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	HAL051041	A. BUILDING: _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

(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 conducted an annual and a follow up survey on 04/19/17 - 04/21/17 and 04/24/17 - 04/26/17.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the door at the end of A Hall of the special care unit (SCU) was equipped with a sounding device that activated when the door mag lock malfunctioned leaving the door unlocked and able to be opened from the inside leading to the staff lounge, which had a door leading to the outside that was unlocked and not equipped with a sounding device. The findings are: Review of a facility census report dated 04/19/17	D 067		

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revealed the facility's census was 54 and 52 residents were currently living in the free-standing special care unit (SCU) and 2 residents were in rehabilitation centers.

Observation of A Hall in the SCU during the tour of the facility on 04/19/17 at 9:30 a.m. revealed:
-There was a door at the end of A Hall that led into the staff lounge.
-There was a keypad on the wall beside the door and a silver mag lock box at the top of the door.
-One end of the silver mag lock box was loose and a screw could be seen hanging down.
-The door opened when the handle was turned and the door was pushed on.
-No alarm sounded and there was no staff observed in the hallway.
-There was a door in the staff lounge that led outside into the parking lot at the front end of the building.
-There was no keypad or mag lock box for the door in the staff lounge leading to the outside of the facility.
-The door opened when the knob was turned and no alarm sounded.
-A personal care aide (PCA) was observed coming out of a resident's room on the A Hall at 9:33 a.m.

Interview with the PCA on 04/19/17 at 9:33 a.m. revealed:
-She had worked at the facility for 1 to 2 months.
-She noticed about 2 weeks ago the door at the end of A Hall was malfunctioning.
-Staff had to slam the door to get it to close and half the time it did not activate the keypad and the door would be unlocked.
-Staff reported it to the Special Care Coordinator (SCC) about two weeks ago.
-The SCC told staff to slam the door hard and

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she told them it was on the list for maintenance to fix.
-The facility did not currently have a maintenance staff.
-Staff was told to watch the door when it was discussed during daily stand up meetings.
-Staff were usually on the 3 hallways of the facility, but could not always see the door because they were assisting residents.
-There was supposed to be a hall monitor sitting at the nurse's station where the 3 halls met at all times on first shift.
-There was currently no hall monitor at the nurse's station because they may be assisting residents or redirecting them.
-Some of the residents wander around on the halls.
-There were at least 2 residents that she had observed going to the door at the end of A Hall and looking through the window.
-They would touch the door and fiddle with the handle but they did not push on the door and they did not exit the door.
-No residents had exited the facility through the A Hall door or any other doors to her knowledge.

Interview with a second PCA on 04/19/17 at 10:45 a.m. revealed:
-About 2 weeks ago, the door at the end of A Hall started sticking and would not lock at times.
-Staff told the SCC about it during stand up meetings.
-The SCC told staff she was going to get maintenance to fix it.
-They did not currently have a maintenance staff and the former one quit about a month ago.
-There was no plan to supervise the door to her knowledge.

Interview with a third PCA on 04/19/17 at 1:58

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p.m. revealed:
-The door at the end of A Hall malfunctioned about 2 weeks ago and was getting stuck.
-She was not sure if the door was unlocked.
-The door had also malfunctioned in the past and had been repaired at least 2 times a long time ago (could not recall timeframe).
-Sometimes if the door was slammed it would start working again.

Interview with the Administrator on 04/19/17 at 9:47 a.m. revealed:
-Staff reported the door at the end of A Hall was malfunctioning about 2 weeks ago.
-The moisture would sometimes cause the door to stick and not open.
-The former maintenance staff tried to tighten the box above the door a couple of weeks ago.
-No one had reported the door was acting up again.
-He was not aware the door was unlocked.

Interview with the SCC on 04/19/17 at 9:58 a.m. revealed:
-She was not aware of any current problems with the door at the end of A Hall.
-The door was sticking in September 2016.
-It was repaired and no problems had been reported since then.
-They had stand up meetings in the mornings and no one had reported any issues with the door.
-She would have documented it in her notes from the stand up meetings.
-The facility did not currently have a regular maintenance staff.
-She had to put any maintenance needs in the corporation's electronic maintenance system and the corporation would send someone to make repairs.
-She had not requested any maintenance for the

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door on A Hall because she did not know it was messing up.
-Staff should report any maintenance issues to her or the Administrator.
-The previous maintenance staff had left the position over a month ago and he had not made any repair to the door to her knowledge.

Observation of the door at the end of A Hall on 04/19/17 at 11:14 a.m. revealed the door was locked and did not open when pushed on.

Interview with the Administrator on 04/19/17 at 11:15 a.m. revealed a maintenance contractor was coming today to repair the door at the end of A Hall.

Interview with the SCC on 04/19/17 at 11:40 a.m. revealed:
-They used to have a maintenance staff assigned to come to the facility about once a week.
-He left the position in March 2017.
-She had to enter any needed repairs into their electronic system.
-The maintenance staff would do tasks that were on his printout of work orders generated by the electronic system.
-The SCC and the Administrator were responsible for putting repair needs in the electronic system.
-No repairs had been requested through the electronic system so no work orders would have printed for the maintenance staff to do any repairs on the door.

Telephone interview with a representative from the facility's contracted Maintenance Company on 04/19/17 at 11:50 a.m. revealed:
-The Administrator just called them today on 04/19/17 and reported a mag lock was coming off a door.

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-They had not been contacted prior to today and there had been no electronic work orders for any door submitted by the facility to his knowledge.
-Their company would have immediately sent someone to work on the door prior to today if they had known there was a problem because it was a safety issue for the residents.
-They usually had a maintenance staff at the facility about twice a week but the position at the facility was currently vacant.
-The maintenance company contacted an outside vendor today to repair the door and the vendor had just completed tightening the mag lock at the top of the door.
-He would double check the computer system to see if there were any work orders for the door on A Hall.

Observations of the door at the end of A Hall on 04/19/17 at 2:05 p.m. and on 04/20/17 at 4:40 p.m. revealed the door was locked and did not open when pushed on.

Telephone interview with a representative from the facility's contracted Maintenance Company on 04/20/17 at 2:35 p.m. revealed:
-He could not locate any open or closed work orders for any door repairs at the facility for the last 30 days.
-The vendor who repaired the door yesterday (04/19/17) replaced 2 loose screws in the mag lock because if the metal plate and magnet did not line up, it would not work.

