care plan on 06/22/2016 with Resident #4.
-The resident was assessed to be a wanderer.
-The resident was assessed to make poor decisions regarding her safety and needed to be in a secure unit.
-The resident was sometimes disoriented and forgetful, needing reminders.
-The resident was currently receiving medications for mental illness/behavior.
-The resident was currently receiving mental health services.

Review of Resident #4's Resident Profile and Care Plan Update Form dated 01/19/17 revealed:
-Resident #4 could be verbally abusive at times.
-Resident #4 required redirection by talking with her to calm her down.

Confidential interviews with 3 staff members revealed:
-Resident #4 was not a wanderer.
-Resident #4 was social and walked up and down the halls a lot; she visited with her friends mostly.
-Resident #4 got agitated easily and cursed a lot.
-Resident #4, at times, became agitated with other residents, but she was "all talk".
-The staff member did not think Resident #4 had ever touched any of the residents but had verbally threatened what she would/could do to them.
-Resident #4 did not like other residents to wander into her room.

Review of a computerized charting note dated 01/16/17 at 2:51 p.m. revealed:
-There was documentation entered by a Medication Aide (MA) and the Memory Care Manager (MCM) under one entry, the MA was listed as the charting note user.
-There was a 12:00 p.m. and a 7:25 p.m. entry in the body of the 2:51 p.m. charting note with the

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MCM's signature at the end of both timed entries.
-The resident was in her room.
-Another resident entered Resident #4's room by mistake.
- Resident #4 threw water in the other resident's face.
-The other resident was redirected so nothing else would happen.
-Resident # 4 was placed on 15 minute checks.
-The primary provider was called and would see Resident #4 the week of 01/16/17.
-The power of attorney was called.
-The MCM called mental health services.
-There were no bruising or marks on Resident #4.
-At 12:00 p.m. the MCM documented family had visited Resident #4, "....resident was doing good", "....staff keeping an eye on her".
-At 7:25 p.m. the MCM documented she had checked on Resident #4, the resident had no further outbursts since that morning, and staff were still watching Resident #4.

Review of Resident #4's computerized charting note dated 01/17/17 at 2:47 p.m. by the MCM revealed:
-The MCM had checked on the resident today.
-The resident remained on 15 minute checks with no issues.
-There was no bruise or marks on her from 01/16/17.

Review of a Behavior Incident report for Resident #4 dated 01/16/17 revealed:
-Resident #4 threw water in another resident's face.
-The resident was placed on 15 minute checks.
-The other resident was placed on 15 minute checks to prevent her from returning to Resident #4's room.
-The person of contact was notified on 01/16/17

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at 8:45 a.m.
-The primary care physician was notified on 01/16/17 at 8:48 a.m

Interview with Resident #4 on 01/23/17 at 12:40 p.m. revealed:
-Some of the residents at the facility "plunder" through her personal belongings.
-She told residents that go into her room "To get the [expletive] out".
-She did not like for people to wander in and out of her room.

Telephone interview with Resident #4's primary care physician on 01/23/17 at 4:20 p.m. revealed:
-The physician was not contacted and made aware of Resident #4 throwing water into another resident's face and Resident #4 being pushed in the chest.
-The physician would have expected be notified of any type of injury or behavioral change with a resident.

Telephone interview with the mental health provider's Certified Medical Assistant on 01/24/17 at 1:56 p.m. revealed:
-Resident #4 was discharged from services in August of 2016.
-There was no other documentation found on Resident #4 after August of 2016.

Telephone interview with Resident #4's Health Care Power of Attorney (HCPOA) on 01/24/17 at 8:35 a.m. revealed:
-The resident seemed happy at the facility.
-The facility informed the HCPOA when changes or issues occurred with the resident.
-The HCPOA did not know of any recent issues, behaviors or incidences involving the resident.
-Resident #4 could get vocal and agitated at

