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	HAL037001	A. BUILDING: _____ B. WING _____	03/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATES HOUSE	11 COMMERCE DRIVE GATESVILLE, NC 27938

(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 Gates County Department of Social Services conducted an annual survey and complaint investigation on March 21-24, 2017 and March 27-28, 2017. The complaint investigation was initiated by the Gates County Department of Social Services on December 20, 2016.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to assure 1 of 7 sampled staff (Staff B) had no substantiated findings listed on the Health Care Personal Registry prior to being hired at the facility. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired at the facility on 03/09/16 as a Personal Care Aide. -Staff B had a Health Care Personnel Registry check done on 03/30/16. Review of Staff B's Health Care Personnel Registry dated for 03/30/16 revealed: -Staff B had substantiated findings of abuse of a	D 137	Note: Facility management restructured to include, but not limited to an interium veteran administrator assigned to Gates House as of 4/20/17 with several support staff to assist with auditing charts, systems, monitoring and implementing new procedures. It is the policy of Gates House to assure each staff shall have no substantiated findings listed on the North Carolina Health Care Registry according to GS 131E-256 & 10A NCAC 13F. 0407 (a) (5) Other Staff Qualifications. Staff B was relieved of duty during the survey ending 3/28/17.	3/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra Flaherty, Interim Executive Director By Sandra Flaherty, Vice President of Quality Assurance & Regulatory Compliance — TITLE — (X6) DATE: 5/8/17

5/11/17 - POC reviewed & accepted. - Tiffany Sewell, RN, MSN

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D 137	Continued From page 1 resident while she was employed in a residential facility for the mentally ill. -This information was entered into the Health Care Personnel Registry on 08/01/07. Confidential telephone Interview with a Staff Member revealed: -Staff B always had an attitude and was rude when she worked with the residents. -Staff B yelled and her tone of voice was mean when she spoke to the residents. -Staff B would say "I ain't gonna do nothing for you, you better get up and do it yourself" to the residents. -If a resident did not move fast enough when Staff B told them to move then Staff B would pull or grab on the resident to make them do whatever she wanted. -Staff member did not specify when Staff B pulled or what resident was pulled on. -Staff member did not specify if notified the Administrator or Resident Care Coordinator (RCC). -The staff member could not specify how many times these incidents occurred with the residents in the facility. -The staff member witnessed Staff B slam a resident in the bed sometime before Christmas 2016. -The staff member reported the incident to the Administrator and the RCC the day after it occurred. -The Administrator nor the Resident Care Coordinator did anything about the event that was reported. -Staff B refused to give snacks to residents if the residents did not do what Staff B wanted. A Confidential interview with a resident revealed: -Resident stated being treated badly by staff but	D 137	Health Care Personnel Registry (HCPR) checks were completed on all existing employees as of 3/30/17. Administrator will review all perspective employee Health Care Personnel Registry checks prior to hire. Quarterly Health Care Registry checks will be conducted by the Business Manager and reviewed by the Administrator. Personnel files will be reviewed for compliance using a orientation check list and the perpetual staff log to ensure Health Care Personnel Registry checks were completed. Additional training was provided to include, but not limited to; -Reporting abuse, neglect and exploitation allegations -Corporate policy on abuse, neglect and exploitation -Health Care 24 hour and 5 day reports -Resident Relations and Human Resource Hotline Posting reviewed and verified -NC Adult Care Licensing complaint number reviewed and verified posting -Consequences reviewed for failure to ensure Resident Rights to be free from abuse and neglect Training conducted by support staff. Documentation of training available upon request in the front office.	3/30/17 4/27/17 4/27/17 4/27/17 4/27/17

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D 137	Continued From page 2 would not identify the staff member during this interview. -Resident informed the RCC of being treated badly by the staff but the resident could not specify when the RCC was informed. -Resident reported the staff member fussed at the resident for no reason. -The staff member hurried the resident when giving the resident a bath. -The staff member refused to give the resident baths sometimes. -The staff member told the resident to empty their own urine container. -The staff member assisted the resident very little when the resident requested help. -Staff member was loud and yelled at the resident. -Resident stated every time he reported the staff member then the verbal abuse got worse. -Resident stated they did not want to name any other staff because they're not very sure and would hate to call out the wrong name. -Resident loved the facility but it's just the way the staff treated the resident that was bad. -Resident was never physical hurt by any staff. -The staff member was verbally abusive to the resident. A Confidential interview with the same resident revealed: -Resident identified Staff B who was verbally abusive with the resident. -Resident stated that Staff B was loud, yelled at the resident, used abusive language and profanity toward the resident. -The resident witnessed Staff B using profanity with other residents but did not want to mention their names. -The resident stated, "It was up to the other residents to tell what was happening to them".	D 137	Facility will ensure that any reported allegation of abuse, neglect or exploitation will be reported to the Health Care Personnel Registry as required. The Executive Director will be responsible to assure that the required reporting documents are submitted timely.	4/27/17
			Executive Director will attend Resident Council Meetings that are held monthly by activity director and led by the residents. ED will speak with residents to assure that no abuse neglect or exploitation will be tolerated by staff and encourage/ reinforce to report any/all concerns. Residents will then be reminded of Open Door Policy and is welcomed at any time by the Administrator. Documentation of Resident Council Meetings will be available in Activity Directors office at any time for review.	4/27/17

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D 137	Continued From page 3 -Resident started crying and stated "Here I am making it worse for myself again, jeopardizing seeing my grandchildren." A Second confidential telephone interview with a Staff Member revealed: -Staff member reported she witnessed Staff B physically abuse a resident in late January/early February 2017. -The staff member was not able to remember the name of the resident from that episode. -The resident was in the sitting area on the assisted living side but was not ready for bed. - Staff B grabbed the resident up from the chair and forced the resident to go down to the resident's room. -Staff B then slammed the resident down in the bed (No injury reported). -Resident did not want to go to bed. -Staff did not report this incident to the Administrator because the Administrator always made excuses to justify Staff B's behaviors. Interview with the front desk receptionist on 03/28/17 at 10:40 AM revealed: -It was the responsibility of the management to do all of the interviewing and hiring process when a new employee was hired at the facility. -The Health Care Personnel Registry search was completed by the business office manager. Interview with the Business Office Manager on 03/28/17 at 11:42 AM revealed: -She had been the Business Office Manager since the facility opened in August of 2015. -The Administrator was responsible for interviewing all new staff. -She was responsible for getting all paperwork done once the employee's criminal background check come back cleared.	D 137		

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D 137	Continued From page 4 -She ran all the Health Care Personnel Registry's checks on all of the new staff when they were hired. -She gave all the Health Care Personnel Registry results to the Administrator. -She would notify the Administrator of any problem with a Health Care Personnel Registry finding for an employee. -She ran the Health Care Personnel Registry on Staff B. -She was not aware of any problems when she ran the Health Care Personnel Registry check for Staff B. -When Staff B's Health Care Personnel Registry had been completed, it was then turned over to the Administrator. -The Administrator that was here during that time is no longer working for the company. -The Administrator was responsible for deciding if a staff member was eligible to work at the facility. -She and the Administrator completed quarterly personnel record audits. -They would only select a few personnel records to review each time they did there quarterly audits. -It was the Business Office Manager and the Administrator's responsibility to make sure that all personnel records were kept up and completed. Interview with the Administrator on 03/28/17 at 10:50 AM revealed: -She was responsible for handling all interview processes. -When someone is hired then corporate runs a criminal background check. -Once the criminal background check comes back completed and clear, then the Business Office Manager will run a Health Care Personnel Registry. -If there are any findings on the Health Care	D 137		

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D 137	Continued From page 5 Personnel Registry then the Business Office Manager will notify the Administrator immediately. -The staff member will not be allowed to work at the facility if there are any findings on the Health Care Personnel Registry. -She has only been the Administrator since August of 2016. -She was not the Administrator when Staff B was hired. -She was not aware of Staff B having any findings of abuse listed on her Health Care Personnel Registry. -She and the Business Office Manager completed Quarterly personnel record reviews. -The last one done was about 3 or four months ago but she was not sure what exact date. -She would be terminating Staff B immediately due to the findings listed on her Health Care Personnel Registry. -She was not aware of any allegations of resident abuse regarding Staff B. Observation on 03/28/17 revealed Staff B was terminated of employment by the Administrator. The facility failed to assure all staff had a completed Health Care Personnel Registry check and did not have any substantiated findings of abuse. The facility's noncompliance placed residents at substantial risk for abuse and neglect and constituted a Type A2 Violation. Review of the Facility's plan of protection dated for 03/28/17 revealed: -The facility shall assure staff have no substantiated findings listed on the North Carolina Health Care Personnel Registry. -Staff B is being terminated immediately. -The Business Office Manager is reviewing all personnel registry's today on 03/28/17.	D 137		

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D 137	Continued From page 6 -The Healthcare Registry will be reviewed upon hire by the Administrator. -There will be quarterly reviews of all employees' files done by 03/30/17. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 27, 2017.	D 137		
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 observations, interviews, and record reviews, the facility failed to assure 1 of 6 sampled residents (#2) reviewed was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #2's current FL-2 dated 2/10/17 revealed: -Resident #2's diagnoses included alzheimers disease/dementia, hypertension, bipolar disorder,	D 234	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of Gates House to assure each resident shall be tested for tuberculosis in compliance with control measures adopted by the Commission for Health Services per 10A NCAC 41A.0205 & 10A NCAC 13F .0703 Tuberculosis Test, Medical Examinations & Immunizations. Chart audits were completed to check for Tuberculosis Requirements. Any missing TB test were given by a nurse and documented in the resident record.	5/15/17

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D 234	Continued From page 7 diabetes, somatization disorder, psoriasis, and benign prostatic hypertrophy. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 8/21/15. Review of Resident #2's record on 3/22/17 revealed: -Tuberculosis (TB) test was completed on 3/22/17. -There was documentation of one tuberculosis skin test completed on 12/19/03 and read as (negative) on 12/22/03. -There was documentation of a second tuberculosis skin test completed on 11/26/03 and read as (negative) on 11/28/03. -There was no documentation to indicate a tuberculosis skin test had been completed since Resident #2 was admitted to the facility. Interview with the Resident Care Coordinator (RCC) on 3/27/17 at 11:10 a.m. revealed: -She did not have a current TB skin test since admission for Resident #2. -The only documentation she had available was noted in Resident #2's record. -She was responsible for ensuring the residents had TB skin testing completed as required. -She was unsure what happened with Resident #2's TB skin testing not being completed. -She would ensure Resident #2's TB skin testing was updated. Interview with the Administrator on 3/24/17 at 12:51 p.m. revealed: -She was unaware Resident #2 did not have documentation of one TB skin test upon admission to the facility. -She did not know Resident #2 did not have a	D 234		

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D 234	Continued From page 8 second TB skin test completed. -She would follow-up with the RCC to update TB skin testing for Resident #2.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 3 of 6 sampled regarding of missed medications used to treat high blood pressure and mental behaviors for 2 residents (#2, #6) and medication refusals for 1 resident (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 2/10/17 revealed: -Resident #2's diagnoses included Alzheimer's disease/dementia, hypertension, bipolar disorder, diabetes, somatization disorder, psoriasis, and benign prostatic hypertrophy. -Resident #2 was intermittently disoriented. -Resident #2's level of care was for the Special Care Unit. Review of a Physician's Order for Resident #2 dated 02/10/17 revealed: -An order for Metoprolol 25 mg once a day at	D 273	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of Gates House to assure Health Care referral and follow-up are met according to 10A NCAC 13F. 0902 Health Care. Chart audits were completed with notification to the Primary Care Provider (PCP) of any discrepancies by 4/27/17. RCC and or designee will clarify physician's orders as residents are admitted, readmitted or new orders are written by physician, now and ongoing. The Administrator or designee will conduct random audits weekly for one month; then monthly to ensure that physicians orders are clarified as needed when residents are admitted, readmitted or new orders are written by physician.	4/27/17 4/27/17