Telephone interview with a representative from the facility's contracted Maintenance Company on 04/21/17 at 11:42 a.m. revealed:
-The facility was an older building and the doors in the facility did not have the capability to alarm.
-The facility could either add screamer stop signs

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D 067	Continued From page 6 to doors or the doors could be upgraded with alarms. Interview with the Administrator and Regional Director of Operations on 04/21/17 at 3:35 p.m. revealed: -The building was old and there were no alarms on the doors to their knowledge. -They would check into getting alarms on the doors.	D 067		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls and floors were kept clean and in good repair for residents' bedrooms and restrooms on the B and C Halls of the facility. The findings are: Observation of the shared restroom for resident room 213 on B Hall on 04/19/17 at 9:37 a.m. revealed: -The floor had black and gray stained areas that circled the front of the toilet. -The floor's transition strip to adjoin the bedroom to the bathroom floor was pulled back inside of the bathroom laying on the floor against the wall that may be a trip hazard.	D 074		

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D 074	Continued From page 7 Observation of the bedroom and shared restroom for resident room 200 on B Hall on 04/19/17 at 10:06 a.m. revealed: -The floor's transition strip to adjoin the bedroom to the bathroom floor was missing leaving a slight gap in the floor's surface that may be a trip hazard. -There were scattered black scuff marks across a middle section of the bedroom's left wall. Observation of a resident's bathroom on C Hall in room 310 on 4/19/17 at 9:30 a.m. revealed: -The bathroom floor had several dark brown and black stained areas. -The bathroom floor was covered with several white and brown grimy particles. -There were several cracked and chipped areas in the floor. Observation of resident room 309 on C Hall and the bathroom on 4/19/17 at 9:38 a.m. revealed: -Two of the four baseboards were missing. -The bathroom floor had several dark brown and black stained areas. -The bathroom floor was dirty and covered with several white and brown grimy particles. Observation of a resident's bathroom on C Hall in room 306 on 4/19/17 at 10:45 a.m. revealed: -The bathroom floor had several dark brown, gray, and black stained areas. -There were several chipped and cracked areas in the floor. Observation of a resident's room 304 on C Hall on 4/19/17 at 10:55 a.m. revealed three of the four walls had black stained areas with chipped and peeling paint at the baseboard areas.	D 074		

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D 074	Continued From page 8 Interview with a resident who resided in room 309 on 4/19/17 at 9:50 a.m. revealed the baseboards had been removed about a month ago to spray for bedbugs and had not been replaced. Interview with the Housekeeper on 4/19/17 at 10:20 a.m. revealed: -She cleaned the resident rooms and bathrooms daily. -The bathroom floors on C Hall had been in that condition for as long as she could recall. She was unable to specify a timeframe. -She had not reported the bathroom floors on C Hall to anyone and was unable to explain why she had not it. Interview with the Administrator and the Regional Director of Operations on 04/20/17 at 6:25 p.m. revealed they would follow up with the concerns related to the walls and floors. Interview with the Administrator on 4/21/17 at 10:12 a.m. revealed: -He was not aware of the missing baseboards or the condition of the bathroom floors on C Hall. -He would have maintenance make all needed repairs and replacements on 4/21/17 since they were onsite. -All repairs and replacements were made prior to survey exit. black and graObservation of the shared restroom for resident room 213 on B Hall on 04/26/17 at 11:13 a.m. revealed: -The floor's transition strip from the bedroom to the bathroom floor had not been repaired. -The floor covering with the y stained areas had not been replaced. Observation of the shared restroom for resident	D 074		

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D 074	Continued From page 9 room 200 on B Hall on 04/26/17 at 11:15 a.m. revealed the missing floor transition strip to adjoin the bedroom to the bathroom floor had not been replaced.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have furniture in good repair in the residents' living areas which included chairs, 3 sofas, and a television stand in the television room on A Hall, chairs in the Quiet Room on C Hall, a bench on C Hall, and the wooden tables and chairs in the residents' dining room. The findings are: Observation of the television room on A Hall on 04/19/17 at 11:10 a.m. revealed: -There was a television cabinet with one open shelf and a 3 drawer section that had scattered scratches and missing wood stain. -The top of the television cabinet had 4 wood chipped and indented areas that exposed the under layer wood color. -There was a blue, 2 cushioned sofa with vinyl type material that had scattered worn and cracked areas in the vinyl covering. There was missing vinyl covering at the end of the sofa's left armrest that exposed the white under layer color	D 076		

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of the fabric. The exposed white fabric on the left armrest had a black dingy boarder.
-There were 2 other blue vinyl sofas with the vinyl worn off on the armrests and seats of the cushions exposing the white material underneath the vinyl.
-There were 3 high back vinyl type chairs with wood stained leg bases and armrests. The wood sections of the chairs were heavily scuffed and worn with missing wood stain.

Interview with the Administrator and the Regional Director of Operations on 04/19/17 at 6:25 p.m. revealed they would have the television stand and the furniture in the television room on A Hall would be replaced as soon as possible.

Observation of the Quiet Room on C Hall on 04/20/17 at 3:00 p.m. revealed:
-There were 5 high back vinyl type chairs with wood stained leg bases and armrests. The wood sections of the chairs were heavily scuffed and worn with missing wood stain.
-One of the high back chairs with a light green vinyl type cover had dried blue ink stains scattered over a section of the chair's seat.

Interview with the Administrator on 04/24/17 at 2:10 p.m. revealed they would be replacing or repairing the high back vinyl type chairs in the Quiet Room on C Hall.

Observation of C Hall on 4/19/17 at 10:30 a.m. revealed a small wooden bench with several chipped and cracked areas in the wood.

Interview with Maintenance on 4/21/17 at 9:55 a.m. revealed:
-A work order had not been completed for the small wooden bench to be repaired.

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-He was unaware of the condition of the small wooden bench on C Hall.

Interview with the Administrator on 4/21/17 at 10:12 a.m. revealed:
-He was not aware of the condition of the small wooden bench in the hallway on C Hall.
-He would have maintenance make all needed repairs and replacements on 4/21/17 since they were onsite.

Observation of the dining room on 04/20/17 at 2:50 p.m. revealed:
-There were 37 dining room chairs with wooden arms and legs and green upholstered seats.
-All 37 chairs had chipped and / or missing stain on the arms, legs and backside of the chairs.
-Ten of the chairs had food stains and / or holes in the upholstered cloth on the seats.
-There were 15 wooden tables in the dining room.
-Eight of the 15 tables had missing stain and chipped wood on the edges and legs of the tables.
-The tables and chairs were sticky when touched.

Interview with the Administrator on 04/21/17 at 5:50 p.m. revealed:
-Dietary staff were supposed to clean the fabric on the dining room chairs after each meal.
-He was not aware of the holes in some of the fabric on the dining room chairs.
-Staff should report any issues to the supervisor on duty.

