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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	R 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6256 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D 000	Initial Comments The Adult Care Licensure Section and the Avery County Department of Social Services conducted an annual and follow-up survey on March 7, 2017 through March 9, 2017.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure 3 of 8 sampled staff (Staff A, B and C) was competency validated for Licensed Health Professional Support (LHPS) tasks. The findings are: Random observations in the Facility on 3/7/17, 3/8/17 and 3/9/17 revealed personal care aides were observed to perform various personal care tasks for residents including feeding assistance, toileting assistance, ambulation assistance and transfer assistance.	D 161	4/13/17 2:31pm PER phone call with the Administrator - completion date for ALL tags will be 4/23/17 LHPS nurse was deficient in completing the required documentation for skills validation for new hires. LHPS nurse who was deficient is no longer an employee, as of 3/31/2017. Job posting for LHPS postion is posted and interviews are being completed. MCM and BOM are monitoring staff requirments for LHPS skills validations; including staff without staff validated dates.	4/23/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Jennelle Fitzgerald — TITLE: Administrator — (X6) DATE: April 10, 2017

STATE FORM 6899 — If continuation sheet 1 of 29

REVIEWED & Accepted Casey Fitzgerald 4/13/17

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D 161	Continued From page 1 Random interviews with eight residents during the initial tour on 3/7/17 from 10:00am to 11:30am revealed: -One resident stated "staff are good" and bring him his medications and water. -One resident stated staff were good to help him when he needed assistance. -One stated staff treated him "very well". -Six residents indicated staff were very helpful and assisted them with their daily living tasks, as needed. Interview with a family member on 3/7/17 at 2:15pm revealed: -She visited with her spouse "almost daily". -Staff were "very good" with assisting the residents. -She had "no concerns" with the care staff provided to the resident. 1. Review of Staff A's personnel record revealed: -A hire date of 11/8/16 as a Medication Aide (MA). -There was no documentation of the LHPS competency validation. Interview with Staff A on 3/8/17 at 3:10pm revealed: -She had started at the facility in November of 2016. -She had been employed at another assisted living facility prior to coming to the facility as a MA and Personal Care Aide (PCA). -The LHPS nurse had not completed the competency validation checklist with her. -She was hired as a MA and rarely assisted the PCA with resident care needs. -"I do help the (PCA's) if I have a minute" with toileting, incontinence care and transferring. Refer to interview with the LHPS nurse on 3/8/17	D 161	Resident's family was given 30 day notice of discharge 3/23/2017; after an incident occurred. Due to resident continuing to exhibit inappropriate behaviors resident was immediately discharged 3/24/2017. Training for staff was given 3/9/2017 focusing on safety of residents. Better screening of residents will be implemented in the future.	

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D 161	Continued From page 2 at 2:00pm. Refer to interview with the Memory Care Manager (MCM) on 3/8/17 at 2:00pm. Refer to interview with the Business Office Manager (BOM) on 3/8/17 at 2:10pm. Refer to interview with the Administrator on 3/8/17 at 2:15pm. 2. Review of Staff B's personnel record revealed: -A hire date of 11/1/16 as a PCA. -There was no documentation of the LHPS competency validation. Interview with Staff B on 3/9/17 at 10:30am revealed: -She had been employed at the facility since 11/14/16. -This was her first job as a PCA and one of the MA's had been spending a lot of time training her with how to care for the residents. -She "pretty much" did everything for the residents ... assist with "dressing, bathing, toileting, transferring and feeding". -She had not been competency validated by the LHPS nurse for assisting residents with their personal care needs. Refer to interview with the LHPS nurse on 3/8/17 at 2:00pm. Refer to interview with the MCM on 3/8/17 at 2:00pm. Refer to interview with the BOM on 3/8/17 at 2:10pm. Refer to interview with the Administrator on 3/8/17	D 161		