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D 273	Continued From page 9 8:00 a.m. (Metoprolol was a medication used for hypertension). -An order for Diazepam 2 mg once daily every 12 hours (Diazepam was a medication used to treat anxiety). Review of the Resident Register revealed an admission date of 08/21/2015 for Resident #2. Review of the Resident #2's Service Plan dated 10/24/16 revealed the resident was disoriented and forgetful. Observation of Resident #2 in the large living room in the Special Care Unit on 03/21/17 at 3:20 p.m. revealed: -Resident #2 was in a group activity with his peers. Based on record review and interview, Resident #2 was not interview-able. Review of the January 2017 Medication Administration Record (MAR) for Resident #2 on 03/22/17 revealed: -An entry for Diazepam 2 mg tablet was documented as "med not in facility." -A second entry for Diazepam 2 mg tablet was documented as "awaiting medication." -An entry for Metoprolol 25 mg tablet was documented as "awaiting medication." During the month of January 2017, medications were missed for three days for Resident #2. Review of the February 2017 MAR for Resident #2 on 3/22/17 revealed three entries for Metoprolol 25 mg tablet were documented as "awaiting medication."	D 273	Mood & Behavior Tracking Log was implemented along with training on 4.26.17 with Medication Aides in SCU. MCM will review Mood & Behavior Tracking log as a part of routine duties to ensure reporting to Primary Care Provider (PCP) and interventions are in place and documented. Training for Hot Box Charting and implementation of 24 Hour Communication Log was conducted 4.26.17. New order tracking system training and implementation was conducted 4.26.17. Care Managers will review care notes weekly and update as needed. Medication Aides and Care Managers will ensure documentation is in the residents records to include any contact with resident's Primary Care Provider regarding care needs for resident. Documentation of training available upon request. Training conducted by a licensed professional in coordination of the clinical support team.	4/27/17 4/27/17 4/27/17 4/27/17 4/27/17 4/27/17

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D 273	Continued From page 10 During the month of February 2017, medications were missed for three days for Resident #2. Review of the March 2017 MAR for Resident #2 on 3/22/17 revealed: -Four entries for Metoprolol 25 mg tablet were documented as "awaiting medication." -An entry for Metoprolol 25 mg tablet was documented as "had to reorder medication from the pharmacy, the wrong dosage was sent." During the month of March 2017, medications were missed for four days for Resident #2. Interview with the contracting Pharmacist for the facility on 3/28/17 at 9:45 a.m. revealed: -There was no record of the facility contacting the pharmacy or the back-up pharmacy. -The facility had contacted the pharmacy via fax on January 22, 2017 regarding missing medications Metoprolol 25 mg and Diazepam 2 mg. -The facility notified the pharmacy regarding missing medications via fax sent on January 22, 2017 but did not contact the backup pharmacy. -Metoprolol 25 mg and Diazepam 2 mg were dispensed on January 24, 2017 -The facility contacted the pharmacy on March 2, 2017 regarding missing medications Metoprolol 25 mg for Resident #2. -Metoprolol 25 mg was dispensed on March 2, 2017. -The pharmacy did not receive notification from the facility regarding the wrong doseage for Metoprolol being sent to the facility as documented on March 4, 2017 MAR. Interview with the physician for the facility on 3/28/17 at 9:00 a.m. revealed: -The physician was not notified by the facility	D 273	Medication Aides received training on the following , but not limited to: -notifying primary care provider -documentation -obtaining physician orders -medication administration tecniques -authorizations /orders required for crushing medications -safety -missed medications -medications not available -verifying consumption of medications Review was conducted by a licensed professional on 3/27/17. Additional training was conducted by a registered nurse on 4/15/17 & 4/16/17. Physician orders were sent to the primary care physician for review and signature.	4/27/17 4/27/17

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D 273	Continued From page 11 when Resident #2 did not receive medications as prescribed. -Metoprolol 25 mg was prescribed to treat high blood pressure and Diazepam 2 mg was prescribed to treat anxiety. -The physician wanted to be notified when Resident #2 missed any medications immediately. Review of Resident #2's Vital Signs form on 3/24/17 revealed: -In January 2017, blood pressures were documented as 152/85 on January 9, 2017, 145/78 on January 16, 2017, 152/83 on January 23, 2017, and 132/92 on January 30, 2017. -In February 2017, blood pressures were documented as 173/93 on February 6, 2017, 154/85 on February 13, 2017, 154/78 on February 20, 2017, and 116/64 on February 27, 2017. -In March 2017, blood pressures were documented as 154/80 on March 6, 2017, 177/92 on March 13, 2017, and 110/78 on March 20, 2017. Review of Care Notes for Resident #2 on 3/28/17 revealed no behaviors were documented for the months of January 2017 through March 27, 2017. Interview with a Medication Aide (MA) on 3/24/17 at 10:30 a.m. revealed: -She would check the residents' charts for any changes in medications. -If medications were not documented as administered on the medication administration record (MAR), she would check the back log for extras on the medication cart. -She would document the missing medication on the medication administration record (MAR) for the resident and inform the Resident Care	D 273		

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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 273	Continued From page 12 Coordinator (RCC) immediately. -She was not aware of a facility policy regarding when to notify the physician for missed medications. -She thought the RCC contacted the physician after being informed by the MAs'. -She could not specify when she had notified the RCC but thought she had. -She had not contacted the physician for any resident who had missed medications. Interview with a second Medication Aide (MA) on 3/27/17 at 11:10 a.m. revealed: -When a medication was not on the medication cart, she would notify the RCC to see if the medication had been discontinued or ordered already. -She would wait for the medication to come in from pharmacy during the week because the medication might have been reordered and just needed time to get to the facility. -She would wait "a couple of days" before contacting the pharmacy. -If it was on a weekend when a medication was not found on the cart, she would contact the pharmacy to get the medication in the facility. -She had not contacted the physician regarding missed medications. -She was unaware of a facility policy with timeframes to notify the physician but she would notify the physician for a resident after two days of missed medications. -She had not notified the physician regarding any residents who had missed medications. Interview with the RCC on 3/27/17 at 11:30 a.m. revealed: -She expected the MAs to immediately contact pharmacy when medications were not on the medication cart.	D 273		

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	HAL037001	A. BUILDING: _____ B. WING _____	03/28/2017

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D 273	Continued From page 13 -She could not specify when the MAs were informed by her to notify her immediately but said they were aware. -The backup pharmacy should be contacted immediately by the MAs after hours, on holidays, and weekends when medications were missing to get those medications in the facility as quickly as possible. -There was no facility policy with timeframes on when to notify the residents' physicians but she expected the physician to be notified after a resident had missed medications three consecutive days. -She notified the physician when informed by the MAs of missing medications. -She had not contacted the residents' physician regarding missed medications. Interview with the Administrator on 3/27/17 at 11:50 a.m. revealed: -She was not aware the residents' physician was not notified when medications were missed. -She expected the RCCs to monitor the MAs and ensure the physician was being notified when needed. -She would meet with the RCCs regarding missed medications and when to notify the physician. 2. Review of Resident #6's current FL-2 dated 10/11/16 revealed: -Resident #6's diagnoses included dementia, essential hypertension, and abnormal weight loss. -Resident #6 was intermittently disoriented with limited speech. -Resident #6's level of care was for the Special Care Unit. Review of a physician's order for Resident #6 dated 03/20/17 revealed:	D 273		

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D 273	Continued From page 14 -An order for two Risperidone 2 mg tablets at bedtime once daily (Risperidone was prescribed to treat behaviors). -An order for Sertraline 50 mg three tablets once daily (Sertraline was prescrided to treat behaviors). -An order for Aspirin 81 mg tablet once daily (Aspirin was prescribed to treat heat related problems. An order for Mirtazapine 15 mg tablet was prescribed to treat behaviors). Review of the Resident Register revealed an admission date of 02/11/16 for Resident #6. Review of the Resident #6's Service Plan dated 03/24/16 revealed the resident was disoriented and forgetful. Observation of Resident #6 in the large living room in the Special Care Unit on 03/21/17 at 3:20 p.m. revealed: -Resident #6 was in a group activity with her peers. Based on record review and interview, Resident #6 was not interview-able. Review of the January 2017 Medication Administration Record (MAR) for Resident #6 on 3/22/17 revealed: -An entry for Aspirin 81 mg tablet was documented as "awaiting medication." -An entry for Risperidone 2 mg tablet was documented as "med not in facility." During the month of January 2017, medications were missed for two days for Resident #6. Review of February 2017 MAR's for Resident #6	D 273		

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D 273	Continued From page 15 on 3/22/17 revealed: -An entry for Mirtazapine 15 mg tablet was documented as "awaiting medication." -Three entries for Risperidone 2 mg tablet were documented as "awaiting medication." -An entry for Risperidone 2 mg tablet was documented as "awaiting medication." During the month of February 2017, medications were missed for five days for Resident #6. Review of the March 2017 MAR for Resident #6 on 3/22/17 revealed: -Four entries for Risperidone 2 mg tablet were documented as "awaiting medication." -Three entries for Risperidone 2 mg tablet were documented as "awaiting medication." -An entry for Sertraline 50 mg tablet was documented as "awaiting medication." During the month of March 2017, medications were missed for eight days for Resident #6. Interview with the contracting Pharmacist for the facility on 3/28/17 at 9:45 a.m. revealed: -There was no record of the facility contacting the pharmacy or the back-up pharmacy. -The facility had contacted the pharmacy via fax on January 22, 2017 regarding missing medications Risperidone 2 mg. -The facility notified the pharmacy regarding missing medications via fax sent on January 22, 2017 but did not contact the backup pharmacy. -Risperidone 2 mg was dispensed on January 24, 2017 -The facility contacted the pharmacy via fax on March 2, 2017 regarding missing medication Risperidone 2 mg for Resident #6. -Risperidone 2 mg was dispensed on March 2, 2017.	D 273		

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D 273	Continued From page 16 -The pharmacy received no other notifications from the facility for Resident #6. Interview with the Physician for the facility on 3/28/17 at 9:00 a.m. revealed: -The physician was not notified by the facility when Resident #6 did not receive medications as prescribed. -The physician wanted to be notified when Resident #6 missed any medications as soon as possible. Review of Resident #6's Vital Signs form on 3/24/17 revealed: -In January 2017, blood pressures were documented as 129/95 on January 9, 2017, 135/114 on January 16, 2017, 133/99 on January 23, 2017, and 140/72 on January 30, 2017. -In February 2017, blood pressures were documented as 138/82 on February 6, 2017, 136/74 on February 13, 2017, 172/109 on February 20, 2017, and 125/96 on February 27, 2017. -In March 2017, blood pressures were documented as 124/74 on March 6, 2017, 139/104 on March 13, 2017, and 160/90 on March 20, 2017. Review of Care Notes for Resident #6 revealed no behaviors were documented for the months of January 2017 through March 27, 2017. Refer to Interview with a Medication Aide (MA) on 3/24/17 at 10:30 a.m. Refer to Interview with a second Medication Aide (MA) on 3/27/17 at 11:10 a.m. Refer to Interview with the RCC on 3/27/17 at 11:30 a.m.	D 273		