Telephone interview with a representative from the facility's contracted Maintenance Company on 04/20/17 at 2:35 p.m. revealed:
-They had not received any work order requests for any furniture repairs.
-If they received any furniture maintenance

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D 076	Continued From page 12 requests, he would assign it to one of their vendors. -He did not recall seeing any request by the facility for furniture repair or replacements. Interview with the Administrator on 04/20/17 at 6:20 p.m. revealed: -There were plans to "upgrade" and bring all the furniture in the dining room, common sitting areas, and bedrooms up to "standards". -There was an "investment team" for the facility here today assessing the furniture in the facility.	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure a resident's room (room 309), the residents' shower room and handicapped bathroom on C Hall, and the television room on A Hall were maintained in an uncluttered, clean and orderly manner, and were free of all obstructions and hazards. The findings are: Observation of a resident's room (room 309) on	D 079		

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D 079	Continued From page 13 4/19/17 at 9:38 a.m. revealed the headboard was detached from the bed and was leaning against the wall. The headboard was in an area the resident could bump into it or trip over it. Interview with the resident residing in room 309 on 4/19/17 at 9:50 a.m. revealed: -Her headboard had been detached and leaning against the wall for about a month and had not been repaired. -She told the Administrator she wanted her headboard reattached but nothing happened. Interview with Maintenance on 4/21/17 at 9:55 a.m. revealed a work order had not been completed prior to 4/21/17 to repair or attach the headboard in room 309. Observation of the shower room on C Hall on 4/19/17 at 10:25 a.m. revealed there was a large, uncovered bin filled with soiled attends. Observation of the handicapped bathroom on C Hall on 4/19/17 at 10:30 a.m. revealed: -There was a large wooden rocking chair with cushions in the shower area. -There was one wooden table lamp with white shade on the seat of the large wooden rocking chair. -There was one light green twin sized mattress in the shower area behind the large wooden rocking chair. -There was one dark blue recliner in the shower area against the wall behind the light green twin sized mattress. -There were two wooden four foot slats in the shower area against the wall in front of the dark blue recliner. Interview with the Housekeeper on 4/19/17 at	D 079		

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10:20 a.m. revealed:
-She cleaned the resident rooms and bathrooms daily.
-The headboard in room 309 had been detached from the bed for "quite some time" but she was unable to specify a timeframe.
-She had not reported the detached headboard to anyone.
-The soiled attends barrel in the shower room on C Hall was kept there all day and emptied on evening shift.
-She was not responsible for emptying the soiled attends barrel.
-The furniture had been stored in the handicapped bathroom on C Hall for two months or longer.
-The residents used both bathrooms on C Hall with staff assistance.

Interview with the Special Care Coordinator (SCC) on 4/21/17 at 5:30 p.m. revealed:
-She was not aware of the headboard that was detached from the bed in room 309.
-No one had informed her of the soiled attends barrel being kept in the shower room on C Hall until the end of the day to be emptied.
-She thought it would be okay to store a few furniture items in the handicapped bathroom on C Hall because she thought the residents were not using this bathroom.
-She would have the soiled attends barrel emptied and the furniture items removed as soon as possible.

Interview with the Administrator on 4/21/17 at 10:12 a.m. revealed:
-He was not aware that the headboard in room 309 was detached but he would submit a work order for maintenance to repair it.
-He would have maintenance make all needed

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D 079	Continued From page 15 repairs and replacements on 4/21/17 since they were onsite. -He was unaware the shower room on C Hall was being used to store the soiled attends barrel. -He was not aware furniture was being stored in the residents' handicapped bathroom on C Hall. -He would follow-up with the SCC to ensure the soiled attends barrel was emptied and the furniture items were removed. Observation in the television room on A Hall on 04/19/17 at 11:10 a.m. revealed there were bent and broken slats across the bottom of the mini blinds hanging in the window on the right side of the outer wall. Interview with the Administrator and the Regional Director of Operations on 04/19/17 at 6:25 p.m. revealed they would replace the blinds in the television room on A Hall.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the facility's	D 113		

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D 113	Continued From page 16 water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 3 of 15 fixtures, including three sinks in the shower room and handicapped bathrooms on C Hall and in resident room 306. The findings are: Observation of the water temperature at the sink located in the shower room on C Hall on 4/19/17 at 10:25 a.m. revealed a temperature of 121 degrees F. The hot water began steaming after being turned on. Observation of the water temperature at the sink located in the handicapped bathroom on C Hall on 4/19/17 at 10:30 a.m. revealed a temperature of 118 degrees F. Observation of the water temperature at the sink located in resident room 306 on 4/19/17 at 10:40 a.m. revealed a temperature of 99 degrees F. Interview with the Housekeeper on 4/19/17 at 10:20 a.m. revealed: -Both bathrooms on C Hall were used by the residents. -The doors of both bathrooms on C Hall were locked for privacy when not in use. -Staff assisted all residents while in both bathroom areas. -She was not aware the water was too hot in the shower bathroom and the handicap bathroom on C Hall. -She was not aware the water temperature in resident room 306 was low. Interview with a Medication Aide (MA) on 4/19/17 at 1:40 p.m. revealed: -Both resident bathrooms on C Hall were used by	D 113		

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residents with staff assistance.
-No one had complained to her about the water being too hot.
-She was not aware the water temperature was low in resident room 306.

Second observation of the water temperature at the sink located in the shower room on C Hall on 4/19/17 at 1:46 p.m. revealed a temperature of 121 degrees F. The hot water began steaming after being turned on.

Second observation of the water temperature at the sink located in the handicapped bathroom on C Hall on 4/19/17 at 1:50 p.m. revealed a temperature of 118 degrees F.

Second observation of the water temperature at the sink located in resident room 306 on 4/19/17 at 1:58 p.m. revealed a temperature of 99 degrees F.

Interview with the Administrator on 4/19/17 at 2:00 p.m. revealed:
-He was not aware there was an issue with the water temperatures on C Hall or in a resident's bathroom.
-He would contact maintenance to come out as soon as possible to check the hot water heater.
-He would post signs in the resident bathrooms on C Hall to alert them of the hot water.

Third observation of the water temperature at the sink located in the shower room on C Hall on 4/20/17 at 5:15 p.m. revealed a temperature of 118 degrees F. A caution hot water sign was posted on the mirror above the sink.

Third observation of the water temperature at the sink located in the handicapped bathroom on C

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D 113	Continued From page 18 Hall on 4/20/17 at 5:20 p.m. revealed a temperature of 120 degrees F. The hot water began steaming after being turned on. A caution hot water sign was posted on the mirror above the sink. Third observation of the water at the sink located in resident room 306 on 4/20/17 at 5:27 p.m. revealed a temperature of 100 degrees F. Interview with the Administrator on 4/20/17 at 5:38 p.m. revealed: -He had contacted maintenance on 4/19/17 and they came to the facility on 4/20/17 but were "too busy" working on other tasks and could not get around to checking the hot water. -He would have maintenance come back on 4/21/17. Fourth observation of the water temperature at the sink located in the shower room on C Hall on 4/21/17 at 9:35 a.m. revealed maintenance's thermometer read 111 degrees F at the sink. The surveyor's thermometer read 110 degrees F at the sink. Fourth observation of the water temperature at the sink located in the handicapped bathroom on C Hall on 4/21/17 at 9:45 a.m. revealed maintenance's thermometer read 120 degrees F, initially, and then fell down to read 114 degrees F at the sink. The surveyor's thermometer read 113 degrees, initially, and then fell down to 110 degrees F at the sink. Fourth observation of the water temperature at the sink located in resident room 306 on 4/21/17 at 10:10 a.m. revealed maintenance's thermometer read 100 degrees F at the sink. The surveyor's thermometer read 100 degrees F at	D 113		

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the sink. (The hot water had to run for approximately 3-5 minutes before getting hot).