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D 161	Continued From page 3 at 2:15pm. 3. Review of Staff C's personnel record revealed: -A hire date of 10/3/16 as a PCA. -There was documentation of Staff C's certified nursing assistant (CNA) certification. -There was no documentation of the LHPS competency validation. Interview with Staff C on 3/8/17 at 2:43pm revealed: -She was the MA on the 11:00pm to 7:00am shift. -The nurse who had done her medication training also did the LHPS competency validation. -She had not been LHPS competency validated for assisting residents with their personal care needs. Refer to interview with the LHPS nurse on 3/8/17 at 2:00pm. Refer to interview with the MCM on 3/8/17 at 2:00pm. Refer to interview with the BOM on 3/8/17 at 2:10pm. Refer to interview with the Administrator on 3/8/17 at 2:15pm. Interview with the LHPS nurse on 3/8/17 at 2:00pm revealed: -He had been hired by the facility in October 2016. -He provided MA training, PCS training, staff LHPS competency validation, resident chart reviews and LHPS resident assessments for the facility. -Once a staff person had been LHPS competency validated, the form was given to the "manager"	D 161		

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D 161	Continued From page 4 (MCM). -He could not recall the last time he had been to the facility to complete staff LHPS competency validation. -He does not keep records of what staff he validates, the facility at which it is done or the date on which it occurred. -He had trained all of the PCAs and MAs the facility had asked him to train. -He did not have any trainings or validations scheduled for the facility at the present time. -He would be at the facility on 3/10/17 to do LHPS resident assessments and chart reviews. -He did not know if he would have time to complete staff LHPS competency validations at that time. Interview with the MCM on 3/8/17 at 2:00pm revealed: -She was hired as the MCM "about 6 months ago" and felt that she was still "new to her position and the facility". -There had been multiple administrative staff changes at the facility and she was still learning her duties and responsibilities. -It was the LHPS nurse's responsibility to complete the competency training checklist with the staff. -It was her responsibility to notify the LHPS nurse when staff needed training. -When the training was completed, the LHPS nurse would submit the checklist to her. -She did not know the reasons the three staff had not been competency validated by the LHPS nurse. Interview with the BOM on 3/8/17 at 2:10pm revealed she was new to the position and was not aware of her role as related to staff trainings.	D 161		

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D 161	Continued From page 5 Interview with the Administrator on 3/8/17 at 2:15pm revealed: -In most buildings it was the BOM who was responsible for tracking staff trainings. -He had become the Administrator for this building about one week ago and was not sure how staff qualifications were being managed at the facility. -It was the LHPS nurse's responsibility to complete the LHPS competency validation checklist.	D 161		
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, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews, observations and record review, the facility failed to assure 1 of 5 sampled residents (Resident #5) with a history of agitated behaviors was supervised in accordance with his assessed needs and care plan resulting in Resident #5 bruising another resident's (#3) arm and randomly knocking on resident doors at all times during the night. The findings are: 1. Review of Resident #5's current FL2 dated 1/4/17 revealed: -Diagnoses included Dementia. -Recommended level of care was documented as special care unit (SCU).	D 338	The Obudsman did a training with staff focusing on Resident Rights 4/7/2017. The Executive Director and Care Management completing daily rounds to aide in assuring resident rights are upheld.	4/23/17

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D 338	Continued From page 6 -The resident was documented as constantly disoriented, ambulatory, wanderer, verbally abusive and injurious to others. Review of Resident #5's current care plan dated 1/25/17 revealed: -The resident was documented as being always disorientated, significant memory loss, must be directed. -Wandering, verbally abusive, physically abusive and resists care had been documented under the mental health and social history section. Review of a NC Medicaid FL2 Level of Care Screening Tool from a hospital dated 12/26/16 revealed: -Recommended level of care at discharge documented as memory care. -Diagnoses included Dementia and major vascular neurocognitive disorder, probable, with behavioral disturbance. -Documented as constantly disoriented, wanderer and verbally and physically aggressive with (family members) only. Review of Emergency Department (ED) Information from a local hospital for Resident #5 dated 1/2/17 revealed: -The reason for ED visit was "aggression". -Under additional notes section: "Give prn (as needed) trazodone (used to treat depression, anxiety and sleep) and Haldol (used to treat mental and mood disorders, helps reduce aggression, negative thoughts, and the desire to harm someone or oneself) as directed". Review of Resident #5's record revealed: -An order dated 1/3/17 for Haldol 5mg, one every 4 hours as needed for agitation, not to exceed (NTE) 4 doses in 24 hours.	D 338		