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D 273	Continued From page 17 Refer to Interview with the Administrator on 3/27/17 at 11:50 a.m. 3. Review of Resident #3's current FL-2 dated 09/16/16 revealed: -Resident #3's diagnoses included dementia with behavioral disturbances, constipation, anxiety disorder, somnolence, unspecified psychosis, essential hypertension, major depressive disorder, cerebral vascular accident, paranoid schizophrenia, unspecified convulsions, hyperlipidemia, and Alzheimer's disease. -Resident #3 was constantly disoriented and limited speech. -Resident #3's level of care was for the Special Care Unit. Review of the Resident Register revealed an admission date of 10/12/2015 for Resident #3. Review of the Resident #3's Service Plan dated 12/13/16 revealed: -Resident #3 was always disoriented, forgetful, and required 30 minute checks. Review of a Physician's Order for Resident #3 dated 03/20/17 revealed: -An order for Xanax 0.25mg three times a day after meals (Xanax is a medication used for anxiety and panic disorders). -An order for Olanzapine 10mg once daily (Olanzapine is a medication used to treat schizophrenia). Observation of a Medication Aide (MA) in the Special Care Unit (SCU) on 03/21/17 at 11:40am revealed: -The MA poured liquid from a clear medicine cup into a 12 ounce cup of tea.	D 273		

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D 273	Continued From page 18 -She stirred the tea with a straw and took the cup to Resident #3's room. -The MA placed the cup of tea on the nightstand next to Resident #3's bed. -She did not inform Resident #3 of any substances dissolved in the tea. -The MA did not attempt to offer the medications to Resident #3 before she dissolved it. Interview with the MA in the Special Care Unit on 03/21/17 at 11:43am revealed: -She had dissolved Resident #3's Xanax and put in her tea because it was the only way she could get the resident to take her medications. -Resident #3 refused to take any medications that staff offered unless the staff hid the medications in Resident #3's drinks. -She had been trained to dissolve Resident #3's medications in tea or milk in order to administer medications to Resident #3. -She had not attempted to administer Resident #3's medications in pill form because she believed Resident #3 would refuse to take the medications. -She did not know if Resident #3's primary care provider had been notified Resident #3 refused her medications. -She did not know if Resident #3's primary care provider was notified staff had to dissolve Resident #3's medications and put it in her drinks in order to get Resident #3 to take her medications. -She had not notified Resident #3's primary care provider of any medication refusals by Resident #3 or dissolving medications in the resident's drinks. Observation of a second MA in the Special Care Unit (SCU) on 03/22/17 at 9:30am revealed: -The MA dissolved 2 pills for Resident #3 in	D 273		

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D 273	Continued From page 19 approximately 5ml of water. -The MA poured the dissolved medication solution in to a cup that contained approximately 12 ounces of milk. -The MA took the cup of milk with the dissolved medication in Resident #3's room and left the cup on the nightstand. -No attempts were observed of the MA trying to get Resident #3 to take her medications prior to dissolving them in milk. -The MA did not tell Resident #3 that her milk contained medications. Interview with the second MA in the SCU on 03/22/17 at 9:35am revealed: -Mixing Resident #3's medications in her drinks was the only way she could get the resident to take her medications. -Resident #3 refused to take any medications that staff offered if the resident knew it was medication. -The MA had dissolved Xanax and Olanzapine in Resident #3's milk. Observation of the second MA on the SCU on 03/22/17 at 12:55pm revealed: -The MA dissolved a Xanax tablet in approximately 5ml of water for Resident #3. -The MA poured the dissolved medication solution into a cup that contained approximately 12 ounces of tea. -The MA left the cup of tea that contained the dissolved medication on the nightstand in Resident #3's room with her lunch tray. -No attempts were observed of the MA trying to get Resident #3 to take her medications prior to dissolving them in tea. -The MA did not tell Resident #3 that her tea contained medication.	D 273		

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D 273	Continued From page 20 Interview with the second MA on the SCU on 03/22/17 at 1:00pm revealed: -She had been trained by a previous Resident Care Coordinator to dissolve all of Resident #3's medications in her drinks to administer them. -Resident #3 refused to take any medications that was offered by staff. -Staff had to dissolve medications in pill form and mix them with Resident #3's drinks in order to get Resident #3 to take any of her medications. -Staff could not get Resident #3 to take any of her medications unless the staff hid the medications by dissolving the medications in her drinks. -She did not know if Resident #3's primary care provider had been notified of Resident #3's refusals or staff had to hide the medications in Resident #3's drinks. -She had not contacted Resident #3's primary care provider about dissolving medications for Resident #3. -Resident #3 did not have knowledge medications were dissolved in her drinks in order to administer her medications. Interview with the SCC on 03/22/17 at1:05pm revealed: -She was aware the MAs dissolved Resident #3's medications in her drinks in order to administer them. -She did not see anything wrong with MAs dissolving the medications in the Resident #3's drinks. -It was the only way the MAs were able to get Resident #3 to take any medications. -If Resident #3 knew staff dissolved medications in her drinks; then the resident would not drink it. -She had not notified Resident #3's primary care provider that Resident #3 refused her medications and staff had to hide Resident #3's medication in her drinks in order to get Resident	D 273		

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D 273	Continued From page 21 #3 to take them. -She would notify Resident #3's primary care provider on 03/22/17 regarding the refusals and staff having to hide medications in Resident #3's drinks in order to get the resident to take them. Interview with the Administrator on 03/22/17 at 1:20pm revealed: -She was not aware the MAs in the SCU dissolved medications in Resident #3's drinks. -She would talk with the SCC to see what other options could be done to get Resident #3 to take her medications. -The SCC would notify Resident #3's primary care provider. Interview with the Primary Care Provider (PCP) for Resident #3 on 03/24/17 at 5:35pm revealed: -His office had not been notified prior to 03/22/17 that Resident #3 refused to take her medications. -He did not know that staff had to hide medications in Resident #3's drinks in order to get her to take her medications. -He last saw Resident #3 on 02/20/17 during an onsite medical visit. -Staff did not inform the PCP when he saw Resident #3 on 02/20/17 that Resident #3 refused medications or staff hid Resident #3's medications in her drinks in order to administer them. -He would have liked to have been notified of the Resident #3's refusal of medications. -He would have tried other routes for Resident #3's medication administration if the facility had notified him of the problems with getting Resident #3 to take her medications. -He did not voice any concerns about Resident #3's medications being dissolved in her drinks. Review of a Facility Medication Aide In-Service	D 273		

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D 273	Continued From page 22 Report revealed: -The facility held a mandatory in-service on 03/24/17 with the SCC and 5 medication aides. -The medication aides must document all medication refusals in the resident's record. -The medication aides must call the resident's primary care provider after a resident has had refused 3 medication doses. The facility failed to notify the primary care provider of missed medication administration for 2 residents (#2, #6) for medications used to treat hypertension, control mental behaviors; and staff failed to notify the primary care provider of alleged medication refusals by 1 resident (#3) with dementia which resulted in staff dissolving medications in the resident's drinks for medication administration without the knowledge of the resident or primary care provider. The failure of the facility to notify the primary care provider of missed medication administration, alleged medication refusals, and dissolving medications without medical consultation resulted in substantial risk to the physical and mental well-being of the residents which constitutes a Type A2 Violation. Review of the Plan of Protection dated 03/28/17 revealed: The facility shall assure that referral and follow-up to meet the routine and acute health care need of residents. -In-Service for Medication Aides held on notification and documentation to physicians. -Medication Aides and Care Managers will ensure documentation is in the resident's records with any contact with resident's physician regarding the care needs of the residents. -Care Manager will review care notes weekly and update as needed.	D 273		

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D 273	Continued From page 23 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 27, 2017.	D 273		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure any substitutions made in the menu to be of equal nutritional value, appropriate for the regular diet and modified diets (No Added Salt [NAS], Low Added Salt (LAS), No Added Table Salt (NATS), Pureed, Chopped, and Mechanical Soft diets for 8 of 8 sampled residents. The findings are: Observation of the kitchen on 03/21/2017 at 11:53 a.m. revealed: -There was a food substitution log posted in the kitchen. -The facility did not have a list of dietician approved substitutions to make substitution selections. -Therapeutic menus were not maintained in the kitchen or available for staff guidance for a Mechanical Soft diet, a Pureed diet, a No Added Salt diet, a No Added Table Salt diet, and a Low Added Salt diets.	D 292	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of Gates House to provide menus in accordance to rule 10A NCAC 13F.0904 Nutrition and Food Service. Training on preparing modified textured altered diets was completed with dietary staff on 5/3/17 by the Corporate Director of Food Services. Approved dietitian substitution list or of equal value was posted and available to all dietary staff on 5/3/17. Training provided by the Corporate Director of Food Service. Chart Audits were completed to ensure all diet orders are of the Affinity approved diet order form. New diet orders were sent to the primary care provider for review and signature.	5/3/17 5/3/17 5/3/17

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D 292	Continued From page 24 Review of Resident #2's Diet Order dated and signed by the physician on 02/10/17 revealed a diet order for a no added salt diet. Review of Resident #5's Diet Order dated and signed by the physician on 3/20/17 revealed a diet order for a mechanical soft/regular diet. Review of Resident #7's Diet Order dated and signed by the physician on 02/09/17 revealed a diet order for a pureed diet. Review of Resident #9's Diet Order dated and signed by the physician on 01/23/17 revealed a diet order for a modified chopped diet. Review of Resident #10's Diet Order dated and signed by the physician on 01/05/17 revealed a diet order for a regular with a no added salt diet. Review of Resident #11's Diet Order dated and signed by the physician on 10/03/16 revealed a diet order for a regular low salt diet. Review of Resident #12's Diet Order dated and signed by the physician on 03/20/17 revealed a diet order for a mechanical soft diet with chopped meats only. Review of Resident #13's Diet Order dated and signed by the physician on 03/03/17 revealed a diet order for a dysphagia diet level 2. Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. revealed: -The facility did not have therapeutic diet menus. -She told the cook what modified diet was ordered for each resident. -She followed the regular diet menu for all	D 292	Corporate Director of Food Service conducted training on 5/3/17 in reference to therapeutic menus and resident diet orders being available to all dietary employees to use a reference when preparing and providing therapeutic meals. 5/3/17 Master copy of the physician order diet list will be kept in the dietary department for easy access and will be maintained by the Dietary Manager. 5/3/17 Dietary Manager will randomly supervise & monitor food substitutions per approved substitution list, use and availability of therapeutic menus, and ensure that meals are serviced per physician ordered diets. 5/3/17	

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D 292	Continued From page 25 therapeutic diets. -The facility did not have a dietician approved substitution listing to select substitutions. Interview with the Cook on 03/21/17 at 12:20 p.m. revealed: -The facility did not have a therapeutic diet listing. -She followed the regular diet menu to prepare meals for each resident. -She was not aware if there was an approved substitution listing to select substitutions from when needed. Review of the "Regular Menu for Gates House" dated 3/22/17 revealed: -The dietician signed the regular menu on 1/08/17. -The regular menu was for Monday through Sunday. -The regular diet menu did not have modified diets, portion sizes or quantities specified. -The regular menu was located in a book in the kitchen area. -The lunch meal included "sloppy joes, green beans, baked seasoned squash, garlic bread sticks, ice cream milk, and beverage of choice. There were no Low Salt Diet, No Added Salt diet, No Added Table Salt diet, Pureed diet, Chopped diet, and Mechanical Soft diet menus available. Observations of the lunch meal on 03/21/17 at 12:10 p.m. revealed the baked seasoned squash was substituted with cheese chips and documented on the substitution log. Review of the facility Substitution Log on 3/21/17 revealed: -On 12/19/17, grilled chicken was substituted with broccoli soup.	D 292		