Interview with Maintenance on 4/21/17 at 9:55 a.m. revealed:
-He was not the regular maintenance staff for the facility but he was filling in until a new maintenance staff was hired.
-He was not informed there was an issue with the water temperatures until 4/20/17 by the Administrator.
-The mixing valve may be attributing to the "up and down" hot water temperatures.
-He had checked the mixing valve and it did not need replacing but adjustments were made.
-The facility should have a water temperature log with water temperatures checked on a weekly basis.
-He was not aware if the water temperatures were checked consistently because there had not been a maintenance staff at the facility for nearly two months.
-He would ensure the hot water temperatures were checked on a regular basis to ensure there would be no further issues.
-If the facility had performed their weekly hot water temperature checks, he could have been notified much sooner to come out to the facility to adjust the hot water heaters as needed.

Review of the facility Water Temperature Monitoring Log on 4/21/17 revealed:
-The facility's documentation of the hot water temperatures were recorded on "3/15/17."
-On 3/15/17, water temperature checks were documented as 97.2 degrees F. for room 109, 97 degrees F. for room 106, and 93.4 degrees F.for room 208.

Interview with the Administrator on 4/21/17 at

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D 113	Continued From page 20 10:12 a.m. revealed: -There was no facility maintenance staff for nearly a month and a half to check the water temperatures. -The water temperatures were supposed to be checked on a weekly basis. -The facility did not have a thermometer and did not conduct weekly internal water temperature checks. -He had not performed any water temperature checks. -It was the responsibility of the maintenance staff to check the water temperatures on a weekly basis and document findings on the water temperature log. Interview with the Administrator on 04/24/17 at 9:43 a.m. revealed: -The Administrator had not rechecked any hot water temperatures. -He thought the contracted maintenance provider rechecked the hot water temperatures for the shower room, the handicapped bathroom and the shared resident bathroom for resident room 306 on C Hall when they "looked at" the mixing valve on Friday, 04/21/17. Observation of the hot water temperature in the shower room on C Hall on 4/24/17 at 1:50 p.m. revealed: -The hot water temperature at the bathroom sink was 106 degrees F. -The hot water temperature at the shower was 106 degrees F. -A caution hot water sign was posted on the mirror above the sink. Observation of the hot water temperature in the handicapped bathroom on C Hall on 4/24/17 at 1:55 p.m. revealed:	D 113		

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D 113	Continued From page 21 -The hot water temperature at the bathroom sink was 112 degrees F. -A caution hot water sign was posted on the mirror above the sink. Observation of the hot water temperature in a shared restroom for resident room 306 on 4/24/17 at 2:00 p.m. revealed the hot water temperature at the sink was 100 degrees F. Interview with the Regional Director of Operations (RDO) on 04/24/17 at 3:30 p.m. revealed: -The Administrator was responsible to have a plan in place to monitor the facility's hot water temperatures. -The contracted maintenance provider only provided follow up work for the facility in regards to hot water temperatures.	D 113		
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: Based on observations, interviews, and review of personnel files, the facility failed to assure 2 of 7 staff (D,F) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry upon hire to the facility. The findings are:	D 137		

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1. Review of Staff D's personnel file revealed:
-Staff D was hired on 07/23/08.
-There was a job description for Food Service Coordinator dated 10/19/10 and Dining Services Manager dated 05/22/12.
-A Health Care Personnel Registry (HCPR) check was completed on 09/07/14 with no substantiated findings.

Observation of Staff D throughout the survey on 04/19/17 - 04/21/17 and 04/24/17 - 04/26/17 revealed Staff D was cooking meals in the kitchen and serving food and beverages to the residents in the dining room each day.

Interview with the Business Office Manager (BOM) on 04/26/17 at 7:50 p.m. revealed:
-She started working at the facility in 2015.
-She did not know if a HCPR check was completed when Staff D was hired in 2008.
-Staff D was not a rehired employee so he should have a HCPR check that was completed upon hire in 2008.
-She had audited all of the personnel files last year for completeness and she did not notice a HCPR check was not completed when Staff D was hired.
-She thought maybe the BOM prior to her may have audited personnel files and did a HCPR check if she was unable to locate one for Staff D.
-She would check to see if Staff D had any thinned personnel files.

No further HCPR information was provided by the facility for Staff D.

2. Review of Staff F's personnel file revealed:
-Staff F was hired as a Personal Care Aide on 10/16/10.
-Staff F's job description was changed on

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D 137	Continued From page 23 05/22/12 to a Medication Aide. -Staff F's job description changed on 01/18/13 to a Supervisor. -A Health Care Personnel Registry (HCPR) check was completed on 09/17/14. Observation of Staff F throughout the survey on 04/19/17 - 04/20/17 and 04/24/17 - 04/26/17 revealed Staff F was working at the facility as a Medication Aide (MA)/Supervisor on first shift. Interview with the Business Office Manager (BOM) on 04/26/17 at 7:50 p.m. revealed: -She started working at the facility in 2015. -She did not know if a HCPR check was completed when Staff F was hired in 2010. -She had audited all of the personnel files last year for completeness and she did not notice a HCPR check was not completed when Staff F was hired. -She thought maybe the BOM prior to her may have audited personnel files and did a HCPR check if she was unable to locate one for Staff F. -She would check to see if Staff F had any thinned personnel files. No further HCPR information was provided by the facility for Staff F.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on observations, interviews, and review of	D 139		

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personnel files, the facility failed to assure 3 of 6 staff (B, D, F) sampled had a criminal background check upon hire in accordance with G.S. 114-19.10 and 131D-40.

The findings are:

1. Review of Staff B's personnel file revealed:
-She was hired on "3/12".
-There was a job description for supervisor dated 01/18/12 and medication aide and personal care aide dated 05/22/12.
-There was a criminal background check completed on 09/17/14.
-There was no documentation of a criminal background check or consent when Staff B was hired in 2012.

Observation on 04/24/17 at 5:00 a.m. revealed Staff B was working as a medication aide on third shift.