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D 270	Continued From page 24 times with other residents. Refer to the confidential interview with a staff member. Refer to the interview with the ED on 01/20/2017 at 10:55 a.m. Refer to the interview with the ED on 01/24/2017 at 9:30 a.m. Refer to the interview with the Medication Aide (MA) on 01/24/17 at 1:40 p.m. Refer to the Interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. Refer to the Interview with the Memory Care Manager (MCM) on 01/24/17 at 5:45 p.m. Refer to the interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. 3. Review of Resident #7's current FL2 dated 07/13/16 revealed: -Diagnoses included Alzheimer's dementia disease and paranoid state simple. -The resident was constantly disoriented -The resident was a wanderer. Review of Resident #7's Resident Service Plan dated 11/18/2015 for revealed: -The Memory Care Manager (MCM) completed the care plan on 12/8/2015 with Resident #7. -The resident was assessed to be a wanderer. -The resident was assessed to make poor decisions regarding her safety and needed to be in a secure unit. -The resident was sometimes disoriented and forgetful, needing reminders.	D 270		

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D 270	Continued From page 25 -The resident was currently receiving medications for mental illness/behavior. -The resident was not receiving mental health services. Review of Resident #7's Resident Profile and Care Plan Update Form dated 01/17/17 revealed: -Resident #7 had no assessed behavior patterns. -Staff redirect the resident when necessary. Confidential interviews with 2 staff members revealed: -Resident #7 was passive and pleasant. -Resident #7 liked to walk down the halls in the facility. -Resident #7 was a known wanderer. -Resident #7 meant no harm to anyone but sometimes would wander into other residents' rooms. Review of Resident #7's computerized charting note dated 01/17/17 at 2:58 p.m. by the Medication Aide (MA) revealed: -Resident #7 walked into the wrong room and another resident threw water in her face. -Resident #7 hit the other resident in the chest. -Staff redirected the Resident #7 back to her room and she was placed on 15 minute checks. -The power of attorney was called. -The primary care physician was called. -There was no bruised areas or marks on Resident #7. Review of Resident #7's computerized charting note dated 01/17/17 at 1:38 p.m. by the Memory Care Manager (MCM) revealed: -The MCM had checked on the resident and there had been no issues. -Staff were keeping an eye on her and Resident #7 remained on 15 minute checks.	D 270		

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(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 26 Telephone interview with Resident #7's primary care physician on 01/23/17 at 4:20 p.m. revealed: -The physician was not contacted and made aware of Resident #7 having water thrown in her face by another resident and Resident #7 pushing a resident in the chest. -The physician would have expected be notified of any type of injury or behavioral change with a resident. Attempted telephone interview on 01/24/17 at 9:14 a.m. with Resident #7's Health Care Power of Attorney was unsuccessful. Refer to the confidential interview with a staff member. Refer to the interview with the ED on 01/20/2017 at 10:55 a.m. Refer to the interview with the ED on 01/24/2017 at 9:30 a.m. Refer to the interview with the Medication Aide (MA) on 01/24/17 at 1:40 p.m. Refer to the Interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. Refer to the Interview with the Memory Care Manager (MCM) on 01/24/17 at 5:45 p.m. Refer to the interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. _____ Confidential interview with a staff member revealed: -Resident #7 had wandered into Resident #4's	D 270		

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	HAL051041	A. BUILDING: _____ B. WING _____	R-C 01/24/2017

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D 270	Continued From page 27	D 270		

room.
-Staff heard screaming and went to Resident #4's room.
-Resident #4 had thrown water in Resident #7's face.
-Staff did not actually see what happened, but Resident #7's face was wet.
-Resident #4 admitted that she threw the water in the Resident #7's face.

Interview with the Executive Director (ED) on 01/20/2017 at 10:55 a.m. revealed:
-To diffuse aggressive behavior, in general, staff were supposed to remove the resident from the environment.
-The ED was not sure how new staff members would know behaviors of the residents at the facility, but guessed the other staff, like the Medication Aides" should tell them, "it comes down to communication".
-The Medication Aides were responsible for contacting the primary care provider when behavior issues occurred.