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D 338	Continued From page 7 -An order dated 1/4/17 for trazodone 50mg, take one at bedtime; trazodone 50mg, one every 4 hours as needed for anxiety/agitation, NTE 4/24. -A change order dated 1/18/17 to discontinue trazadone 50mg and start trazadone 100mg, one at bedtime, may repeat in 2 hours if not asleep. -An order dated 1/18/17 for hydroxyzine pamoate (used to treat anxiety and tension) 25mg, take one every 4 hours as needed for anxiety/agitation, may give 2 hours after Haldol -A discontinue order dated 2/23/17 for Haldol due to drug interaction. Review of Resident #5's care notes from 12/26/16 through 3/9/17 revealed: -On 3/9/17: "Resident remains on 15 minute checks, he is currently out in the hallway, will continue to monitor", signed by the 3rd shift Medication Aide (MA). -On 3/8/17: "Resident is on 15 minute watch since 5:00pm onwards, he had prn at 3:48pm and 8:47pm", signed by the 2nd shift MA. -On 3/8/17: "Resident currently walking the hallways, he has been directed to bed, he refuses to go, will continue to monitor", signed by the 3rd shift medication aide (MA). -On 3/7/17: "Resident is very confused, he has been asking for his wife and saying, I'm leaving one way or another, will continue to monitor", signed by the 3rd shift MA. -On 3/1/17: "Resident is extremely confused and agitated, he had prn at 8:35pm, he needs to be monitored", signed by the 2nd shift MA. -On 3/1/17: "Resident was up late, he has now gone to bed, resting well, will continue to monitor", signed by the 3rd shift MA. -On 1/25/17: "Resident is agitated, he had prn at 9:41pm, he needs to be monitored", signed by the 2nd shift MA. -On 1/25/17: "Resident is up wandering in the	D 338		

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D 338	Continued From page 8 hallway, staff has tried to redirect him to bed but he refuses to go, will continue to monitor", signed by the 3rd shift MA. -On 1/11/17:"Resident is still confused but less agitated", signed by the 2nd shift MA: -On 1/11/17: "Resident is currently walking the hallway, will continue to monitor", signed by the 3rd shift MA. -On 1/4/17: "Resident still agitated and cannot sleep, he had prn a 5:00pm and 10:00pm", signed by the 2nd shift MA. -On 1/4/17: "Resident did not go to bed until 4:30am, until then he paced the halls, wandering in other resident's rooms ...", signed by the 3rd shift MA. -On 1/4/17: "Resident is up wandering the halls, he was administered a prn for anxiety, will continue to monitor for any changes", signed by the 3rd shift MA. -On 1/2/17: "Resident has been up all night, he continues not to sleep and will not go to his room at night", signed by the 3rd shift MA. -On 1/1/17: "Resident refuses to sleep in his room, he sleeps very little in the television room, when staff tries to direct him to go to bed, he gets agitated ...", signed by the 3rd shift MA. -On 12/28/16: "Resident has been up most of the night wandering the hallway ...personal care aide (PCA) has offered to assist him to bed but resident refuses, will continue to monitor", signed by the 3rd shift MA. -On 12/27/16: "Resident got up at 12:30am, he started screaming at staff ...resident laid down on floor ... MA explained he could not lay in the floor and that the (MA) would help him to his room where he had a bed, he (Resident) screamed and stated he did not want to go to bed ...resident was left alone, PCA went and was able to redirect him to his room, will continue to monitor", signed by the 3rd shift MA.	D 338		