Interview with the Business Office Manager (BOM) on 04/26/17 at 7:50 p.m. revealed:
-She started working at the facility in 2015.
-She was not sure of Staff B's exact hire date but she thought "3/12" meant she was hired on 03/12/12.
-She did not know if a criminal background check was completed when Staff B was hired in 2012.
-Staff B was not a rehired employee so she should have a criminal background check that was completed upon hire in 2012.
-She had audited all of the personnel files last year for completeness and she did not notice a criminal background check was not completed when Staff B was hired.
-She thought maybe the BOM prior to her may have audited personnel files and did a criminal background check if she was unable to locate

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one for Staff B.
-She would check to see if Staff B had any thinned personnel files.

No further criminal background check information was provided by the facility for Staff B.

2. Review of Staff D's personnel file revealed:
-Staff D was hired on 07/23/08.
-There was a job description for Food Service Coordinator dated 10/19/10 and Dining Services Manager dated 05/22/12.
-There was a criminal background check completed on 12/14/12.
-There was no documentation of a criminal background check or consent when Staff D was hired on 07/23/08.

Observation of Staff D throughout the survey on 04/19/17 - 04/21/17 and 04/24/17 - 04/26/17 revealed Staff D was cooking meals in the kitchen and serving food and beverages to the residents in the dining room each day.

Interview with the Business Office Manager (BOM) on 04/26/17 at 7:50 p.m. revealed:
-She started working at the facility in 2015.
-She did not know if a criminal background check was completed when Staff D was hired in 2008.
-Staff D was not a rehired employee so he should have a criminal background check that was completed upon hire in 2008.
-She had audited all of the personnel files last year for completeness and she did not notice a criminal background check was not completed when Staff D was hired.
-She thought maybe the BOM prior to her may have audited personnel files and did a criminal background check if she was unable to locate one for Staff D.

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D 139	Continued From page 26 -She would check to see if Staff D had any thinned personnel files. No further criminal background check information was provided by the facility for Staff D. 3. Review of Staff F's personnel file revealed: -Staff F was hired as a Personal Care Aide on 10/16/10. -Staff F's job description was changed on 05/22/12 to a Medication Aide. -Staff F's job description changed on 01/18/13 to a Supervisor. -Staff F had a criminal background check on 12/13/12. -There was no other documentation of a criminal background check or consent when Staff F was hired in 2010. Observation of Staff F throughout the survey on 04/19/17 - 04/20/17 and 04/24/17 - 04/26/17 revealed Staff F was working at the facility as a Medication Aide (MA)/Supervisor. Interview with the Business Office Manager (BOM) on 04/26/17 at 7:50 p.m. revealed: -She started working at the facility in 2015. -She did not know if a criminal background check was completed when Staff F was hired in 2010. -She had audited all of the personnel files last year for completeness and she did not notice a criminal background check was not completed when Staff F was hired. -She thought maybe the BOM prior to her may have audited personnel files and did a criminal background check if she was unable to locate one for Staff F. -She would check to see if Staff F had any thinned personnel files.	D 139		

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D 139	Continued From page 27 No further criminal background check information was provided by the facility for Staff F.	D 139		
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 (#5) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #5's current FL-2 dated 8/31/16 revealed diagnoses included vascular dementia, depression, cerebral vascular accident in 2009, right sided hemiplegia, gastroesophageal reflux disease (GERD), bronchial asthma, insomnia, and mood disorder. Review of Resident #5s Resident Register revealed the resident was admitted to the facility on 07/15/14.	D 234		

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D 234	Continued From page 28 Review of Resident #5's Immunzation History revealed: -There was no documentation of a completed first or second tuberculosis skin test. -There was no documentation to indicate a tuberculosis skin test had been completed since Resident #5 was admitted to the facility. -A chest x-ray had been completed on 7/15/14 by the physician with no documentation of positive or negative tuberculosis skin test findings. -The chest x-ray was performed for Resident #5 to be admitted to the facility on an emergency basis. -The chest x-ray was performed in the place of TB skin testing. Interview with the Physician on 4/21/17 at 3:30 p.m. revealed: -There was not a current TB skin test on file for Resident #5. -A chest x-ray was performed on 7/15/14 for emergency admission of Resident #5 to the facility. -There was not enough time to administer a first and second tuberculosis skin test for Resident #5 to be admitted to the facility due to the 48 hour waiting period between each test. -The facility had not contacted the physician to conduct TB screenings since admission of Resident #5. Interview with the Special Care Coordinator (SCC) on 4/21/17 at 5:30 p.m. revealed: -She did not have a current TB skin test on file for Resident #5. -The only documentation she had available was a chest x-ray noted in Resident #5's record. -The SCC was responsible for ensuring the residents had TB skin testing completed as	D 234		

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D 234	Continued From page 29 required. -She was not in the role of a SCC at the time Resident #5 was admitted. -The Administrator was responsible for ensuring each resident had one of the two required TB skin tests completed at admission. -The SCC was responsible for ensuring a second TB skin test was performed after admission. -She was unsure what happened with Resident #5's TB skin testing not being completed. -She would ensure Resident #5's TB skin tests were updated. Interview with the Administrator on 4/21/17 at 5:56 p.m. revealed: -He was unaware Resident #5 did not have documentation of a TB skin test upon admission to the facility. -It was not his responsibility to ensure a first TB skin test had been administered at admission for Resident #5. -The SCC was responsible for ensuring both TB skin tests were performed for all residents. -He would follow-up with the SCC to update TB skin testing for Resident #5.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION	D 270		

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D 270	Continued From page 30 The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 5 residents (#1, #3) sampled including a resident with multiple falls resulting in 3 visits to the emergency room (ER) for head injuries requiring staples or liquid sutures (#3) and a resident with multiple falls resulting in two ER visits for bruising and pain in the buttocks (#1). The findings are: Review of the facility's Falls Management Program policy revealed: -It was the policy of the facility for residents to be monitored and identified for risk of falls. -The policy included staff completing incident reports for any fall and notifying the family and physician. -The Executive Director (ED) / Administrator was required to review all incident reports. -The ED/Administrator and Special Care Coordinator (SCC) should determine any immediate interventions based on the circumstances of the fall. -Staff was to complete the 72 Hour Follow-up on Resident Fall forms after each fall to investigate possible circumstances contributing to the fall and document observations for the period of 72 hours after the fall. -The 72 hour documentation included vital signs initially and every shift for 72 hours and 15 minutes checks for 72 hours.	D 270		

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D 270	Continued From page 31 -The facility was to have a Falls Management Team consisting of the ED / Administrator, SCC, medication aide / supervisor, personal care aide, and any other discipline determined by the team. -The Falls Management Team was to meet monthly and document on the Team Meeting QA form for each resident with falls. -The Team should review all resident falls from the past month during the monthly meetings to determine trends for falls, steps the team would implement to assist in preventing falls, and to assure 72 hour follow-up was completed. 1. Review of Resident #3's current FL-2 dated 09/14/16 revealed: -The resident's diagnoses included history of cerebrovascular accident, diabetes mellitus, vascular dementia, hyperlipidemia, anemia, schizophrenia, depressive disorder, and Vitamin B12 deficiency. -The resident was intermittently disoriented. -The resident was a wanderer and verbally abusive. -The resident was non-ambulatory. -The resident required assistance with bathing and dressing. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 02/27/96. Review of Resident #3's current assessment and care plan completed 02/22/17 revealed: -The resident was a wanderer and verbally abusive. -The resident was in a wheelchair and required staff assistance at all times. -The resident would sometimes pull herself down the hall in the wheelchair by the railing on the wall.	D 270		

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-There were times when the resident would pull herself out of the wheelchair to the floor.
-The resident was always disoriented, had significant memory loss, and must be redirected.
-The resident's vision was limited.
-The resident required extensive assistance with bathing, grooming, dressing, and toileting.
-The resident required limited assistance with ambulation and transferring.
-The resident required supervision with eating.