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D 292	Continued From page 26 -The reason noted for the substitution was "had already." -On 1/01/17, corn was substituted with French fries. -The reason noted for the substitution was "no corn." -On 1/30/17, pork chops were substituted with ravioli. -The reason noted for the substitution was "no pork chops," -On 3/21/17, baked seasoned squash was substituted with cheese chips for the lunch meal. -There was no reason noted for the substitution on the log. Observation of a breakfast meal on 03/22/17 at 8:40 a.m. revealed residents were served pancakes, eggs, bacon, fruit, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. The substitution of sausage for bacon was documented on the substitution log. Second interview with the Dietary Manager on 03/22/17 at 4:30 p.m. revealed: -She followed the regular menu to prepare all meals for all of the residents. -She thought it was "okay" to substitute cheese chips for baked seasoned squash. -She knew the residents liked the cheese chips and would not mind the substitution. -She did not have time to unpack the delivered canned goods with vegetables from that morning. -She did not have therapeutic diet menus available to follow. -All residents received the same food items and portions. -The substitution for one of the vegetables for the lunch meal was documented on the substitution log. -She served bacon to all of the residents because	D 292		

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D 292	Continued From page 27 the residents had "already had sausage." -She made sure the bacon was as soft as possible for those residents with a modified diet. -There was no approved substitution listing for her to follow to make appropriate substitutions. -She had completed food service orientation. Interview with the Administrator on 03/23/17 at 12:23 p.m. revealed: -She was unaware the facility did not have therapeutic menus for residents. -She was not aware regular diet menus were followed for all residents. -The meals were supposed to be prepared according to the residents physician ordered diets. -She wanted all substitutions in food items to be made according to nutritional guidelines. -She was not aware that food substitution listings for appropriate substitutions were needed for reference for food service staff. -The facility would get a food substitution listing for substitutions from their Dietitian.	D 292	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets for 6 of 8	D 309	It is the policy of Gates House to serve Therapeutic Diets in accordance with rule 10A NCAC 13F.0904 (e)(3)Nutrition and Food Service.	

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D 309	Continued From page 28 sampled residents (#5, #9, #10, #11, #12, and #13) prescribed therapeutic diets including No Added Salt (NAS), Low Added Salt (LAS), No Added Table Salt (NATS), Pureed, Chopped, and Mechanical Soft diets for the guidance of food service staff The findings are: 1. Review of Resident #5's current FL-2 dated 03/20/16 revealed: -Diagnoses included dementia, nonthematic mitral valve prolapse, essential hypertension, anxiety disorder, and gastro esophageal reflux disease. -There was an order for a regular diet. Review of Resident #5's diet order dated and signed by the physician on 3/20/17 revealed a diet order for a mechanical soft/regular diet. Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #5 was served a regular diet which included one pancake, scrambled eggs, two strips of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. Based on record review and interview, Resident #5 was not interview-able. Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #5 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. Record review of the Resident Register dated	D 309	Chart Audits were completed to ensure all diet orders are of the Affinity approved diet order form. New diet orders were sent to the primary care provider for review and signature. 5/3/17 Master copy of the physician order diet list will be kept in the dietary department for easy access and will be maintained by the Dietary Manager. 5/3/17 Corporate Director of Food Service conducted training on 5/3/17 in reference to therapeutic menus, types of diet orders, resident diet orders being available to all dietary employees to use a reference when preparing and providing therapeutic meal. 5/3/17	

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D 309	Continued From page 29 12/18/08 revealed the resident was admitted to the facility on 12/18/08. Observations of the kitchen and dining room areas on 3/21/17 revealed there was no therapeutic diet list available for guidance of dietary staff. Interview with Resident #5's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed: -There was a signed and dated physician's order on 3/20/17 for a mechanical soft diet. -The physician was not aware a therapeutic diet was not being served. Refer to Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. Refer to Interview with the Cook on 03/21/17 at 12:20 p.m. Refer to Interview with the Resident Care Coordinator (RCC) on 3/27/17 at 11:10 a.m. Refer to Interview with the Administrator on 03/23/17 at 12:23 p.m. 2. Review of Resident #9's current FL-2 dated 11/15/16 revealed: -Diagnoses included dementia, Alzheimer's disease, hypertension, hyperlipidemia, gastro esophageal reflux disease, hearing loss, depression, benign localized hyperplasia prostate, and constipation. -The resident was intermittently disoriented. -There was an order for a regular diet. Review of Resident #9's diet order dated and signed by the physician on 01/23/17 revealed a	D 309	Dietary Manager will randomly supervise & monitor food substitutions per approved substitution list, use and availability of therapeutic menus, and ensure that meals are serviced per physician ordered diets.	5/3/17

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D 309	Continued From page 30 diet order for a modified chopped diet. Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #9 was served a regular diet which included one pancake, scrambled eggs, two strips of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. Based on record review and interview, Resident #9 was not interview-able. Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #9 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. Interview with Resident #9's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed: -There was a signed and dated physician's order on 3/20/17 for a chopped diet. -The physician was not aware a therapeutic diet was not being served. Refer to Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. Refer to Interview with the Cook on 03/21/17 at 12:20 p.m. Refer to Interview with the Resident Care Coordinator (RCC) on 3/27/17 at 11:10 a.m. Refer to Interview with the Administrator on 03/23/17 at 12:23 p.m. 3. Review of Resident #10's current FL-2 dated	D 309		

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D 309	Continued From page 31 07/12/16 revealed: -Diagnoses included sepsis, urinary tract disorder, kidney disease, bipolar disorder, hypothermia, and schizophrenia. -The resident was intermittently disoriented. -There was an order for a regular diet. Review of Resident #10's Diet Order dated and signed by the physician on 01/05/17 revealed a diet order for a regular with no added salt diet. Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #10 was served a regular diet which included one pancake, scrambled eggs, two strps of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. Based on record review and interview, Resident #10 was not interview-able. Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #10 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. Interview with Resident #10's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed: -There was a signed and dated physician's order on 3/20/17 for a No Added Salt diet. -The physician wanted the resident to receive a therapeutic diet. -The physician was not aware a No Added Salt diet was not being served. Refer to Interview with the Dietary Manager on 03/21/17 at 12:00 p.m.	D 309		

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D 309	Continued From page 32 Refer to Interview with the Cook on 03/21/17 at 12:20 p.m. Refer to Interview with the Resident Care Coordinator (RCC) on 3/27/17 at 11:10 a.m. Refer to Interview with the Administrator on 03/23/17 at 12:23 p.m. 4. Review of Resident #11's current FL-2 undated and unsigned revealed: -Diagnoses included dementia, Alzheimer's, hypertension, heart disease, and osteoarthritis. -The resident was intermittently disoriented. -There was an order for a regular diet. Review of Resident #11's diet order dated and signed by the physician on 10/03/16 revealed a diet order for a regular low salt diet. Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #11 was served a regular diet which included one pancake, scrambled eggs, two strips of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. Based on record review and interview, Resident #11 was not interview-able. Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #11 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. Interview with Resident #11's primary physician's	D 309		

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D 309	Continued From page 33	D 309		

nurse on 03/28/17 at 9:30 a.m. revealed:
-There was a signed and dated physician's order on 10/03/16 for a low salt diet.
-The physician wanted the resident to receive a therapeutic diet and was not aware it was not being served.

Refer to Interview with the Dietary Manager on 03/21/17 at 12:00 p.m.

Refer to Interview with the Cook on 03/21/17 at 12:20 p.m.

Refer to Interview with the Resident Care Coordinator (RCC) on 3/27/17 at 11:10 a.m.

Refer to Interview with the Administrator on 03/23/17 at 12:23 p.m.

5. Review of Resident #12's current FL-2 dated 03/20/17 revealed:
-Diagnoses included dementia, Alzheimer's with behavioral disturbance, hypertension, hypothyroidism, hyperlipidemia, gastro esophageal reflux disease, anxiety, depression, and osteoarthritis.
-The resident was constantly disoriented.
-There was an order for a chopped meats diet.

Review of Resident #12's diet order dated and signed by the physician on 3/20/17 revealed a diet order for a mechanical soft diet with chopped meats only.

Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #12 was served a regular diet which included one pancake, scrambled eggs, two strips of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk.

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D 309	Continued From page 34 Based on record review and interview, Resident #12 was not interview-able. Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #12 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. Interview with Resident #12's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed: -There was a signed and dated physician's order on 3/20/17 for a mechanical soft diet with chopped meats. -The physician wanted the resident to receive a therapeutic diet. Refer to Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. Refer to Interview with the Cook on 03/21/17 at 12:20 p.m. Refer to Interview with the Resident Care Coordinator (RCC) on 3/27/17 at 11:10 a.m. Refer to Interview with the Administrator on 03/23/17 at 12:23 p.m. 6. Review of Resident #13's current FL-2 dated 03/13/16 revealed: -Diagnoses included dementia, heart failure, cerebral infraction, anxiety, and peripheral vascular disease. -The resident was constantly disoriented. -There was no diet order for the resident documented.	D 309		

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D 309	Continued From page 35 Review of Resident #13's diet order dated and signed by the physician on 3/03/17 revealed a diet order for a dysphagia diet level 2. Interview with Resident #13's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed: -There was a signed and dated physician's order on 3/03/17 for a dysphagia diet level 2. -The physician wanted the resident to receive a therapeutic diet. Resident #13 was hospitalized during this survey due to sickness and was not observed during mealtimes. Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. revealed: -The facility did not have therapeutic diet menus. -She told the cook what modified diet was ordered for each resident based on her memory. -She followed the regular diet menu for all therapeutic diets. -She thought the residents received a regular diet. Interview with the Cook on 03/21/17 at 12:20 p.m. revealed: -She was unaware if the facility had a therapeutic diet menu. -She followed the regular diet menu to prepare meals for all residents. -She thought residents received a regular diet. Interview with the Resident Care Coordinator (RCC) on 3/27/17 at 11:10 a.m. revealed: -She was responsible for updating the facility diet list. -The facility diet list needed to be updated. -She was not sure when the diet list was last	D 309		

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D 309	Continued From page 36 updated. -She was not aware of any resident receiving a therapeutic diet. -There were no therapeutic diets offered or available in the facility. Interview with the Administrator on 03/23/17 at 12:23 p.m. revealed: -She was unaware the facility did not have therapeutic diet menus for residents. -She was not aware regular diet menus were followed for all residents. -The residents' meals were supposed to be prepared according to the residents' physician ordered diets. -The Administrator was not aware there was a physician's order for a modified diets. -The facility would follow residents current physician orders and clarify as needed to better meet what the facility offered.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served to 3 of 8 residents sampled (#5, #9, and #12) with orders for a mechanical soft diet with chopped meats and chopped diets.	D 310	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of Gates House to serve Therapeutic Diets in accordance with rule 10A NCAC 13F.0904 (e) (4)Nutrition and Food Service.	