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D 338	Continued From page 9 Review of Resident #5's March 2017 electronic medication administration record (EMAR) revealed: -Hydroxyzine pamoate 25mg had been documented as administered six times, one time daily from 3/1/17 to 3/6/17, 4:49pm to 10:38pm for agitation, with a result of effective (2) or semi-effective (4). -Trazodone 100mg documented as administered on 3/8/17 at 11:30pm for anxiety, non-effective. Review of Resident #5's February 2017 EMAR revealed: -Hydroxyzine pamoate 25mg had been documented as administered fourteen times, one time daily from 2/1/17 to 2/28/17, 5:04pm to 11:32pm for agitation, with a result of effective (7), semi-effective (4) or non-effective (3). -Trazodone 100mg documented as administered on 2/6/17 at 10:59pm for anxiety, effective and on 2/24/17 at 10:14pm for cannot sleep, semi-effective. Review of Resident #5's January 2017 EMAR revealed: -Hydroxyzine pamoate 25mg had been documented as administered six times, one time daily from 1/19/17 to 1/24/17, 7:00pm to 12:27am for agitation and anxiety, with a result of effective (4) or non-effective (2). -Trazodone 50mg documented as administered four times, one time daily from 1/3/17 to 1/17/17, 5:43pm to 12:33am for agitation and anxiety, with a result of effective (1), semi-effective (2) or non-effective (1). -Trazodone 100mg documented as administered on 1/27/17 at 11:44pm for anxiety, with a result of semi-effective. -Haldol 5mg documented as administered nine	D 338		

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D 338	Continued From page 10 times, one time daily from 1/3/17 to 1/26/17, 5:59pm to 12:29am for agitation, with a result of effective (3), semi-effective (3) or non-effective (3) and documented as administered twice on 1/5/17 at 4:18pm (effective) and 10:24pm (non-effective). Review of an Incident and Accident report for Resident #5 dated 3/5/17 revealed: -At 8:05pm, the resident had been documented as "very agitated" and had grabbed another resident (Resident #6) by the arm. -Resident #5 had been re-directed to his room and placed on 15 minute checks. -A family member/power of attorney had been notified at 8:20pm and she came and had talked with him. -The Primary Care Physician's Family Nurse Practitioner (FNP) had been notified on 3/6/17 at 4:10pm. Interview with the Memory Care Manager (MCM) on 3/8/17 at 8:45am revealed the Incident and Accident report for Resident #5 had been completed on 3/5/17 when he had grabbed another resident, thinking the other resident (#6) was "his wife" and wanted to head back to his room. Interviews with a resident on 3/7/17 at 10:55am and on 3/9/17 at 9:15am revealed: -She had been at the facility for about 1 year. -She indicated there was one "rather large gentleman" who will knock on her door and state that her room was his room. -She knew the gentleman was a resident at the facility, but did not know his name. -She was afraid of him because of "his size and the look in his eyes, everyone is afraid of him". -She "in general" kept her door locked because	D 338		

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D 338	Continued From page 11 there are "others who wander in and out" [of her room]. -"The same man knocked on her door around 1:30am this morning" [3/9/17]. -It sounded like an "urgent" knock and she thought it was a staff person attempting to get her attention. -She had opened the door and it was the male resident. -She closed the door and locked it. -The knocking had awoken her from her sleep. -"I'm a small person and it frightened me." -This male resident has been knocking on other doors "a couple of times per week" for about the last "4 to 6 weeks". -When the male resident first came to the facility he was being given a tour and being introduced to other residents. He came into her room and stated moving pillows off of her chair, "he may "think that this is his room". -Given a description, she was able to identify this male resident as Resident #5. -She indicated Resident #5 had not been physically aggressive towards her, and was not aware of any physical aggression towards and other resident. -She had discussed her concerns with a MA. Interviews with another resident on 3/7/17 at 11:04am and 3/8/17 at 11:00am revealed: -There was a male resident who "loses his temper very easily, everyone walks around him". -He "bellows and yells". -She would avoid him. -"Everyone stands back when he comes around because he is very threatening and temperamental. You don't know what he is going to do." -She was afraid of the male resident, his "expressions and body language".	D 338		