Review of physical therapy (PT) progress notes dated 10/20/16 for Resident #3 revealed:
-PT attempted to evaluate the resident on 10/20/16 but the resident was agitated and uncooperative.
-PT was unable to perform the evaluation on 10/20/16.

Review of accident / injury reports and progress notes from December 2016 - April 2017 for Resident #3 revealed:
-Resident #3 had 11 falls from 12/08/16 - 04/20/17.
-Five of the 11 falls required visits to the emergency room (ER) including 12/11/16, 01/29/17, 03/22/17, 04/05/17, and 04/13/17.
-Three of the ER visits required either staples or skin adhesive to close head wounds including 12/11/16, 03/22/17, and 04/13/17.

Review of accident / injury report and falls worksheets for Resident #3's fall on 12/08/16 revealed:
-On 12/08/16 (10:25 a.m.), the resident threw herself out of wheelchair and fell on floor when trying to roll herself down the hallway by pulling on the handrail. The resident was cursing at staff continuously. No injuries. She was placed on 15 minute checks for fall and behavior.

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D 270	Continued From page 33 -The Falls Risk Worksheet was blank. -The 15 minute checks on the 72 Hour report were not documented from 6:00 a.m. - 10:30 a.m. on 12/11/16. Review of accident / injury report and falls worksheets for Resident #3's fall on 12/11/16 revealed: -On 12/11/16 (1:30 a.m.), the resident was sitting on the floor in her room with a small cut above her left eye. Emergency Medical Services (EMS) was called. -The Falls Risk Worksheet was blank. -The 15 minute checks on the 72 Hour report were not documented from 6:00 a.m. on 12/13/16 through 1:30 a.m. on 12/14/16. Review of Resident #3's hospital emergency room visit form dated 12/11/16 revealed: -The resident was diagnosed with head injury and laceration of forehead without complications. -The laceration was closed with an adhesive. Review of accident / injury report and falls worksheets for Resident #3's fall on 01/29/17 revealed: -On 01/29/17 (1:00 p.m.), the resident was touching the handrail, went forward, fell on the floor and hit her head. The resident had swelling to the forehead and EMS was called and the resident was taken to the hospital. -The Falls Risk Worksheet was blank. -The assessment section to evaluate possible causes of the fall and document vital signs on the 72 Hour Follow-up form was incomplete. -The 15 minute checks for the 72 hour report were not documented from 3:00 p.m. - 3:30 p.m. on 01/30/17, from 11:00 p.m. on 01/30/17 - 6:45 a.m. on 01/31/17, from 9:15 p.m. - 10:45 p.m. on 01/31/17, and from 3:45 a.m. - 1:00 p.m. on	D 270		

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D 270	Continued From page 34 02/01/17. Review of accident / injury report and falls worksheets for Resident #3's fall on 02/08/17 revealed: -On 02/08/17 (5:00 a.m.), the resident was laying on the floor in her room on her right side. No bruises or injuries were found at this time. -The Falls Risk Worksheet was blank. Review of a primary care provider (PCP) visit summary dated 02/08/17 for Resident #3 revealed the resident was seen for a fall and the PCP had no new orders. Review of accident / injury report and falls worksheets for Resident #3's fall on 02/12/17 revealed: -On 02/12/17 (10:00 a.m.), the resident slid down and hit her left foot. The resident had a skin tear on left foot. -The Falls Risk Worksheet was blank. -The 15 minute checks for the 72 hour report were not documented from 7:00 a.m. - 10:00 a.m. on 02/15/17. Review of accident / injury report and falls worksheets for Resident #3's fall on 02/15/17 revealed: -On 02/15/17 (10:15 a.m.), the resident was in the hallway and fell out of wheelchair. No injury noted. -The Falls Risk Worksheet was blank. -The 15 minute checks for the 72 hour report were not documented from 6:00 a.m. - 10:15 a.m. on 02/18/17. Review of a primary care provider (PCP) visit summary dated 02/15/17 for Resident #3 revealed:	D 270		

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D 270	Continued From page 35 -The reason for the visit was fall, dementia, and anxiety. -The resident had no injuries per staff. -The PCP wrote no new orders. Review of accident / injury report and falls worksheets for Resident #3's fall on 03/19/17 revealed: -On 03/19/17, there was no accident report for a fall on 03/19/17 at 9:35 p.m. -The Falls Risk Worksheet was blank. -The 15 minute checks for the 72 hour report were not documented from 6:00 p.m. - 11:00 p.m. on 03/20/17 and from 6:00 a.m. - 8:15 a.m. and at 2:45 p.m. on 03/22/17. Review of accident / injury report and falls worksheets for Resident #3's fall on 03/22/17 revealed: -On 03/22/17 (4:45 a.m.), the resident was laying on the floor in her room with blood coming from her head. EMS was called immediately. -The Falls Risk Worksheet was blank. -The assessment section to evaluate possible causes of the fall and document vital signs on the 72 Hour Follow-up form was incomplete. -The 15 minute checks for the 72 hour report were not documented from 10:00 p.m. on 03/22/17 - 5:45 a.m. on 03/23/17, from 2:45 p.m. - 10:45 p.m. on 03/23/17, and from 7:00 a.m. 10:45 p.m. on 03/24/17. Review of Resident #3's hospital emergency room visit form dated 03/22/17 revealed: -The resident was diagnosed with a head injury, a cut on skin on top or back of head, and contusion of right forearm. -The wound was closed with staples. Review of a primary care provider (PCP) visit	D 270		

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summary dated 03/22/17 for Resident #3 revealed:
-The reason for the visit was for a follow-up to a fall and scalp abrasion.
-The PCP ordered to discontinue the resident's twice weekly blood pressure checks.
-There were no other orders noted.

Review of a primary care provider (PCP) visit summary dated 03/29/17 for Resident #3 revealed:
-The PCP removed staples from the resident's scalp.
-The PCP had no new orders.

