STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Human Services conducted an annual and follow-up survey on February 22, 23, 24,28, 2017 and March 01, 2017.	D 000		
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 interviews and observations, the facility failed to safely store oxygen tanks for 1 of 2 facility residents in a manner to prevent obstructions and hazards by storing 21 "E" tanks of oxygen and one large "M" tank in the resident's room (#8). The lack of floor space did not allow the resident to easily move about the room using his wheelchair. The findings are: Observation on 3/1/17 at 10:30am in Resident #8's room revealed: -The resident was sitting in a wheelchair, watching television and reading mail. -The resident was fully dressed in street clothes, and was wearing a nasal cannula attached to a working oxygen concentrator.	D 079		

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D 079	Continued From page 1 -The nasal cannula tubing was laying down the resident's chest, was looped around the wheelchair's left armrest, and approximately three feet of tubing was lying on the floor behind the resident. The other end of the tubing was attached to the oxygen concentrator positioned beside his bed. The resident's wheelchair was positioned over the tubing lying on the floor. -The resident asked for assistance in gathering up the tubing. -The resident's room was used to store a large "M" oxygen tank in a heavy black metal stand. The tank was estimated to be 52 inches in height and 9 inches in diameter. -Twenty "E" tanks of oxygen were stored in the resident's room. The tanks were stored in plastic crates that supported the bottom 2 inches of the tanks. -Seven "E" size oxygen tanks with intact seals (indicating the tanks were full), were positioned on the floor in a plastic rack that supported only the bottoms of the tanks. -Thirteen "E" size oxygen tanks with no seal (indicating the tanks had been used) were positioned on the floor in a plastic rack that supported only the bottoms of the tanks. -One "E" tank was in a nylon bag tied down to the back of his wheelchair. -"E" tanks were 25 inches high and approximately 4 inches in diameter. -There were no chains or supports, such as a ring to stabilize each tank at the midpoint of height, or a tall crate that surrounded the tanks to prevent them from falling over. Interview with Resident #8 on 3/1/17 at 10:45am revealed: -He was glad to have a visitor to check on him. -A family member helped him move here, and was his Power of Attorney.	D 079		

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D 079	Continued From page 2	D 079		

-He had been in a nursing home and received hospice care before coming to this facility.
-He was concerned about the lack of space to move about in his room.
-Other health care facilities always used full-length stands for oxygen tanks.
-Other facilities had a metal stand on the back of the wheelchairs to support the tanks.
-He was afraid the tank in the nylon bag was unstable, and wanted a metal stand on his wheelchair to support and protect the tank.
-He used about 2 of the "E" tanks daily to go to the dining hall, "They last about an hour".
-He was concerned that he could have caused an explosion this morning, when he knocked over an empty "E" tank, trying to turn around in his wheelchair.
-His room was not big enough to store all his oxygen; it was "just too crowded".
-Hospice and nursing home personnel told him that oxygen needed to be stored in a cool place and not dropped; "it could cause an explosion".
-He thought the oxygen canisters needed support midway up their length; other nursing homes secured them with a chair or used a tall stand with several rings for support.
-Resident #8 knew the big oxygen tank needed to stay in his room. "It's too heavy and bulky to move. It's my emergency oxygen if the power goes out. That will store four or five days of oxygen for me."

Interview on 3/1/17 at 2:30pm with two Personal Care Aides (PCAs) revealed:
-Only Medication Aides (MAs) worked with the oxygen tanks.
-PCAs may assist MAs with changing out tanks, at the request of and supervision by the MA.

Interview on 3/1/17 at 2:45pm with a MA

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D 079	Continued From page 3	D 079		

revealed:
-The MAs had received training from several sources on administration of oxygen.
-The oxygen supply company trained the MAs on the equipment supplied by their company.
-She did not question that the storage racks provided that support only the bottom of the oxygen tank.
-"We use the equipment we got from them, they know more than me [about storage and handling]."
-MAs were checked off on oxygen administration by their Licensed Health Professional Support (LHPS) consultant.
-The Health and Wellness Coordinator and the Resident Care Coordinator also conducted training and spot-checked their job performance.
-The tanks were stored in Resident #8's room as there was not enough space in the room where the oxygen used by another resident was stored.
-The oxygen company delivered the tanks to Resident #8's room.

Interview with the facility Nurse Consultant revealed:
-She had never heard of a rule in Adult Care that addressed storage of oxygen tanks.
-There were metal racks for storage and transport of oxygen tanks available in the facility if needed.

The Executive Director was not available for interview on 3/1/17 due to illness.