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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 338	Continued From page 12 -"Mainly he just (exhibits) threatening behaviors." -Staff were aware of his behaviors and intervened as needed. -She was unable to identify the male resident and did not know his name. Interview on with a 1st shift Personal Care Aide (PCA) on 3/8/17 at 2:15pm revealed: -She had seen Resident #5 agitated, "he gets frustrated and doesn't follow prompts". -She was not afraid of him and did not think he would hurt her. -She thought Resident #5 believed another resident (#6) was "his wife". Observation of Resident #5 on 3/8/17 at 3:01pm revealed: -He was walking down the hallway, hand-in-hand with Resident #6. -A PCA approached and attempted to separate Resident #5 and #6 when Resident #5 said, "Get your damn hands off of her". -The PCA had immediately stepped away from Residents #5 and #6, walked away from the down the hall, returned approximately 2 minutes later with another staff and they seperated the two residents without further incident. -Resident # 5 had continued to walk the hallway with Resident #6. Interviews with Resident #5's family member and Power of Attorney (POA) on 3/7/17 at 2:15pm and on 3/9/17 at 12:35pm revealed: -She had visited "almost daily" with Resident #5 since his admissions to the facility, "except for maybe 5 days". -About the "first week" after admission, Resident #5 had become agitated when he thought staff was hurting another resident. -He hit a staff person and (Resident #5) was sent	D 338 -		

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	HAL006007	A. BUILDING: _____ B. WING _____	R 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6265 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D 338	Continued From page 13 to the hospital. -The facility staff did contact her. -"About 2 nights ago it was the same scenario" when (Resident #5) pulled out a pair of fingernail clippers and threatened staff with it. It was "her fault" for leaving the clippers in his room. -She indicated staff was unsure for the reason Resident #5 had become agitated. -It had been discussed with her at admission that the facility would need to discharge him if he became "too aggressive", but did not know what too aggressive meant. -She indicated Resident #5 had his "days and nights" mixed-up. -"I pity the folks who work nights, I had that go on for two years, up all through the night, wander away from the house." Review of staff training record dated 3/8/17 at 5:12pm revealed eight staff had received training on the "appropriated techniques to redirect residents exhibiting aggressive behaviors". Interview with a 2nd shift PCA on 3/9/17 at 10:30am revealed: -Resident #5 would go to Resident #6's room thinking she was "his wife". -Resident #5 only gets aggressive and hits staff. -She felt she knew how to approach Resident #5 so as not to upset him. Interview with a 2nd shift MA on 3/8/17 at 3:23pm revealed: -When Resident #5 was admitted, he would tell staff that "did not want to be here". -"We" had to encourage and help him to dinner and bed. -"He had a hard time sleeping, his nights and days were mixed-up." -He would get up around 4:00pm and walk the	D 338		

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D 338	Continued From page 14 hallways and would still be up at 11:00pm. -His behaviors started around 5:00pm, he would be "bossy". -He would "escalate" if he was approached assertively. -"It all depends on how you approach him." -He did hit [a MA]. -One time he was walking "arm-in-arm" with [Resident #6] and when staff tried to separate them he held on tight to her [Resident #6's] arm and he left a bruise on her right arm. -His [family member] would come and visit with him and she would leave when Resident #5 fell asleep on a couch. -When walking the hallways he would go door-to-door and knocking on each door, looking for his "wife". -The MA had seen "improvements" in his behaviors with the medication changes by the FNP. -"But when the medications wear off, he can get agitated again." Interview with a 3nd shift (11:00pm to 7:00am) MA on 3/8/17 at 2:30pm regarding Resident #5 revealed: -He could be pretty agitated, aggressive and confrontational. -He had threatened her with a balled up fist on several occasions, stating he was going to hit her in the face. -He had bitten her upper right arm but had not broken the skin. -He had chased a PCA down the hall one night threatening her with a pair of toe nail clippers. -"I think he has threatened all of the staff on this shift." -"When he was upset, I would have the staff walk away and give him time to relax." -"When he had calmed down, I would have a	D 338		