Review of accident / injury report and falls worksheets for Resident #3's fall on 04/05/17 revealed:
-On 04/05/17 (10:55 a.m.), staff was walking down the hallway pushing the resident in the wheelchair when resident went forward and lunged onto the floor, bumping her head. The resident had swelling and laceration to head. EMS was called. A note written by the Special Care Coordinator (SCC) at the bottom of the form dated 04/06/17 indicated the SCC spoke with the resident's legal guardian and she was going to check with physical therapy to see if they could get a wheelchair that reclined back so the resident would not be leaning forward when falling asleep.
-The Falls Risk Worksheet was blank.
-The assessment section to evaluate possible causes of the fall and document vital signs on the 72 Hour Follow-up form was incomplete.
-The 15 minute checks on the 72 hour report were not documented from 9:00 a.m. - 5:45 p.m. on 04/06/17 and from 6:00 a.m. on 04/07/17 - 11:00 a.m. on 04/08/17.

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D 270	Continued From page 37 Review of a hospital emergency room visit form dated 04/05/17 for Resident #3 revealed the resident was diagnosed with a fall and bruise of the face, neck, or scalp. Review of a primary care provider (PCP) visit summary dated 04/05/17 for Resident #3 revealed: -The resident had a left frontal scalp contusion with no fracture. -The resident continued to remain a fall risk due to cognitive and physical debility. Review of a hospital emergency room visit form dated 04/13/17 for Resident #3 revealed the resident was diagnosed with a fall and cut on forehead closed with an adhesive. Review of accident / injury report and falls worksheets for Resident #3's fall on 04/13/17 revealed: -On 04/13/17 (2:34 p.m.), staff was pushing the resident in the wheelchair and the resident was leaning forward. Staff was trying to hold on to her shoulder and all of a sudden, the resident jumped out of her wheelchair. The resident had swelling and laceration to right side of head. EMS was called. -The Falls Risk Worksheet was blank. -The assessment section to evaluate possible causes of the fall and document vital signs on the 72 Hour Follow-up form was incomplete. -The 15 minute checks on the 72 hour report were not documented from 3:45 p.m. - 4:45 p.m. and 5:15 p.m. - 5:45 p.m. on 04/14/17 and from 6:00 a.m. on 04/15/17 - 2:30 p.m. on 04/16/17. Review of accident / injury report and falls worksheets for Resident #3's fall on 04/20/17 revealed:	D 270		

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-On 04/20/17 (1:20 a.m.), the resident was found sitting on the floor on her bottom beside the bed. No injuries.
-The Falls Risk Worksheet was blank.
-The 15 minute checks on the 72 hour report were not documented from 1:45 p.m. - 10:45 p.m. on 04/20/17, from 10:30 a.m. - 11:15 a.m. and 2:00 p.m. - 2:45 p.m. on 04/21/17, from 6:00 p.m. - 11:30 p.m. on 04/22/17, and from 12:00 a.m. - 1:30 a.m. on 04/23/17.

Review of the Fall Management Team Meeting worksheets from 12/2016 - 04/2017 revealed no monthly evaluations had been completed for Resident #3 to assess causes and to determine interventions needed.

Observation of Resident #3 on 04/24/17 at 5:35 a.m. and 6:00 a.m. revealed:
-The resident was sitting in her wheelchair near the nurses' station.
-The resident was leaning forward in the wheelchair.
-The resident would not speak when asked questions.

Interview with a PCA on 04/21/17 at 2:50 p.m. revealed:
-Resident #3 fell out of bed and hit her head about 1 to 2 weeks ago on third shift.
-The PCA was not working on Resident #3's hall when she fell.

Interview with a medication aide (MA) on 04/25/17 at 3:40 p.m. revealed:
-She thought Resident #3 needed one-on-one supervision but they did not have enough staff to do that.
-Staff had to hold Resident #3's shoulder when they were pushing her in the wheelchair because

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the resident would lean forward.
-The resident would rock forward in the wheelchair to self-propel it and she would lose her balance and fall forward.

Interview with a personal care aide (PCA) on 04/25/17 at 6:10 p.m. revealed:
-Staff could not get 15 minute or 30 minute supervision checks done because there was not enough staff to do it.
-She thought staff could help prevent some falls if they had more staff to supervise the residents.
-Resident #3 sat on the edge of her wheelchair.
-Resident #3 did not want staff to touch her wheelchair when staff would try to push the resident in her wheelchair.
-Resident #3 would lunge forward to try to get away from staff.
-The resident would scoot with one foot and pull on the hand rail on the wall to self-propel the wheelchair.

Review of Resident #3's current special care unit quarterly profile and care plan dated 04/25/17 revealed:
-The resident required extensive assistance with ambulation.
-Staff assisted the resident in the wheelchair at times.
-The resident could pull herself with the railing while in the wheelchair to ambulate.
-The resident had a fall mat on the floor when she was in bed and staff made sure the mat was in place.
-The resident required extensive assistance with toileting, bathing, dressing, grooming, and transferring.

Telephone interview with Resident #3's legal guardian on 04/26/17 at 12:15 p.m. revealed:

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-The resident had a succession of falls because she pulled herself out of the wheelchair.
-The resident used the handrails on the walls to pull herself in the wheelchair.
-She recently had another fall last week and was sent to the ER.
-She did not know how often staff monitored the resident.
-She was concerned because the resident continued to have falls and had injuries from the falls.

Interview with Resident #3's primary care provider (PCP) on 04/26/17 at 12:38 p.m. revealed:
-She was aware of Resident #3's falls.
-The resident had been to the emergency room on a few occasions due to falls.
-The resident seemed to be having mechanical falls and sliding out of the wheelchair.
-The resident had advanced dementia and was always anxious.
-The PCP did not think the resident called for help when she needed it due to cognitive limitations.
-She thought a fall alarm may help with the resident's falls because of the way the resident would lean forward in the wheelchair.
-She thought one-on-one supervision would help decrease Resident #3's falls.
-The SCC just asked the PCP today about either a higher level of care or hospice services for the resident.
-The PCP was planning to make a referral to hospice for the resident today.

Interview with the Special Care Coordinator (SCC) on 04/26/17 at 1:15 p.m. revealed:
-They tried to keep Resident #3 close to the front of the facility.
-Resident #3 had a fall mat at bedside.
-Staff check on Resident #3 during routine 30

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minute checks unless she had a fall and then it would be 15 minute checks for 72 hours.
-She had not evaluated if supervision was adequate for Resident #3 and if the resident could benefit from 15 minutes checks all the time instead of only for 72 hours after a fall.

Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staffing.

Refer to interview with the Administrator on 04/26/17 at 3:10 p.m.

Refer to interview with the Special Care Coordinator (SCC) on 04/24/17 at 6:15 p.m.

Refer to interview with the SCC on 04/26/17 at 1:15 p.m.