Attempts to interview a representative from the oxygen supply company during the afternoon of 3/1/17 from 1:30pm to 4:00pm were not successful. Neither the sales representative nor the delivery personnel of the oxygen supply company returned telephone calls to the surveyor

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D 079	Continued From page 4 by the close of the survey.	D 079		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure Tuberculosis (TB) disease testing had been completed upon admission for 1 of 7 (#5) sampled residents in accordance with the Commission for Public Health. The findings are: Review of Resident #5's current FL-2 dated 7/11/16 revealed diagnoses included seizure disorder, down syndrome and dementia. Review of Resident #5's Resident Register revealed the date of admission was 6/03/16. Review of Resident #5's TB skin test documented a TB skin test given on 11/18/15 and read as negative on 11/20/15. Attempted interview with Resident #5 on 2/23/17	D 234		

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D 234	Continued From page 5 at 3:30 p.m. revealed the resident was confused and did not understand what was being asked of him during the interview. Interview with the Resident Care Coordinator (RCC) on 3/01/17 at 3:28 p.m. revealed: -She could not find another TB skin test in Resident #5's record. -The first and second step TB skin test for Resident #5 would be completed within 2 weeks. -The facility's monitoring plan that was in place for residents' TB was that the first step TB skin test would be completed prior to admission, and the second step TB skin test would be completed within 2 weeks of admission. -The Memory Care Manager was responsible for making sure residents had a TB skin test. -The Memory Care Manager would audit the TB skin test for residents quarterly, and information would be kept on a tracking log. The Memory Care Manager was off duty during the survey. Interview with the Co-Administrator on 3/01/17 at 3:40 p.m. revealed she referred questions related to residents' TB skin test to the Resident Care Coordinator (RCC).	D 234		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social	D 321		

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D 321	Continued From page 6	D 321		

services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to provide transportation after an Emergency Department (ED) visit for 1 of 1 sampled resident (#7) who had a fall on 2/18/17 and was transported to the ED via Emergency Medical Services (EMS).

The findings are:

Review of Resident #7's current FL-2 dated 12/19/16 revealed diagnoses included vascular dementia, atrial fibrillation and essential primary hypertension.

Review of Resident #7's Resident Register revealed an admission date of 1/19/16.

Review of the Care Notes dated 2/18/17 revealed:
-Resident #7 had a fall on 2/18/17 at 10:00 a.m. which resulted in a "knot on mid right side of head."
-Resident #7 was transported from the facility to the ED via EMS on 2/18/17 at 10:00 a.m.
-Resident #7 was transported from the ED to the facility via mobile transport on 2/18/17 at 9:10 p.m.

Review of the facility's Assisted Living Resident Agreement dated 08/01/13 for scheduling

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D 321	Continued From page 7 transportation services revealed: -"In the case of emergency, the Community will make the necessary arrangements for transport of the Resident to an appropriate medical facility. The cost of any emergency transportation will be the Resident's expense." Attempted interview with Resident #7 on 2/23/17 at 11:00 a.m. revealed the resident was confused and did not understand what was being asked of her during the interview. Telephone interview with the Medical Center Social Worker (MCSW) on 02/24/2017 at 8:51 a.m. revealed: -A staff nurse notified her that a resident had been cleared for discharge from the ED. -The staff nurse stated the facility did not provide transportation on the weekend. -She called the facility and talked to a staff on 2/18/17 at 4:20 p.m., and stated the facility should be responsible for transportation on the weekend. -The Social Worker was contacted by the Memory Care Manager (MCM) on 2/18/17 at 4:40 p.m. -The MCM stated the facility did not provide transportation on the weekend, and Resident #7 would have to stay in the hospital until 02/20/17. -The Social Worker told the MCM on 2/18/17 at 4:40 p.m. that the resident could not stay in the hospital until 02/20/17. -The Social Worker requested that the Executive Director (ED) call her. -The Social Worker was contacted by the ED on 2/18/17 (no time), and he stated the facility did not provide transportation on the weekend. -"I told the ED I would have to report the facility to the state and he said, "Please do" -The resident had to stay in the ED for 4-5 hours after being cleared for discharge.	D 321		

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D 321	Continued From page 8 -She notified the mobile transport service on 2/18/17 at 8:45 p.m. that Resident #7 needed to be transported to the facility. The hospital's staff nurse was unavailable for interview. The Memory Care Manager was off duty during the survey. Interview with the transportation coordinator on 2/24/17 at 2:30 p.m. revealed: -The staff was responsible for providing or arranging transportation for residents after 3:00 p.m. and before 7:00 a.m and on the weekends. -She worked Monday-Friday from 7:00 a.m.-3:00 p.m. Telephone interview with Resident #7's Power of Attorney (POA) on 3/01/17 at 8:39 a.m. revealed: -Resident #7 had a fall 2 weeks ago, and she was sent to the ED. -He was not aware the facility did not provide transportation for residents on the weekend. -He did not feel comfortable transporting Resident #7 in his car. -Resident #7 had not rode in a car for over 2 years. -He did not talk to anyone at the facility on 2/18/17. -He had not signed an Admission package for Resident #7 since he became her POA less than a year ago. Interview with the Co-Administrator on 3/01/17 at 3:55 p.m. revealed: -The facility was only responsible for providing transportation for scheduled appointments only. -Otherwise, the resident was responsible for transportation cost.	D 321		

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D 321	Continued From page 9 The ED was off duty on 3/01/17.	D 321		