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D 310	Continued From page 37 The findings are: 1. Review of Resident #5's current FL-2 dated 03/20/16 revealed: -Diagnoses included dementia, nonthematic mitral valve prolapse, essential hypertension, anxiety disorder, and gastro esophageal reflux disease. -The resident was constantly disoriented. -There was an order for a regular diet. Review of Resident #5's Diet Order dated and signed by the physician on 3/20/17 revealed a diet order for a mechanical soft/regular diet. Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #5 was served a regular diet which included one pancake, scrambled eggs, two strips of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. Based on record review and interview, Resident #5 was not interview-able. Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #5 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. During mealtime observations, Resident #5 did not experience difficulty with chewing and swallowing while eating. Confidential interviews with four staff members revealed: -All residents were served regular diets except for	D 310	Training on preparing modified textured altered diets was completed with dietary staff. Training provided by the Corporate Director of Food Service on 5/3/17. Approved dietitian substitution list or of equal value was posted and available to all dietary staff on 5/3/17. Chart Audits were completed to ensure all diet orders are of the Affinity approved diet order form. New diet orders were sent to the primary care provider for review and signature. Master copy of the physician order diet list will be kept in the dietary department for easy access and will be maintained by the Dietary Manager. Corporate Director of Food Service conducted training on 5/3/17 in reference to therapeutic menus, types of diet orders, resident diet orders being available to all dietary employees to use a reference when preparing and providing therapeutic meal.	5/3/17 5/3/17 5/3/17 5/3/17 5/3/17

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D 310	Continued From page 38 one resident who received a pureed diet. -Every resident's food on their plates looked the same to them. -They thought all of the resident's plates were supposed to "look alike so no one resident would have something different on their plate than another resident." -Resident #5 had received a regular diet with no modifications. -Resident #5 did not seem to have any problems while eating. -The staff were not aware Resident #5 had an order for a modified diet. Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. revealed: -The facility did not have therapeutic diet menus. -She told the cook what modified diet was ordered for each resident. -She followed the regular diet menu for all therapeutic diets. -Resident #5 received a regular diet. Interview with the Cook on 03/21/17 at 12:20 p.m. revealed: -She was unaware if the facility had a therapeutic diet listing or menu. -She followed the regular diet menu to prepare meals for all residents. -She thought Resident #5 received a regular diet. Interview with Resident #5's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed: -There was a signed and dated physician's order on 3/20/17 for a mechanical soft diet. -The physician was not aware a modified diet was not being served. Interview with the Administrator on 03/23/17 at 12:23 p.m. revealed:	D 310	Dietary Manager will randomly supervise & monitor food substitutions per approved substitution list, use and availability of therapeutic menus, and ensure that meals are serviced per physician ordered diets.	5/3/17

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D 310	Continued From page 39 -She was unaware the facility did not have therapeutic menus for residents. -She was not aware regular diet menus were followed for all residents. -The residents' meals were supposed to be prepared according to the residents physician ordered diets. -The Administrator was not aware there was a physician's order for a modified diet for Resident #5. -The facility would follow Resident #5's current physician order for a mechanical soft diet and clarify the resident's diet with the physician and dietician as soon as possible to better meet what the facility offered. 2. Review of Resident #9's current FL-2 dated 11/15/16 revealed: -Diagnoses included dementia, Alzheimer's disease, hypertension, hyperlipidemia, gastro esophageal reflux disease, hearing loss, depression, benign localized hyperplasia prostate, and constipation. -The resident was intermittently disoriented. -There was an order for a regular diet. Review of Resident #9's Diet Order dated and signed by the physician on 01/23/17 revealed a diet order for a chopped diet. Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #9 was served a regular diet which included one pancake, scrambled eggs, two strips of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. Based on record review and interview, Resident #9 was not interview-able.	D 310		

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D 310	Continued From page 40 Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #9 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. During mealtime observations, Resident #9 did not experience difficulty with chewing or swallowing while eating. Confidential interviews with four staff members revealed: -All resident diets were served a regular diets except for the one resident who received a Pureed diet. -Every resident's food on their plates looked the same to them. -They thought all of the resident's plates were supposed to "look alike so no one resident would have something different on their plate than another resident." -Resident #9 received a regular diet with no modifications. -The staff were not aware Resident #9 had an order for a modified diet. Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. revealed: -The facility did not have therapeutic diet menus. -She told the cook what modified diet was ordered for each resident. -She followed the regular diet menu for all therapeutic diets. -Resident #9 received a regular diet. Interview with the Cook on 03/21/17 at 12:20 p.m. revealed: -She was unaware if the facility had a therapeutic	D 310		

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D 310	Continued From page 41 diet listing or menu. -She followed the regular diet menu to prepare meals for all residents. -She thought Resident #9 received a regular diet. Interview with Resident #9's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed there was a signed and dated physician's order on 3/20/17 for a chopped diet. Interview with the Administrator on 03/23/17 at 12:23 p.m. revealed: -She was unaware the facility did not have therapeutic menus for residents. -She was not aware regular diet menus were followed for all residents. -The residents' meals were supposed to be prepared according to the residents physician ordered diets. -The Administrator was not aware there was a physician's order for a modified diet for Resident #9. -The facility would follow Resident #9's current physician order for a chopped diet and clarify the resident's diet order with the physician and dietician as soon as possible to better meet what the facility offered. 3. Review of Resident #12's current FL-2 dated 03/20/17 revealed: -Diagnoses included dementia, Alzheimer's with behavioral disturbance, hypertension, hypothyroidism, hyperlipidemia, gastro esophageal reflux disease, anxiety, depression, and osteoarthritis. -The resident was constantly disoriented. -There was an order for a chopped meats diet. Review of Resident #12's Diet Order dated and signed by the physician on 3/20/17 revealed a	D 310		

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D 310	Continued From page 42 diet order for a mechanical soft diet with chopped meats only. Observation of the breakfast meal on 03/22/17 at 8:40 a.m. revealed Resident #12 was served a regular diet which included one pancake, scrambled eggs, two strips of bacon, sliced peaches, 8 ounces of juice, 8 ounces of water, and 8 ounces of milk. Based on record review and interview, Resident #12 was not interview-able. Observation of the lunch meal on 03/22/17 at 12:15 p.m. revealed Resident #12 was served a regular diet which included tuna salad on two slices of whole bread, french fries (whole), broccoli and carrots mixed vegetables, mixed fruit cup, and 8 ounces unsweet tea, and 8 ounces of water. During mealtime observations, Resident #12 did not have difficulty chewing or swallowing while eating. Confidential interviews with four staff members revealed: -All resident diets were regular diets except for the one resident who received a Pureed diet. -Every resident's food on their plates looked the same to them. -They thought all of the resident's plates were supposed to "look alike so no one resident would have something different on their plate than another resident." -Resident #12 had always received a regular diet with no modifications. -The staff were not aware the resident had an order for a modified diet.	D 310		

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D 310	Continued From page 43 Interview with the Dietary Manager on 03/21/17 at 12:00 p.m. revealed: -The facility did not have therapeutic diet menus. -She told the cook what modified diet was ordered for each resident. -She followed the regular diet menu for all therapeutic diets. -Resident #12 received a mechanical soft diet. Interview with the Cook on 03/21/17 at 12:20 p.m. revealed: -She was unaware if the facility had a therapeutic diet listing or menu. -She followed the regular diet menu to prepare meals for all residents. -She thought Resident #12 received a "regular diet." Interview with Resident #12's primary physician's nurse on 03/28/17 at 9:30 a.m. revealed: -There was a signed and dated physician's order on 3/20/17 for a mechanical soft diet with chopped meats. -The physician wanted the resident to receive a therapeutic diet. -The physician was not aware a modified diet was not being served. Interview with the Administrator on 03/23/17 at 12:23 p.m. revealed: -She was unaware the facility did not have therapeutic menus for residents. -She was not aware regular diet menus were followed for all residents. -The residents' meals were supposed to be prepared according to the residents physician ordered diets. -The Administrator was not aware there was a physician's order for a modified diet for Resident #12.	D 310		

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D 310	Continued From page 44 -The facility would follow Resident #12's current physician order for a mechanical soft diet with chopped meats and clarify the resident's diet with the physician and dietician as soon as possible to better meet what the facility offered.	D 310		
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: TYPE A1 VIOLATION Based on interviews, the facility failed to assure 2 of 6 residents sampled were free of physical and mental abuse as evidenced by reports of alleged mental and physical abuse by Staff A, Staff B, and Staff D. The finding are: 1. A confidential interview with a resident revealed: -The resident witnessed Staff A pull and yank another resident by both arms while this resident was in a wheelchair in the hallway area of the assisted living side. -The resident who was yanked by Staff A cried and asked repeatedly for Staff A to stop. -Staff A was yelling and cursing at this resident and said, "Get the [expletive] up, get your [expletive] up." -Staff A "fussed, cursed, and put her hands" on	D 338	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of Gates House to ensure all residents are free from any mental, physical abuse, exploitation or neglect as in accordance to GS 131D-21 & 10A NCAC 13F .0909 Resident Rights. Previous Executive Director conducted an inservice& training on reporting of any abuse or neglect 3.27.17. Review of Declaration of Resident Rights was conducted with employees on 4/24/17 by clinical support staff.	4/27/17 4/27/17

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D 338	Continued From page 45 this same resident several times (unable to specify a timeframe). -The resident saw Staff A "shove and push" on the same resident in the wheelchair. -The assaulted resident asked Staff A "over and over again" to stop shoving and pushing because it hurt. -Staff A responded to the assaulted resident "you just don't like me because I'm black." -The resident did not tell anyone what she witnessed Staff A did to the other resident so not to get in trouble. -Staff A did not bother the reporting resident because the resident would speak up for themselves and tell the Administrator and family about any staff mistreatment. -The assaulted resident was treated that way by Staff A because the resident would not speak up. A confidential interview with a second resident revealed: -The resident heard Staff A yelling loudly and cursing at same resident saying, "shut the [expletive] up, be quiet." -The resident heard other resident crying and asking Staff A to stop. -The resident did not witness this same resident being mistreated but heard when the resident cried out, Staff A yelling and cursing, and the sounds of furniture being moved around. -It sounded like a struggle was taking place in the resident's bedroom. -The resident was unable to specify how often or when it happened, but said it happened often. -Staff A and no other staff "messed with me because I keep to myself." -The resident did not report what was happening to the other resident because "It was best to mind my own business."	D 338	Note: Additional training requested: Ombudsman contacted to provide additional training. The first available dates are as follows; 1)Elder Abuse Training-Offsite on 5/11/17 for select personnel. 2)Sensitivity Training scheduled for 6/20 & 6/30/17 with the Ombudsman onsite. These were the first dates the Ombudsman had available. Body evaluations and assessments completed on all residents. Any areas of concern were forwarded to the primary care provider for review. Training provided on personal care, hygiene, dignitry and respect. Training conducted by licensed nurse on 4/26/17. Aides were competency revalidated on personal care skills by a registered nurse on 4/16 & 4/17/17.	4/27/17 4/27/17 4/27/17

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D 338	Continued From page 46 Confidential interviews with a third and fourth resident revealed: -They heard the same resident cry out for Staff A to stop because the same resident was being hurt. -They heard Staff A curse, fuss, and said "get your [expletive] up, shut the [expletive] up" to this same resident. -They had not witnessed the resident being mistreated but had heard the same resident being mistreated by Staff A several times and could not specify a timeframe or how often. -They did not report anything to anyone regarding these incidents with Staff A and could not explain why. A confidential interview with the allegedly assaulted resident revealed: -Staff A worked at night and the resident was "treated badly" by Staff A. -Staff A would yell and used profanity at the resident several times (unable to specify). -Staff A's behaviors made the resident feel bad. -The resident had asked Staff A to stop with the mistreatment but Staff A would not stop. -Staff A had pulled the resident by arms on many occasions and pushed the resident roughly. -The resident could not specify how many and how often that occurred. -The resident could not understand Staff A's mistreatment of the resident. -Maybe Staff A had personal problems or was tired of working at night. -Staff A must have something against the resident but the resident did not know what it was. -Staff A would yell to "hurry up" because the resident moved slowly. -The resident had asked Staff A to stop hurting and yelling countless times but nothing had changed.	D 338	Additional training was provided to include, but not limited to; -Reporting abuse, neglect and exploitation allegations -Corporate policy on abuse, neglect and exploitation -Health Care 24 hour and 5 day reports -Resident Relations and Human Resource Hotline Posting reviewed and verified -NC Adult Care Licensing/DHSR complaint number reviewed and verified posting -Consequences reviewed for failure to ensure Resident Rights to be free from abuse and neglect Training conducted by support staff. Documentation of training available upon request in the front office. Complaint box is located in the front lobby that provides three avenues to voice concerns ,which include notification to the administrator, calling resident relations hotline and mailing concerns to the corporate office. This system also allows for anonymous reporting of concerns.	4/27/17 4/27/17