Interview with the ED on 01/24/2017 at 9:30 a.m. revealed:
-There was no written supervision policy or procedure.
-It was not like staff had to guard each resident.
-There was no set frequency or time for staff to see each resident.
-Staff were expected to "lay eyes on each resident and make sure they're in the building".
-When residents were observed entering another residents room, staff were required to redirect that resident.
-Staff interventions were put in place if something abnormal happened between the residents such as redirection and the resident would be placed on 72 hour monitoring with every 15 minute

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D 270	Continued From page 28 checks. Interview with a Medication Aide (MA) on 01/24/17 at 1:40 p.m. revealed: -The MA was working the day Resident #4 threw water in Resident #7's face. -Resident #7 was known to often walk up and down the hallways, opening doors. -No one actually saw the incident occur on 01/16/17 between Resident #4 and Resident #7. -It happened in Resident #4's room; we only heard "screaming". -Staff went down, immediately to Resident #4's room and found both Resident #4 and Resident #7 standing at the doorway. Resident #7 was wiping water from her face. -Resident #4 was angry because Resident #7 wandered into her room. -Both residents were redirected and placed on 15 minute checks. -The MA did not call the primary care provider to report the incident. -Typically the physician was called when residents had outbursts so possible medication adjustments and treatment options could be done. -She was not sure why she documented the physician was called on the behavior report dated 01/16/17 at 8:48 a.m."It must have been an oversight". Interview with the Memory Care Manager (MCM) on 01/24/17 at 5:45 p.m. revealed: -She thought the physician had been notified about the incident on 01/16/17 between Resident #4 and Resident #7. -Resident #4 was seen by the primary care provider the same week of the incident, after 01/16/17.	D 270		

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D 270	Continued From page 29 Interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. revealed: -He was not aware that Resident #4 and Resident #7's primary care provider was not contacted regarding the incident that occurred on 01/16/17. -The ED would have expected staff to notify the primary care provider of the incident that occurred on 01/16/17 with Resident #4 and Resident #7. _____ The facility's failure to assure residents with aggressive behaviors and anger outbursts resulted in a resident being pushed down by a resident who had been identified by the facility as aggressive. The resident who was pushed down sustained a hip fracture that required surgical intervention. The failure of the facility to provide supervision according to assessed needs and symptoms resulted in an injury of substantial risk. This noncompliance constitutute a Type A1 Violation. _____ Review of the Plan of Protection submitted by the facility on 01/20/2017 revealed: -The Executive Director will immediately review with staff on 2nd shift, 3rd shift and 1st shift residents that are known to show aggressive behaviors to residents that enter their personal space and residents go into other resident rooms. -Staff will attempt to de-escalate or re-direct the resident -A Mood and Behavior form will be initiated for residents exhibiting aggressive behaviors. -Staff will be directed to remain in their assigned areas. -Inservices will be documented with a sign-in sheet. -The facility will implement a change of shift "Stand Up Meeting." During this meeting the medication aides and personal care aides will	D 270		

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D 270	Continued From page 30 discuss any significant changes in behaviors or interventions needed for any resident identified on the behavior log. -Charts and Behavior Mood forms will have a turquoise dot to identify residents known to show aggression. -Immediate inservice on the dot system. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 23, 2017.	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: Based on record reviews and interviews the facility failed to notify a primary care provider regarding a behavioral incident for 2 of 4 sampled residents (Resident #4, Resident #7). The findings are: 1. Review of Resident #4's current FL-2 dated 08/31/2016 revealed: -Diagnoses included dementia, Alzheimer's, psychosis, convulsions, and osteoporosis. -The resident was constantly disoriented -The resident was a wanderer. Review of Resident #4's Resident Register revealed an admission date of 06/24/14.	{D 273}		

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{D 273}	Continued From page 31	{D 273}		

Review of Resident #4's Resident Service Plan dated 06/16/2016 revealed:
-The resident was assessed to be a wanderer.
-The resident was assessed to make poor decisions regarding her safety and needed to be in a secure unit.
-The resident was sometimes disoriented, and forgetful needing reminders.
-The resident was currently receiving medications for mental illness/behavior.
-The resident was currently receiving mental health services.

Review of Resident #4's Resident Profile and Care Plan Update Form dated 01/19/17 revealed:
- Resident #4 could be verbally abusive at times.
-Resident #4 required redirection by talking with her to calm her down.