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D 338	Continued From page 15 different staff member approach him and help him." -"The PRN (as needed) medication he has ordered will help mellow him out but that is only about 50 percent effective. -Redirecting him only was not always successful. -His behaviors seemed to worsen when staff would take him into his room for toileting or for bed. -His room was at the other end of the building on the 400 Hall. -He spent most of the shift walking the hallways or on the 200 Hall couch across the hall from where a female resident, he thought was his wife, had a room. -He would wander into specific female resident's rooms and sit on their beds. -She had never seen him put his hands on any female residents. Interview with Resident #5's FNP on 3/8/17 at 12:25pm revealed: -She was "very aware" of his behaviors. -She saw him last week and was going to see him again today. -His agitation was being managed when he was on Haldol, and was not pleased she had to discontinue the medication to a pharmacy drug interaction assessment [on 2/23/17]. -She was adjusting his medications and "in the process" of finding another medication regimen to replace the Haldol. -The facility kept her informed of his behaviors. Second interview with the MCM on 3/9/17 at 10:00am revealed: -She had been aware of Resident #5's behaviors from his admissions paperwork and the reason he was in the hospital prior to admissions. -At the time of Resident #5's admission, the	D 338		

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facility had a "marketing" staff that was responsible for processing new admissions.
-[The marketer] conducted all of the preadmission interviews with the hospital, resident's PCP, with the resident and family, complete the resident assessments.
-They would then discuss the information with her and the Executive Director (ED).
-The ED would make the final admission decision.
-She knew the facility screened new admissions based on age, mental health history, current medications and behaviors.
-The marketing staff had spoken with the hospital and they were told Resident #5 "was stable".
-Resident #5 had "no issues" after his admission, he was just confused and stated "he was not staying in this motel".
-His aggression started when he hit a staff.
-His aggression had only been directed towards staff.
-She was aware of his walking the hallways behaviors at night and knocking on resident doors.
-He hit a staff around 1/4/17 because the staff had taken something from another resident and "he was protecting" the resident.
-She had spoken with Resident #5's family member/POA about his behaviors with Resident #6.
-Resident #6 was also confused and thinks Resident #5 is her spouse.
-Staff had been instructed to watch Resident #5 and #6 and not allow them to be alone.
-Resident #5 had "only been polite" towards Resident #6.
-Resident #5 had grabbed Resident #6's arm and was trying to move her away from staff.
-There had been no residents talk to her about being afraid of Resident #5.

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D 338	Continued From page 17 -She would expect staff to report any resident comments to her, as needed. -Resident #6 was beginning not to remember his [family member] when she comes to visit. The ED was not available for interview due to being out on personal leave from the facility. Interview with the Administrator on 3/9/17 at 10:08am revealed: -There was an assessment tool used for preadmission screenings. -It was the responsibility of the marketing staff to complete the initial referral paperwork. -The marketing staff would discuss the information with the facility's clinical staff and ED. -The marketing staff would do a full assessment and obtain a completed FL2. -They would screen and scrutinize closely for mental health issues and how the new resident would influence the current community at the facility. -The final decision for admissions would be the responsibility of the ED. -He had been the Administrator for this facility as of 2/27/17 and did not know the reason Resident #5 had been admitted. 2. Review of Resident #6's current FL2 2/13/17 revealed: -Diagnoses included dementia with behavioral disturbances. -Recommended level of care documented as special care unit (SCU). -The resident was documented as intermittently disorientated and ambulatory with a walker. Review of staff notes dated 3/5/15 revealed at 8:05pm Resident #6's arm had been "grabbed by another resident causing a small bruise."	D 338		

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D 338	Continued From page 18 Review of an Incident/Accident report for Resident #6 dated 3/5/17 revealed: -At 8:05pm, the resident's arm had been grabbed by another resident (Resident #5) causing a small bruise. -The resident had been re-directed to her room, PCA's monitored closely. -A family member/power of attorney had been notified at 10:00am on 3/6/17. -The FNP had been notified on 3/6/17 at 4:10pm. Observation of Resident #6's right arm on 3/9/17 at 11:35am revealed: -A partially faded yellow/blue bruise on the inner aspect of the right forearm, approximately 1 inch below the bend of the elbow. -The bruise was approximately 3 inches long and 2 inches wide. Interview with Resident #6's POA on 3/9/17 at 11:29am revealed: -He had been notified of the incident on 3/5/17 and of the bruising on the resident's right forearm by a family member. -The POA had been aware another resident (Resident #5) thought Resident #6 was his wife. -At first, the situation had upset the family, especially when the resident referred to Resident #5 as her husband. -They now realized it is the worsening of her dementia and she is no longer the person she used to be. The failure of the facility to provide supervision in accordance with Resident #5's assessed needs, care plan and history of aggressive behavior was detrimental to other facility residents health, safety and welfare due to the fact that Resident #5 had inadvertently bruised the arm of another	D 338		