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D 338	Continued From page 47 -The resident told the "lady in the office" and other staff but could not remember when or who the staff were. -The resident did not want any more trouble and decided to deal with how Staff A treated the resident and "not say anything anymore." A confidential telephone interview with a staff member revealed: -Staff A had been verbally and physically abusive to a resident. -The staff member had witnessed Staff A pulling, pushing, and handling the resident in a rough manner. -The staff member heard the resident cry out for Staff A to stop because Staff A was hurting the resident. -The staff member had heard Staff A cursing and yelling at the resident to "get the [expletive] up." -The staff member reported the incidents to the Administrator. A second confidential telephone interview with the same staff member revealed: -Staff A was verbally and mentally abused to residents. -Staff A referred to a resident as a "pain in the butt" because he complained all the time of not feeling well (Time Frame around October - November 2016). -The staff member heard Staff A being loud and verbally abusive to the residents. -Staff A had been verbally abusive to residents several times but the staff member could not recall how many times or how many residents. -Staff A yelled at the residents when they asked for assistance. -Examples given were: "What do you want now?", Why do you keep calling me?", "Why do you keep ringing that call bell?", "You keep ringing that bell	D 338		

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D 338	Continued From page 48 and I am going to stop coming." -The staff member reported to the Administrator that Staff A yelled at the residents in 9/2016. -The Administrator did not do anything about Staff A yelling at the residents. Confidential telephone interview with a second staff member revealed: -A resident had told her that Staff A would be mean to the resident. -Staff A would holler and curse at the resident about taking so long to get in and out of the bed. -The resident said Staff A would pick the resident up and slam the resident down in the bed and the wheel chair when being transferred. -The resident had been complaining about this for about 3-4 months. -She had reported this information to the Resident Care Coordinator (RCC). -She had only reported to the RCC (could not specify when she reported to the RCC). -The RCC was going to talk with Staff A and the resident about the accusations. -She had never seen any bruises on the resident. -No other residents had complained to her about Staff A. Confidential telephone interview with the allegedly assaulted resident family member revealed: -The family member denied concerns or complaints related to how a staff member treated the resident because of the resident's dementia diagnosis. -The resident seemed happy when the family visited at the facility. -The resident had mentioned during a visit around the Christmas holidays that a staff member had fussed at the resident. -The family member had tried to question the resident more about this incident.	D 338		

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D 338	Continued From page 49 -The resident seemed to have forgotten about the incident and the family member left the subject alone. -The family was unaware of any mistreatment of the resident by the facility staff. Review of the facility's "Staff Training Folder" revealed: -Staff A received a certificate of completion for the "AHHC Elderly Abuse and Neglect Training on June 17, 2012. -Staff A received a certificate of continuing education completion for "Abuse 1" training on 11/25/16. -Staff A received a certificate of continuing education completion for "Abuse 2" training on 11/19/16. 2. A confidential telephone interview with a staff member revealed: -The staff member stated she witnessed Staff B physically abuse a resident in late January/early February 2017. -The staff member was not able to remember the name of the resident from that episode. -The resident was in the sitting area on the assisted living sided but was not ready for bed. - Staff B grabbed the resident up from the chair and forced the resident to go down to the resident's room. -Staff B then slammed the resident down in the bed (No injury reported). -Resident did not want to go to bed. -Staff did not report this incident to the Administrator because the Administrator always made excuses to justify Staff B's behaviors. A second confidential telephone interview with the same staff member revealed: -Staff B always had an attitude and was rude	D 338		

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D 338	Continued From page 50 when she worked with the residents. -Staff B yelled and her tone of voice was mean when she spoke to the residents. -Staff B would say "I ain't gonna do nothing for you, you better get up and do it yourself" to the residents. -If a resident did not move fast enough when Staff B told them to move then Staff B would pull or grab on the resident to make them do whatever she wanted. -Staff Member could not specify when Staff B pulled or what resident was pulled on. -Staff Member did not specify if the Administrator or Resident Care Coordinator (RCC) was notified for this incident. -Staff Member could not specify how many times these incidents occurred with the other residents in the facility. -Staff Member did recall two residents Staff B handled roughly repeatedly. -Staff Member witnessed Staff B slam one of these residents in the bed sometime before Christmas 2016. -Staff Member reported the incident to the Administrator and the RCC the day after it occurred. -The Administrator nor the RCC did anything about the event that was reported. -Staff B refused to give snacks to residents if the residents did not do what Staff B wanted. 3. A confidential telephone interview with a staff member revealed: -Staff D who worked in the Special Care Unit had been physically abusive to a resident in 12/2016. -Resident did not want to go bed so Staff D grabbed this resident under the arms. -Staff D dragged the resident down the hallway. -Staff D slammed the resident in the bed when Staff D got to the resident's room.	D 338		

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D 338	Continued From page 51 -Staff member did report this incident to the Administrator in 12/2016 but no actions were taken. Interview with the Resident Care Coordinator on 03/24/17 at 11:55am revealed: -A resident had complained to another staff member about Staff A being rough with her and cussing and hollering at her. -Staff A had told the RCC the resident was about to fall and Staff A grabbed to the resident to keep the resident from falling. -The RCC believed that what was meant by Staff A being rough with the resident. -The resident denied Staff A being verbally or physically abusive. -She would never allow any of the residents to be abused. -If the resident had given her any other story then Staff A would have been terminated. -She does not allow anyone who provides minimal care or has a bad attitude. Interview with the Administrator on 03/24/17 at 12:51 pm revealed: -She had worked at the facility since July 2016 as the Administrator. -She followed the state policy for reporting incidents of abuse and neglect. -She suspended and removed a staff person during her investigation. If substantiated, then the staff person would be fired. -No one had reported any physical or mental abuse to her involving any other resident. She would not tolerate it. -When she heard about one resident from staff, she immediately removed the Staff A for two days and conducted her own internal investigation. -Staff were trained annually on residents' rights and should have known better than to harm any	D 338		

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D 338	Continued From page 52 resident or speak to them in a disrespectful way. -She would ensure all staff received training on abuse and neglect of the residents immediately. The facility failed to assure the mental and physical wellbeing of the residents. The failure of the facility to ensure the residents were free of physical constitutes a Type A1 Violation. Review of the Plan of Protection dated 03/24/17 revealed: The facility will ensure that residents are free from any mental, physical abuse, exploitation, or neglect. -Any staff that is reported to have any allegations of abuse or neglect, will be suspended, reported to registry by 3/24/17. -Administrator will conduct training on reporting abuse and neglect by 3/27/17. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 27, 2017.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358		

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D 358	Continued From page 53 TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to observe the medication administration of 1 of 6 sampled resident (#3) as evidenced by staff dissolving medications (that included a narcotic) in tea and/or milk and leaving the dissolved medication mixture in the resident's room unattended without verification of the resident taking the medication(s). The findings are: Review of Resident #3's current FL-2 dated 09/16/16 revealed: -Resident #3's diagnoses included dementia with behavioral disturbances, constipation, anxiety disorder, somnolence, unspecified psychosis, essential hypertension, major depressive disorder, cerebral vascular accident, paranoid schizophrenia, unspecified convulsions, hyperlipidemia, and Alzheimer's disease. -Resident #3 was constantly disoriented and limited speech. -Resident #3's level of care was for the Special Care Unit. Review of the Resident Register revealed an admission date of 10/12/2015 for Resident #3. Review of a Physician's Order for Resident #3 dated 03/20/17 revealed: -An order for Xanax 0.25mg three times a day after meals (Xanax is a medication used for anxiety and panic disorders). -An order for Olanzapine 10mg once daily (Olanzapine is a medication used to treat schizophrenia).	D 358	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of Gates House to assure rule is met in accordance to 10A NCAC 13F .1004(a) Medication Administration. Training was provided to 5 medication aides on 3/24/17 to provide guidance and direction on observing residents take their medications and not leaving medications unattended at any time. Training was conducted by the previous administrator in coordination with the memory care manager.	4/27/17

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D 358	Continued From page 54 Review of the Resident #3's Service Plan dated 12/13/16 revealed the resident was always disoriented and forgetful. Observation of a Medication Aide (MA) in the Special Care Unit (SCU) on 03/21/17 at 11:40am revealed: -She poured liquid from a clear medicine cup into a 12 ounce cup of tea. -She stirred the tea with a straw and took the cup to Resident #3's room. -The MA placed the cup of tea on the nightstand next to Resident #3's bed and left the room. -No attempts were observed of the MA trying to get Resident #3 to drink the tea while the MA was in the room. Interview with the MA in the Special Care Unit on 03/21/17 at 11:43am revealed: -She had been working at the facility for about a month. -She had dissolved a Xanax tablet and put the mixture in Resident #3's tea because it was the only way she could get the resident to take her medications. -This is the way she had been trained to administer medications to Resident #3. -She had been trained by another MA who worked in the SCU to administer all of Resident #3's medications dissolved in her drinks. -Resident #3 refused to take any medications the MAs tried to administer to Resident #3. -The MA had been trained to dissolve Resident #3's medications in her drinks in order to administer medications for Resident #3. Observation of Resident #3 in her room on 03/21/17 at 11:50am revealed: -Resident #3 was lying in bed with a doll cradled in her left arm.	D 358	Medication Aide training and revalidation was conducted on 4/16 & 4/17/17 by a registered nurse. Training included, but was not limited to; -Revalidation of medication aides -Proper medication administration techiques -Authorizations requried to crush medications -Physician orders -Medications not available -Refusals -Notification of primary care provider -Missed medications -Safety, confirming consumption of po (by mouth) medications, not leaving medications unattended Medication aides were revalidated on 4/16 & 4/17/17 by registered nurse. Random observations and additional training will be conducted as determined by licensed profesionals. Resident # 3's primary care provider was notified on 3/22/17and informed of the issues around resident refusing, medication aides disolving medications and leaving area so resident would take her medications. Primary care provider reviewed circusmtances and provided new orders to address needs of the resident. Orders were carried as as specified.	4/27/17 4/27/17 4/27/17

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D 358	Continued From page 55 -Resident #3's speech was garbled. -Resident #3 had not drank any of the tea in the cup left on the nightstand. -Resident #3's room door was open. Observation of the SCU on 03/21/17 at 11:53am revealed: -Twelve residents were in the dining room area for lunch. -Two Personal Care Aides (PCAs) were assisting residents in the dining room. -Two residents were in the main sitting area of the SCU with the Activity Director. -The MA was sitting at the desk at the nurse's station. -One resident was observed wandering the hallways of the SCU. -This resident was not monitored by the staff as the resident wandered. -Survey staff observed the wandering resident go into an unoccupied room located across the hall from Resident #3's room and got into the bed. -No staff noticed when the wandering resident had gotten into the unoccupied room. -Survey staff alerted the PCAs and the MA of the location of the wandering resident. -A PCA and the Activity Director removed the wandering resident from the room and brought her out to the main sitting area. -The MA did not check on Resident #3 or medication left in the cup in Resident #3's room. -No other residents were observed wandering in the hallways. Observation of Resident #3 in her room on 03/21/17 at 12:05pm revealed: -Resident #3 was still lying in bed with a doll cradled in her left arm. -The cup of tea on Resident #3's nightstand was still full.	D 358		