Confidential interviews with 3 staff members revealed:
-Resident #4 was not a wanderer.
-Resident #4 was social and walked up and down the halls a lot. She visited with her friends mostly.
-Resident #4 got agitated easily and cursed a lot.
-Resident #4, at times, became agitated with other residents, but she was "all talk".
-The staff member did not think Resident #4 had ever touched any of the residents but had verbally threatened what she would/could do to them.
-Resident #4 did not like other residents to wander into her room.

Review of a Behavior Incident report for Resident #4 dated 01/16/17 revealed:
-Resident #4 threw water in another resident's face.
-The water was taken away, and the resident was placed on 15 minute checks.
-The other resident was placed on 15 minute

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{D 273}	Continued From page 32	{D 273}		

checks to prevent her from returning to Resident #4's room.
-The person of contact was notified on 01/16/17 at 8:45 a.m.
-The primary care physician was notified on 01/16/17 at 8:48 a.m

Interview with Resident #4 on 01/23/17 at 12:40 p.m. revealed:
-Some of the residents at the facility "plunder" through her personal belongings.
-She told residents that go into her room "To get the [expletive] out".
-She did not like for people to wander in and out of her room.

Telephone interview with Resident #4's primary care physician on 01/23/17 at 4:20 p.m. revealed:
-The physician was not contacted and made aware of Resident #4 throwing water into another resident's face and Resident #4 being pushed in the chest.
-The physician would have expected be notified of any type of injury or behavioral change with a resident.

Telephone interview with the mental health provider's Certified Medical Assistant on 01/24/17 at 1:56 p.m. revealed:
-Resident #4 was discharged from services in August of 2016.
-There was no other documentation found on Resident #4 after August of 2016.

Telephone interview with Resident #4's Health Care Power of Attorney on 01/24/17 at 8:35 a.m. revealed:
-The resident seemed happy at the facility.
-The facility informed the HCPOA when changes or issues occurred with the resident.

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{D 273}	Continued From page 33 -The HCPOA did not know of any recent issues, behaviors or incidences involving the resident. -Resident #4 could get vocal and agitated at times with other residents. Refer to the confidential interview with a staff member. Refer to the interview with the ED on 01/20/2017 at 10:55 a.m. Refer to the interview with the Medication Aide (MA) on 01/24/17 at 1:40 p.m. Refer to the Interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. Refer to the Interview with the Memory Care Manager (MCM) on 01/24/17 at 5:45 p.m. Refer to the interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. 2. Review of Resident #7's current FL2 dated 07/13/16 revealed: -Diagnoses included Alzheimer's dementia disease. -The resident was constantly disoriented. -The resident was a wanderer. Review of Resident #7's Resident Service Plan dated 11/18/2015 for revealed: -The resident was assessed to be a wanderer. -The resident was assessed to make poor decisions regarding her safety and needed to be in a secure unit. -The resident was sometimes disoriented and forgetful, needing reminders. -The resident was currently receiving medications for mental illness/behavior.	{D 273}		

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{D 273}	Continued From page 34 -The resident was not receiving mental health services. Review of Resident #7's Resident Profile and Care Plan Update Form dated 01/17/17 revealed: -Resident #7 had no assessed behavior patterns. -Staff redirect the resident when necessary. Confidential interviews with staff members revealed: -Resident #7 was passive and pleasant. -Resident #7 liked to walk down the halls in the facility. -Resident #7 was a known wanderer. -Resident #7 meant no harm to anyone but sometime would wander into other residents' rooms. -Resident #7 thought she was the "mother of the house". Telephone interview with Resident #7's primary care physician on 01/23/17 at 4:20 p.m. revealed: -The physician was not contacted and made aware of Resident #7 having water thrown in her face by another resident, and Resident #7 pushing a resident in the chest. -The physician would have expected be notified of any type of injury or behavioral change with a resident. Refer to the confidential interview with a staff member. Refer to the interview with the ED on 01/20/2017 at 10:55 a.m. Refer to the interview with the Medication Aide (MA) on 01/24/17 at 1:40 p.m. Refer to the Interview with the Executive Director	{D 273}		