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D 338	Continued From page 19 resident (#6) and that Resident #5 would stay awake during the night and wake-up other residents up by randomly knocking on their doors, which constitutes a Type B violation. A Plan of Protection was submitted by the facility on 3/8/17 that included: -Resident (#5) will be placed on 15 minute checks until visible signs of aggressive behaviors decrease. -Give a review of appropriate re-directing technique(s) to current staff on resident's exhibiting aggressive behaviors. -Resident (#5) will be issued a 30 day discharge due to all other aspects of care being exhausted. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 23, 2017.	D 338		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's	D 400	A pharmacy review was completed 3/8/2017. MCM will monitor to ensure that pharmacy review is completed each quarter. If review is not completed MCM will contact pharmacy and set up a time and date for pharmacy review.	4/23/17

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D 400	Continued From page 20 orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain the services, at least quarterly, of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care which involves the identification, prevention and resolution of medication related problems during on-site medication reviews, for 5 of 5 sampled residents (Residents #1, #2, #3, #4, and #5) in the memory care unit. The findings are: A. Review of Resident #1's current FL2 dated 7/18/16 revealed: -Diagnoses included dementia, HTN (high blood pressure), and COPD (chronic obstructive pulmonary disease). Review of the physicians notes in Resident #1's	D 400		

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D 400	Continued From page 21 record dated 5/24/16 revealed additional diagnoses of diabetes, anxiety, depression and heart failure. Review of Resident #1's Resident Register revealed an admission date of 5/22/08. Review of Resident #1's record revealed: -The last pharmacy review had been completed on 10/17/16. -No recommendations had been made at that time. -There had not been a pharmacy review completed in January 2017 or February 2017. Refer to interview with Memory Care Manager (MCM) on 3/8/17 at 10:20am. Refer to interview with Administrator on 3/8/17 at 11:50am. Refer to interview with Pharmacy General Manager on 3/8/17 at 2:26pm B. Review of Resident #2's current FL2 dated 3/1/17 revealed: -Diagnoses included Alzheimer's Disease, diabetes mellitus, depression, and psychotic episodes. Review of Resident #2's Resident Register revealed an admission date of 2/11/15 Review of the physicians notes in Resident #2's record dated 11/17/16 revealed additional diagnoses of hypertension and blindness in her right eye. -Review of Hospice notes in Resident #2's record dated 12/23/16 revealed additional diagnoses of:	D 400		

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D 400	Continued From page 22 -An MI (heart attack). -Heart failure -Bipolar/schizophrenia. -(CAD) Coronary artery disease. -Chronic kidney disease (Stage 3). -Chronic back pain. Review of Resident #2's record revealed: -The most current pharmacy review had been completed on 10/17/16. -Recommendations had been made to increase the Levemir insulin she received. -There had not been a pharmacy review completed in January 2017 or February 2017. Refer to interview with Memory Care Manager (MCM) on 3/8/17 at 10:20am. Refer to interview with Administrator on 3/8/17 at 11:50am. Refer to interview with Pharmacy General Manager on 3/8/17 at 2:26pm C. Review of Resident #3's current FL2 dated 11/16/16 revealed: -Diagnoses included vascular dementia, chronic kidney disease, hypertension, heart failure, mood disorder, edema. Review of Resident #3's Resident Register revealed an admission date of 11/21/16. Review of Resident #3's record revealed there was no pharmacy review sheet in the record. Refer to interview with Memory Care Manager (MCM) on 3/8/17 at 10:20am. Refer to interview with Administrator on 3/8/17 at	D 400		