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D 358	Continued From page 56 -Resident #3's room door was open. Observation of Resident #3 in her room on 03/21/17 at 12:30pm revealed the cup on Resident #3's nightstand was empty and her room door was open. Interview with Resident #3 on 03/21/17 at 12:30pm revealed Resident #3 was unable to verify she drank the tea from the cup. Second observation of the MA on 03/21/17 at 12:35pm revealed: -The MA removed the empty cup from Resident #3's room. -She did not ask Resident #3 if the resident drank the tea. -The MA documented she administered Xanax in Resident #2's medication administration record (MAR). Interview with the MA in the Special Care Unit on 03/21/17 at 12:36pm revealed: -She assumed Resident #3 had drank the tea placed in her room. -She did not see Resident #3 drink the tea but the cup was empty when she removed it from Resident #3's room. -She always mixed Resident #3's medications in fluids like tea or milk to get Resident #3 to take the medications. -She assumed when the cup with the dissolved medications was empty that the resident had taken the medications. -She documented on Resident #3's MAR that she administered the medications after she found the cup in Resident #3's room empty. -She did not have a set time that she checked to see if Resident #3 had taken the dissolved medications in her drink.	D 358		

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D 358	Continued From page 57 -She was not concerned about other residents getting to the dissolved medications left in Resident #3's room because staff could see if another resident went in Resident #3's room. Review of care notes for Resident #3 revealed: -It was documented Resident #3 drank milk that contained her medications on 01/21/17, 01/22/17, 01/27/17, and 01/30/17. -There was no documentation of medications being administrated in Resident #3's drinks in February 2017. -There was no documentation of medications being administrated in Resident #3's drinks from March 1 - March 21, 2017. Observation of a second MA in the Special Care Unit (SCU) on 03/22/17 at 9:30am revealed: -The MA dissolved Olanzapine 10mg and Xanax 0.25mg in approximately 5ml of water. -The MA poured the dissolved medication solution in to a cup that contained approximately 12 ounces of milk. -The MA left the cup of milk that contained the dissolved medications on the nightstand in Resident #3's room. -The MA told Resident #3 that she would come back later (time unspecified) to see if Resident #3 had drank the milk. -No attempts were observed of the MA trying to get Resident #3 to drink the milk while the MA was in the room. Interview with the second MA in the SCU on 03/22/17 at 9:35am revealed: -She had been working at the facility for about a year. -She had dissolved Olanzapine and Xanax in water in the medicine cup for Resident #3. -Mixing Resident #3's medications in her drinks	D 358		

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D 358	Continued From page 58 was the only way she could get the resident to take her medications. -Resident #3 refused to take any medications that staff offered if the resident knew it was medication. Observation of the SCU on 03/22/17 at 9:40am revealed: -Ten residents were in the main sitting room area of the SCU with one PCA present. -No residents were observed wandering the hallways in the SCU. Observation of Resident #3 in her room on 03/22/17 at 10:00am revealed: -Resident #3 was lying in bed with eyes closed. -Resident #3 had not drank any of the milk in the cup left on the nightstand. Second observation of the second MA on the SCU on 03/22/17 at 10:02am - 10:25am revealed: -MA prepared and administered other medications to other residents in the SCU. -No attempts were observed of the MA trying to get Resident #3 to drink the milk with the dissolved medications in room. -No attempts were observed of the MA checking on Resident #3 or the cup of milk with the dissolved medications. Observation of Resident #3 in her room on 03/22/17 at 10:26am revealed: -Resident #3 was lying in bed with eyes closed. -The cup with dissolved medications on the nightstand was empty. Third observation of the second MA on the SCU on 03/22/17 at 10:35am revealed: -The MA removed the empty cup from the	D 358		

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D 358	Continued From page 59 nightstand in Resident #3's room. -She did not ask Resident #3 if the resident drank the milk. Fourth observation of the second MA on the SCU on 03/22/17 at 12:55pm revealed: -The MA dissolved Xanax 0.25mg in approximately 5ml of water for Resident #3. -The MA poured the dissolved medication solution in to a cup that contained approximately 12 ounces of tea. -The MA left the cup of tea that contained the dissolved medications on the nightstand in Resident #3's room with her lunch tray. -No attempts were observed of the MA trying to get Resident #3 to drink the tea while the MA was in the room. -The MA returned back to the nurse's station. Interview with the second MA on the SCU on 03/22/17 at 1:00pm revealed: -She had been trained by a previous Resident Care Coordinator to dissolve all of Resident #3's medications in her drinks to administer them. -She had trained the first MA to dissolve all of Resident #3's medications in her drinks for medication administration. -Resident #3 would refuse to take medications unless the staff dissolved it in her drinks. -She checked on Resident #3 about every 15 minutes when she put cups that contained dissolved medications in her room. -She had not witnessed Resident #3 drink the dissolved medications from the cup. -She assumed since the cup was empty in Resident #3's room that Resident #3 drank it. -She could not verify if Resident #3 drank the tea with the dissolved medications -There were at least 5 residents who were known wanderers in the SCU.	D 358		

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D 358	Continued From page 60 -She had never thought of "the possibility of [Resident #3] pouring out the medication or another resident accidently drinking the dissolved medication in the cup left in [Resident #3] room". -She would make sure to watch Resident #3 from now on to make sure Resident #3 drank all of her drink that contained dissolved medications. -She would not leave dissolved medications in Resident #3's room unattended anymore. Interview with the Special Care Coordinator on 03/22/17 at1:05pm revealed: -She was aware the MAs dissolved Resident #3's medications in her drinks in order to administer them. -She did not see anything wrong with MAs dissolving the medications in the Resident #3's drinks and leaving the drink in Resident #3's room unattended. -It was the only way the MAs were able to get Resident #3 to take any medications. -Resident #3 would throw the medications across the room if the MAs tried to administer medications in pill form. -There was not a set frequency on how often the MAs checked on Resident #3 when they left dissolved medications in her room. -The SCC said, "She had never thought about it; but it was possible for [Resident #3] to pour out the dissolved medications and not take the medications." -The SCC said, "It was possible for other residents in the SCC to wander in [Resident #3's] room and drink the dissolved medications left in the cup on Resident #3's room". -She would make sure the MAs watched Resident #3 when they administered dissolved medications in her drinks. Interview with the Administrator on 03/22/17 at	D 358		

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D 358	Continued From page 61 1:20pm revealed: -She was not aware the MAs in the SCU dissolved medications in Resident #3's drinks and left the dissolved medications in Resident #3's room unattended. -It was expected for the MAs to make sure Resident #3 took her medications and not leave dissolved medications in the room. -She understood "the MAs could not verify [Resident #3] had taken the dissolved medications left on the nightstand just because the cup had been emptied". -She understood "it was possible for other residents in the SCU to wander in to [Resident #3's] room and drink the cup with the dissolved medications". -She would talk with the SCC to see what other strategies could be used to get Resident #3 to take her medications. Interview with the Primary Care Provider (PCP) for Resident #3 on 03/24/17 at 5:35pm revealed: -He did not know that staff had to hide medications in Resident #3's drinks in order to get her to take her medications. -He last saw Resident #3 on 02/20/17 during an onsite medical visit. -Staff did not inform the PCP on 02/20/17 that Resident #3 refused medications or staff hid Resident #3's medications in her drinks in order to administer them. -He did not think "it was a good idea to leave medications in any resident's room". -He would have liked to have been notified staff was having problems getting Resident #3 to take her medications as ordered. -He would have tried other routes for staff to administer Resident #3's medications. -He understood "staff could not verify [Resident #3] took the dissolved medications mixed in	D 358		

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D 358	Continued From page 62 [Resident #3's] drink after it was left at her bedside unattended". -It was possible for Resident #3 to pour out the medication left in the cup. -It was possible another resident in the SCU could easily take the medication left in Resident #3's room by the staff. Review of a Facility Medication Aide In-Service Report revealed: -A mandatory in-service was held on 03/24/17 with the SCC and 5 medication aides. -Medication aides must watch residents take all medications. -Medications are not to be left in residents' rooms. The facility failed to observe the medication administration of 1 of 6 sampled residents (#3) by leaving dissolved medications that included a narcotic in tea and milk at the bedside unattended in a Special Care Unit. The failure of the facility to witness the ingestion of dissolved medications by Resident #3 resulted in substantial risk for physical harm to the residents within the Special Care Unit which constitutes a Type A2 Violation. Review of the Plan of Protection dated 02/16/17 revealed: -The facility shall assure that the preparation and administration of medication by staff are in accordance with the rule 10 NCAC 13F .1004 by 03/22/17. -The facility called the primary care provider in reference to resident's medication and for recommendations on 03/22/17. -The facility referred the resident for an On-site Health Service visit schedule for 03/23/17. -Pharmacy Consultant reviewed medications for resident on 03/22/17.	D 358		

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D 358	Continued From page 63 -The primary care provider recommended 03/22/17 changing medications to liquid and/or IM injections by home health every 4 weeks. -Mandatory in-service for all Medication Aides on 03/24/17. -LHPS nurse will revalidated Medications Aide quarterly. -LHPS nurse will conduct random medication checks. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 27, 2017.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to report allegations of physical and mental abuse against 3 of 6 staff sampled (Staff A, B, and D) to the Health Care Personnel Registry (HCPR) within 24 hours and provide documentation the alleged acts were investigated and reported to HCPR within 5 days. The findings are: 1. A confidential telephone interview with a staff	D 438	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. It is the policy of Gates House to assure any allegations of physical and mental abuse are reported to the Health Care Personnel Registry in accordance with rule 10A NCAC 13F .1205 Health Care Personnel Registry.	

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D 438	Continued From page 64 member revealed: -Staff A had been verbally and physically abusive to a resident. -The staff member had witnessed Staff A pulling, pushing, and handling the resident in a rough manner. -The staff member heard the resident cry out for Staff A to stop because Staff A was hurting the resident. -The staff member had heard Staff A cursing and yelling at the resident to "get the [expletive] up." -The staff member reported the incidents to the Administrator. A second confidential telephone interview with the same staff member revealed: -Staff A was verbally and mentally abusive to residents. -Staff A referred to a resident as a "pain in the butt" because he complained all the time of not feeling well (occurred around October - November 2016). -The staff member heard Staff A being loud and verbally abusive to the residents. -Staff A had been verbally abusive to residents several times but the staff member could not recall how many times or how many residents. -Staff A yelled at the residents when they asked for assistance. -Examples given were: "What do you want now?", Why do you keep calling me?", "Why do you keep ringing that call bell?", "You keep ringing that bell and I am going to stop coming." -The staff member reported to the Administrator that Staff A yelled at the residents in 9/2016. -The Administrator said it was ok because some aides had more than one job and used 3rd shift to rest up. -The Administrator did not do anything about Staff A yelling at the residents.	D 438	Training was provided to include, but not limited to; -Reporting abuse, neglect and exploitation allegations -Corporate policy on abuse, neglect and exploitation -Health Care 24 hour and 5 day reports -Resident Relations and Human Resource Hotline Posting reviewed and verified -NC Adult Care Licensing/DHSR complaint number reviewed and verified posting -Consequences reviewed for failure to ensure Resident Rights to be free from abuse and neglect Training conducted by support staff. Documentation of training available upon request in the front office. Any allegations reported to previous administrator during the survey were reported and handled by the previous administrator. The identified staff are no longer employed at Gates House. Health Care Personnel Registry was re-run on all current employees on 3/28/17. Administrator will be responsible for reviewing Health Care Personnel Registry Checks on any new applicant prior to hire.	4/27/17 4/27/17 4/27/17 4/27/17

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D 438	Continued From page 65 A confidential interview with a resident revealed: -The resident witnessed Staff A pull and yank another resident by both arms while this resident was in a wheelchair in the hallway area of the assisted living side. -The resident who was yanked by Staff A cried and asked repeatedly for Staff A to stop. -Staff A was yelling and cursing at this resident and said, "Get the [expletive] up, get your [expletive] up." -Staff A "fussed, cursed, and put her hands" on this same resident several times (unable to specify a timeframe). -The resident saw Staff A "shove and push" on the same resident in the wheelchair. -The assaulted resident asked Staff A "over and over again" to stop shoving and pushing because it hurt. -Staff A responded to the assaulted resident "you just don't like me because I'm black." -The resident did not tell anyone what she witnessed Staff A did to the other resident so not to get in trouble. -Staff A did not bother the reporting resident because the resident would speak up for themselves and tell the Administrator and family about any staff mistreatment. -The allegedly assaulted resident was treated that way by Staff A because the resident would not speak up. A confidential interview with a second resident revealed: -The resident heard Staff A yelling loudly and cursing at same resident saying, "shut the [expletive] up, be quiet." -The resident heard the other resident crying and asking Staff A to stop. -The resident did not witness this same resident	D 438	Note: Additional training requested: Ombudsman contacted to provide additional training. The first available dates are as follows; 1)Elder Abuse Training-Offsite on 5/11/17 for select personnel. 2)Sensitivity Training scheduled for 6/20 & 6/30/17 with the Ombudsman onsite. These were the first dates the Ombudsman had available.	