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{D 273}	Continued From page 35 (ED) on 01/24/17 at 5:54 p.m. Refer to the Interview with the Memory Care Manager (MCM) on 01/24/17 at 5:45 p.m. Refer to the interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. _____ Confidential interview with a staff member revealed: -Resident #7 had wandered into Resident #4's room. -Staff heard screaming and went to Resident #4's room. -Resident #4 had thrown water in Resident #7's face. -Staff did not actually see what happened, but Resident #7's face was wet. -Resident #4 admitted that she threw the water in the Resident #7's face. Interview with the Executive Director (ED) on 01/20/2017 at 10:55 a.m. revealed the Medication Aides were responsible for contacting the primary care provider when behavior issues occurred. Interview with the Medication Aide (MA) on 01/24/17 at 1:40 p.m. revealed: -The MA was working the day Resident #4 threw water in Resident #7's face. -Both residents were redirected and placed on 15 minute checks. -The MA did not call the primary care provider to report the incident. -Typically the physician was called when residents had outbursts so possible medication adjustments and treatment options could be done. -She was not sure why she documented the	{D 273}		

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{D 273}	Continued From page 36 physician was called on the behavior report dated 01/16/17 at 8:48 a.m., "It must have been an oversight". Interview with the Memory Care Manager (MCM) on 01/24/17 at 5:45 p.m. revealed: -She thought the physician had been notified about the incident on 01/16/17 between Resident #4 and Resident #7. -Resident #4 was seen by the primary care provider the same week of the incident, after 01/16/17. Interview with the Executive Director (ED) on 01/24/17 at 5:54 p.m. revealed: -He was not aware that Resident #4 and Resident #7's primary care provider was not contacted regarding the incident that occurred on 01/16/17. -The ED would have expected staff to notify the primary care provider of the incident that occurred on 01/16/17 with Resident #4 and Resident #7.	{D 273}		
{D 465}	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, record reviews, and	{D 465}		

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{D 465}	Continued From page 37 interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 24 of 42 shifts from 12/25/16-01/07/17. The findings are: Review of the Master Schedule by Shift for December 2016 and January 2017 revealed: -First shift hours were documented as 7:00am-3:00pm. -Second shift hours were documented as 3:00pm-11:00pm. -Third shift hours were documented as 11:00pm-7:00am. Review of the "Census Daily Detail" Report dated 12/25/16 revealed: -The census for the SCU was 49 residents. -49 hours of staff time was required for first and second shifts. -39.2 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 12/25/16 revealed: -There was 31.25 staff hours provided on first shift. -There was 33.25 staff hours provided on second shift. -There was 37.97 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 12/26/16 revealed: -The census for the SCU was 50 residents. -50 hours of staff time was required for first and second shifts. -40 hours of staff time was required for third shift.	{D 465}		

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{D 465}	Continued From page 38 Review of the "Punch Detail" Report dated 12/26/16 revealed: -There was 49.49 staff hours provided on first shift. -There was 33.35 staff hours provided on second shift. -There was 31.25 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 12/27/16 revealed: -The census for the SCU was 50 residents. -50 hours of staff time was required for first and second shifts. -40 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 12/27/16 revealed: -There was 40.75 staff hours provided on second shift. -There was 24.51 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 12/28/16 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 12/28/16 revealed: -There was 50.43 staff hours provided on second shift. -There was 31.37 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 12/29/16 revealed:	{D 465}		

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{D 465}	Continued From page 39 -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 12/29/16 revealed: -There was 49.14 staff hours provided on second shift. -There was 33.83 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 12/30/16 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 12/30/16 revealed there was 36 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 12/31/16 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 12/31/16 revealed: -There was 32.34 staff hours provided for second shift. -There was 18.62 staff hours provided for third shift.	{D 465}		

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(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 465}	Continued From page 40 Review of the "Census Daily Detail" Report dated 01/01/17 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 01/01/17 revealed: -There was 46.97 staff hours provided on second shift. -There was 15.72 hours provided on third shift. Review of the "Census Daily Detail" Report dated 01/02/17 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 01/02/17 revealed: -There was 45.25 staff hours provided on second shift. -There was 24.67 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 01/03/17 revealed: -The census for the SCU was 49 residents. -49 hours of staff time was required for first and second shifts. -39.2 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 01/03/17 revealed there was 35.13 staff hours provided on third shift.	{D 465}		