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D 400	Continued From page 23 11:50am. Refer to interview with Pharmacy General Manager on 3/8/17 at 2:26pm D. Review of Resident #4's current FL2 dated 5/11/16 revealed: -Diagnoses included vascular dementia, Parkinson's Disease, heart failure, HTN (high blood pressure),depression, and TIA (trans-ischemic accident-a stroke). Review of Resident #4's Resident Register revealed an admission date of 5/2/14. Review of Resident #4's record revealed: -The most current pharmacy review had been completed on 10/17/16. -No recommendations had been made at that time. -There had not been a pharmacy review completed in January 2017 or February 2017. Refer to interview with Memory Care Manager (MCM) on 3/8/17 at 10:20am. Refer to interview with Administrator on 3/8/17 at 11:50am. Refer to interview with Pharmacy General Manager on 3/8/17 at 2:26pm E. Review of Resident #5's current FL2 dated 1/4/17 revealed: -Diagnoses included dementia, COPD (chronic obstructive pulmonary disease), high cholesterol, prostrate disease, CAD (coronary artery disease), rheumatoid arthritis, and an MI (heart attack). -Noted to be a wanderer, verbally abusive and injurious to others.	D 400		

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D 400	Continued From page 24 Review of Resident #5's Resident Register revealed an admission date of 12/26/16. Review of Resident #5's record revealed: -He had been in the facility a short time and did not qualify for a pharmacy review by the new pharmacy. -A drug interaction assessment form dated 2/23/17, completed by the previous pharmacy and sent to the facility. -The form identified a potentially life threatening drug interaction between two of the residents medication and recommended one of the medications be discontinued. -The form had been reviewed by the FNP caring for the resident, and she had discontinued the medication on 2/23/17. Refer to interview with Memory Care Manager (MCM) on 3/8/17 at 10:20am. Refer to interview with Administrator on 3/8/17 at 11:50am. Refer to interview with Pharmacy General Manager on 3/8/17 at 2:20pm Interview with Memory Care Manager (MCM) on 3/8/17 at 10:20am revealed: -The facility had switched to a different pharmacy the end of December 2016. -She was not aware the pharmacy reviews had not been completed as required. -The Executive Director (ED) was responsible for ensuring the reviews were received, the recommendations were sent to the physicians and returned to the facility. -The ED was currently on vacation.	D 400		

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CRANBERRY HOUSE	8255 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D 400	Continued From page 25 Interview with Administrator on 3/8/17 at 11:50am revealed: -He had been at the facility for one week. -In December 2016, the facility switched to a different pharmacy. -He had no knowledge the pharmacy reviews were overdue. -He had called the former Administrator of Record who had been unaware pharmaceutical services had not been provided. -He had also called the Clinical Operations Director who had been unaware the pharmaceutical services were not being provided. -It was the ED responsibility to make sure the pharmacy reviews were completed quarterly. -She should have let the MCM know they hadn't been done before she went on vacation. Interview with Pharmacy General Manager on 3/8/17 at 2:26pm revealed: -The end of December 2016, the pharmacy took over the building. -Initially, the facility had wanted their old pharmacy to continue to provide the pharmaceutical services and had not signed a contract with the new pharmacy. -On 1/23/17 the facility signed a contract with the new pharmacy for pharmaceutical services. -"We (the pharmacy) had added other facilities and were in the process on scheduling pharmacists to go out and review these places but had missed this one." -When the facility called to find out why there were no current drug reviews, the pharmacy realized ,"Unfortunately, this facility fell through the cracks." -She had talked to the person at the pharmacy responsible for assigning/scheduling facility's for review and planned to send someone out next week to this facility.	D 400		

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	R 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	8258 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 400	Continued From page 26 Interview with a pharmacist in the facility on 3/9/17 at 10:05am revealed: -The new pharmacy had sent him to review resident records and to perform medication reviews on the Medication Administration Records (MARs) on the medication carts. -When completed, he would type up the reports and copies would be delivered in a tote from the pharmacy the beginning of the following week.	D 400		
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 observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to supervision. The findings are: Based on interviews, observations and record review, the facility failed to assure 1 of 6 sampled residents (Resident #5) with a history of agitated behaviors was supervised in accordance with his assessed needs and care plan resulting in Resident #5 bruising another resident's (#6) arm and randomly knocking on resident doors at all	D912	4/23/17	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	R 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 27 times through the night [Refer to Tag 338, Rule 10A NCAC 13F .0909 (Type B Violation)].	D912		