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D 438	Continued From page 66 being mistreated but heard when the resident cried out, Staff A yelling and cursing, and the sounds of furniture being moved around. -It sounded like a struggle was taking place in the resident's bedroom. -The resident was unable to specify how often or when it happened, but said it happened often. -Staff A and no other staff "messed with me because I keep to myself." -The resident did not report what happened to the other resident because "It was best to mind my own business." Confidential interviews with a third and fourth resident revealed: -They heard the same resident cry out for Staff A to stop because the same resident was being hurt. -They heard Staff A curse, fuss, and said "get your [expletive] up, shut the [expletive] up" to this same resident. -They had not witnessed the resident being mistreated but had heard the same resident being mistreated by Staff A on several times and could not specify a timeframe or how often. -They did not report anything to anyone regarding these incidents with Staff A and could not explain why. Confidential telephone interview with a second staff member revealed: -A resident had told her that Staff A would be mean to the resident. -Staff A would holler and curse at the resident about taking so long to get in and out of the bed. -The resident said Staff A would pick the resident up and slam the resident down in the bed and the wheel chair when being transferred. -The resident had been complaining about this for about 3-4 months.	D 438		

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D 438	Continued From page 67 -The staff member had reported this information to the Resident Care Coordinator (RCC). -The staff member had only reported to the RCC one time (could not specify when she reported to the RCC). -The RCC was going to talk with Staff A and the resident about the accusations. -She had never seen any bruises on the resident. -No other residents had complained to her about Staff A. A confidential interview with the allegedly assaulted resident revealed: -Staff A worked at night and the resident was "treated badly" by Staff A. -Staff A would yell and used profanity at the resident several times (unable to specify). -Staff A's behaviors made the resident feel bad. -The resident had asked Staff A to stop with the mistreatment but Staff A would not stop. -Staff A had pulled the resident by the arms on many occasions and pushed the resident roughly. -The resident could not specify how many and how often that occurred. -The resident could not understand Staff A's mistreatment of the resident. -Maybe Staff A had personal problems or was tired of working at night. -Staff A must have something against the resident but the resident did not know what it was. -Staff A would yell to "hurry up" because the resident moved slowly. -The resident had asked Staff A to stop hurting and yelling at the resident countless times but nothing had changed. -The resident told the "lady in the office" and other staff but could not remember when or who the staff were she told. -The resident did not want any more trouble and decided to deal with how Staff A treated the	D 438		

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D 438	Continued From page 68 resident and "not say anything anymore." Confidential telephone interview with the alleged assaulted resident's family member revealed: -The family member denied concerns or complaints related to how a staff member treated the resident because of the resident's dementia diagnosis. -The resident seemed happy when the family visited at the facility. -The resident had mentioned during a visit around the Christmas holidays that a staff member had fussed at the resident. -The family member had tried to question the resident more about this incident. -The resident seemed to have forgotten about the incident and the family member left the subject alone. -The family was unaware of any mistreatment of the resident by the facility staff. Interview with the RCC on 03/24/17 at 11:55am revealed: -A resident had complained to another staff member about Staff A being rough with her and cussing and hollering at her. -Staff A had told the RCC the resident was about to fall and Staff A grabbed the resident to keep the resident from falling. -The RCC believed that was what was meant by Staff A being rough with the resident. -The resident denied Staff A being verbally or physically abusive. -She would never allow any of the residents to be abused. -If the resident had given her any other story then Staff A would have been terminated. -She does not allow anyone who provides minimal care or has a bad attitude.	D 438		

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D 438	Continued From page 69 Interview with the Administrator on 03/24/17 at 12:51pm revealed: -She had worked at the facility since July 2016 as the Administrator. -She followed the state policy for reporting incidents of abuse and neglect. -She suspended and removed a staff member during her investigation. -If an allegation of abuse was substantiated, then the staff member would be fired. -She heard from another staff member that Staff A had abused a resident. -She immediately removed the Staff A for two days and conducted her own internal investigation. -She did not report Staff A to the Healthcare Personel Registry and was unsure why she did not. -The Administrator would report the allegations against Staff A to HCPR. Interview with the RCC on 03/27/17 at 10:45am revealed: -She was aware a resident had reported Staff A of being verbally abusive and physically abusive sometimes around October or November 2016. -The Administrator did investigate the report about Staff A and Staff A was suspended for a couple of days (unable to specify the number of days). -She believed the allegation of abuse by Staff A was a misunderstanding between the resident and Staff A. 2. A confidential telephone interview with a staff member revealed: -The staff member stated she witnessed Staff B physically abuse a resident in late January/early February 2017. -The staff member was not able to remember the	D 438		

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D 438	Continued From page 70 name of the resident from that episode. -The resident was in the sitting area on the assisted living sided but was not ready for bed. - Staff B grabbed the resident up from the chair and forced the resident to go down to the resident's room. -Staff B then slammed the resident down in the bed (No injury reported). -Resident did not want to go to bed. -Staff did not report this incident to the Administrator because the Administrator always made excuses to justify Staff B behaviors. A second confidential telephone interview with the same staff member revealed: -Staff B always had an attitude and was rude when she worked with the residents. -Staff B yelled and her tone of voice was mean when she spoke to the residents. -Staff B would say "I ain't gonna do nothing for you, you better get up and do it yourself" to the residents. -If a resident did not move fast enough when Staff B told them to move then Staff B would pull or grab on the resident to make them do whatever she wanted. -Staff Member could not specify when Staff B pulled or what resident was pulled on. -Staff Member did not specify if the Administrator or Resident Care Coordinator (RCC) was notified for this incident. -Staff Member could not specify how many times these incidents occurred with the other residents in the facility. -Staff member did recall two residents Staff B handled roughly repeatedly. -Staff Member witnessed Staff B slam one of these residents in the bed sometime before Christmas 2016. -Staff Member reported the incident to the	D 438		

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D 438	Continued From page 71 Administrator and the RCC the day after it occurred. -The Administrator nor the RCC did anything about the event that was reported. -Staff B refused to give snacks to residents if the residents did not do what Staff B wanted. Interview with the Administrator on 03/24/17 at 12:51 pm revealed no one had reported any physical or verbal abuse regarding any other staff. Interview with the RCC on 03/27/17 at 10:45am revealed: -She did not recall any other reports of any other staff abusing residents. -Any staff would be terminated if it was found out the staff member was abusive to any resident. -She did not understand why staff was being accused of being abusive to the residents. 3. A confidential telephone interview with a staff member revealed: -Staff D worked in the Special Care Unit and had been physically abusive to a resident in 12/2016. -Resident did not want to go bed so Staff D grabbed this resident under the arms. -Staff D dragged the resident down the hallway. -Staff D slammed the resident in the bed when Staff D got to the resident's room. -Staff member did report this incident to the Administrator in 12/2016 but no actions were taken. Interview with the Administrator on 03/24/17 at 12:51 pm revealed no one had reported any abuse physical or verbal regarding any other staff. Interview with the RCC on 03/27/17 at 10:45am	D 438		

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D 438	Continued From page 72 revealed: -She did not recall any other reports of any other staff abusing residents. -Any staff would be terminated if it was found out the staff member was abusive to any resident. -She did not understand why staff was being accused of being abusive to the residents. The facility failed to report allegations of physical and mental abuse to the Healthcare Personnel Registry. The failure of the facility to report allegations of physical and mental abuse by the Staff A, B, and D placed residents at substantial risk of serious harm which constitutes a Type A2 Violation. Review of the Plan of Protection dated 03/24/17 revealed: The facility will ensure any staff member who has been reported for abuse and neglect will immediately be reported to the Healthcare Registry. -The Administrator will be responsible for reporting as of 3/24/17. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 27, 2017.	D 438		
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.	D912		

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D912	Continued From page 73 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations regarding failing to observe medication administration. The findings are: 1. Based on interviews and record reviews, the facility failed to assure 1 of 7 sampled staff (Staff B) had no substantiated findings listed on the Health Care Personal Registry prior to being hired at the facility [Refer to Tag 137, 10A NCAC Other Staff Qualifications .0407(a)(5) (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 3 of 6 sampled regarding of missed medications used to treat high blood pressure and mental behaviors for 2 residents (#2, #6) and medication refusals for 1 resident (#3) [Refer to Tag 273, 10A NCAC 13F Health Care .0902(b) (Type A2 Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to observe the medication administration of 1 of 6 resident (#3) sampled as evidenced by staff dissolving medications (that included a narcotic) in tea and/or milk and leaving the dissolved medication mixture in the resident's room unattended without verification of the resident taking the medication(s) [Refer to Tag 358, 10A NCAC 13F Medication Adminstration .1004(a)(2) (Type A2 Violation)].	D912	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. 1. Refer to Plan of Correction for Tag 137, 10A NCAC 13F .0407(a) (5) Other Staff Qualifications (Type A2 Violation) 2. Refer to Plan of Correction Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation) 3. Refer to Plan of Correction for Tag 358, 10A NCAC 13F .1004(a)(2) Medication Administration (Type A2 Violation)	4/27/17 4/27/17 4/27/17

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D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure residents were free of neglect as related to reporting of allegations of physical and mental abuse to the Health Care Personnel Registry and residents rights. The findings are: 1.Based on interviews, the facility failed to assure 2 of 6 residents sampled were free of physical and mental abuse as evidenced by reports of alleged mental and physical abuse by Staff A, Staff B, and Staff D. [Refer to Tag D338, 10A NCAC 13F .0909 Residents Rights (Type A1 Violation)]. 2.Based on interviews and record reviews, the facility failed to report allegations of physical and mental abuse against 3 of 6 staff sampled (Staff A, B, and D) to the Health Care Personnel Registry (HCPR) within 24 hours and provide documentation the alleged acts were investigated and reported to HCPR within 5 days. [Refer to Tag D438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].	D914	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law. 1. Refer to Plan of Correction for Tag D 338, 1OA NCAC 13F .0909 Resident Rights (Type A1 Violation) 2. Refer to Plan of Correction for Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)	4/27/17 4/27/17