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	HAL051041	A. BUILDING: _____ B. WING _____	R-C 01/24/2017

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{D 465}	Continued From page 41 Review of the "Census Daily Detail" Report dated 01/05/17 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 01/05/17 revealed there was 35.67 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 01/07/17 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 01/07/17 revealed: -There was 40.17 staff hours provided on first shift. -There was 25.58 staff hours provided on second shift. -There was 20.15 staff hours provided on third shift. Review of the "Census Daily Detail" Report dated 01/04/17 and 01/06/17 revealed: -The census for the SCU was 51 residents. -51 hours of staff was required for first and second shifts. -40.8 hours of staff time was required third shift. Review of the PDR dated 01/04/17 and 01/06/17 revealed the staffing requirement was met on all three shifts.	{D 465}		

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{D 465}	Continued From page 42 Confidential staff interview revealed: -Staff were told by the Memory Care Manager (MCM) that corporate made the schedule. -Some staff members were allowed to only work on first shift which limited coverage on all other shifts. -When staff called out, the MCM would call other staff to come into work. A second confidential staff interview revealed: -The only shift that was covered with enough staff was first shift. -Second shift usually had 4 to 5 staff members working. -First shift staff would stay occasionally until 7:00 p.m. to help second shift out. -When the shifts were short due to staff calling out, the MCM and the Executive Director (ED) would call additional staff or get staff to stay. "Sometimes we get people to stay or come in and sometime we don't". -When a shift was short in staffing, we did the best we could. A third confidential staff interview revealed: -The facility's shifts were short at times related to staff calling out, and at other times because the shifts were scheduled with short staffing. -There was a staffing shortage on third shift. A fourth confidential staff interview revealed: -Sometimes there were only four Personal Care Aides (PCA) working on 2nd shift. -When there were only 4 PCAs working, there was one PCA assigned to each hall, and the fourth PCA was a "floater". -The "floater" PCA provided care on all three halls and did laundry.	{D 465}		

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{D 465}	Continued From page 43 Interview with the MCM on 01/19/17 at 11:13 a.m. revealed: -The MCM and corporate staff were responsible for scheduling staff on each shift. -The staffing ratio on first and second shift was one staff person to 8 residents and one staff person to 10 residents on third shift. -The MCM would schedule 7 to 8 staff members (PCAs/Certified Nursing Assistants (CNA)/Medication Aides) on first and second shift and 5 to 6 staff members on third shift, but that all depended on the number of residents in the facility. -There were times when 7 to 10 staff members were scheduled on day shifts to allow staff to go with residents for medical appointments outside of the facility. -The MCM and the Executive Director (ED) were responsible to assure adequate staff were maintained in the facility at all times. -Staff would be required to stay over their scheduled work time if needed, until the "floor was covered". -There had been times for the last 3 months the facility was short staffed due to staff call outs and staff members not showing up for work as scheduled. "We work with what we have". -The MCM would fill in and take assignments when needed. -The facility had hired new staff and continued to hire new employees. -The MCM was on vacation starting 12/25/16 through the beginning of 2017. Interview with the ED on 01/23/17 at 2:45 p.m. revealed: -On days when the MCM was off, the Supervisor or the Medication Aides (MA) would be responsible for calling other staff to work when there were staff call outs (PCA/MA/CNAs).	{D 465}		

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{D 465}	Continued From page 44 -It was an expectation for the MAs and or the Supervisor to call the ED when staffing needs occurred from 12/25/16-01/03/17. -The ED would also attempt to replace staff when someone called out of work for a scheduled shift. -The ED recalled needing help on several occasions from 12/25/16 through 01/07/17, but could not recall specific dates.	{D 465}		
{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 all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 4 of 4 sampled residents (#3, #4, #6, #7) with behaviors including wandering (#6, #7) and increased agitation and aggression (#3, #4) were adequately supervised according to assessed needs, resulting in injuries to residents including a hip fracture requiring surgical intervention (#6).	{D912}		

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{D912}	Continued From page 45 [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision(Type A1 Violation)].	{D912}		