2. Review of Resident #1's current FL-2 dated 08/03/16 revealed:
-The resident's diagnoses included Alzheimer's dementia, tardive dyskinesia, coronary artery disease, and Asperger's syndrome (autism).
-The resident was constantly disoriented.
-The resident was semi-ambulatory and had a wheelchair.
-The resident required assistance with bathing and dressing.

Review of Resident #1's special care unit pre-admission screening dated 08/20/15 revealed:
-The resident's gait was impaired from dyskinesia (a movement disorder).
-The resident's coordination was poor at times.
-The resident had a history of falls.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility

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D 270	Continued From page 42 on 08/20/15. Review of Resident #1's current assessment and care plan completed 03/30/17 revealed: -The resident had limited ability with ambulation. -The resident had limited strength and range of motion in upper extremities. -The resident had daily incontinence of bowel and bladder. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required extensive assistance with bathing, grooming, dressing, and toileting. -The resident required limited assistance with transferring and eating. -The resident required supervision with ambulation. Review of accident / injury reports and progress notes from January 2017 - April 2017 for Resident #1 revealed: -Resident #1 had 8 falls from 01/13/17 - 04/10/17. -The resident had 2 visits to the emergency room (ER) on 03/17/17 and 03/18/17 with bruising and pain in buttocks from falls that required an order for pain medication. Review of accident / injury reports, progress notes and falls worksheets for Resident #1's fall on 01/13/17 revealed: -On 01/13/17 (8:30 a.m.), the resident tripped on shoe and fell. No injuries. The resident was put on 15 minutes checks and 72 hour follow-up. -The Fall Risk Worksheet was blank. -The 15 minute checks on the 72 hour report were not documented from 6:00 a.m. - 8:30 a.m. on 01/16/17. Review of a PCP visit summary dated 01/18/17 for Resident #1 revealed the resident was seen	D 270		

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for follow-up to a fall and there were no new orders.

Review of a progress note dated 02/15/17 (1:34 p.m.) revealed Resident #1 was seen by the PCP today and his medication for overactive bladder was decreased.

Review of accident / injury reports, progress notes and falls worksheets for Resident #1's falls on 03/01/17 revealed:
-03/01/17 (6:20 a.m.): The resident was found on floor by an aide in a sitting position and resident advised that only his buttocks were hurt. No bruising or redness was noted at the time and the resident stated he was okay.
-03/01/17 (3:50 p.m.): The resident tripped over his feet falling to the floor hitting his right knee. The resident had bruising on his right knee. The PCP's office was notified.
-The Fall Risk Worksheet was blank.

Review of a PCP visit summary dated 03/01/17 for Resident #1 revealed the resident had a fall today with no injuries and the PCP discontinued the resident's overactive bladder medication.

Review of progress notes dated 03/01/17 (2:26 p.m.) for Resident #1 revealed the resident received Tylenol for pain from a fall the resident had early this morning.

Review of a PCP visit summary dated 03/08/17 for Resident #1 revealed the resident was seen for recurrent falls and the PCP ordered blood pressures twice a week for one month.

Review of accident / injury reports, progress notes and falls worksheets for Resident #1's fall on 03/10/17 revealed:

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-03/10/17 (10:45 a.m.): The resident tripped over his shoe and fell to his buttocks. No injuries and PCP was notified. The resident was put on 15 minute checks and 72 hour follow-up report.
-The Fall Risk Worksheet was blank.
-The 15 minute checks on the 72 hour report were not documented from 6:00 a.m. - 11:00 a.m. on 03/13/17.

Review of physical therapy (PT) notes for Resident #1 revealed:
-The resident started physical therapy on 03/16/17 for unsteadiness on feet and generalized muscle weakness.
-The resident was last seen by PT on 04/07/17.

Review of accident / injury reports, progress notes and falls worksheets for Resident #1's fall on 03/17/17 revealed:
-03/17/17 (5:30 a.m.): The resident had a fall this morning at 3:30 a.m. No bruises / injuries were visible at that time. The family and PCP were notified. At 5:30 a.m., staff noticed swelling on left side of resident's bottom. Staff reported the resident had a bruise on his left buttock due to fall earlier in the morning. Emergency Medical Services (EMS) was called and the resident was taken to the emergency room (ER).
-03/17/17 (10:16 a.m.): The resident returned from the ER at 10:00 a.m. He was diagnosed with pain in buttock and he has been put on 15 minute checks and 72 hour follow-up.
-The Fall Risk Worksheet was blank.
-The assessment section to evaluate possible causes of the fall and document vital signs on the 72 Hour Follow-up form was incomplete.

Review of Resident #1's hospital emergency room form dated 03/17/17 revealed the resident was seen for bruising after a fall and pain in

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D 270	Continued From page 45 buttocks. Review of accident / injury reports, progress notes and falls worksheets for Resident #1's fall on 03/18/17 revealed: -03/18/17 (3:20 a.m.): The resident was laying on the floor in his room. No injuries found. -03/18/17 (3:36 p.m.): The resident fell on the floor. The resident stated he was trying to stand up and put on his incontinence brief. Around 1:00 p.m. staff contacted the SCC via phone and reported the resident's family member was at the facility and upset because she did not think the facility was looking after the resident like they should. The SCC explained to the family member that the resident was already on 15 minutes checks and staff helped the resident when he needed it. Staff was not going to stay in the resident's room every minute because there were other residents that needed assistance too. -03/18/17 (11:31 p.m.): The resident was sent back to the ER on 03/18/17 for symptoms from a previous fall of bruising on the buttocks and the groin area from a fall on 03/17/17 at the family's request. The resident returned from the ER with diagnoses of simple bruising and a prescription for Naproxen (a pain medication). -The Fall Risk Worksheet was blank. -The 15 minute checks on the 72 hour report were not documented from 6:00 a.m. - 6:45 a.m. on 03/20/17. Review of Resident #1's hospital emergency room form dated 03/18/17 revealed the resident was seen for simple bruising and a fall and was given an order for Naproxen (for pain). Review of a PCP visit summary dated 03/19/17 for Resident #1 revealed the resident was seen for follow-up to a fall and there were no new	D 270		

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orders.

Review of a progress note dated 03/21/17 (1:46 p.m.) for Resident #1 revealed the resident had an order for a urinalysis to be done. The resident was on 15 and 30 minute checks and staff was helping him with assistance.

Review of a PCP visit summary dated 03/22/17 for Resident #1 revealed:
-The resident was seen for follow-up to a fall, pain in hip and sacral area, and depression.
-The PCP ordered a referral for the resident to see a mental health provider for depression.

Review of accident / injury reports, progress notes and falls worksheets for Resident #1's fall on 04/05/17 revealed:
-04/05/17 (1:50 a.m.): The resident screamed for help. The resident was found on the floor by the bed. The resident had a small scratch on the lower right side of his back. The SCC documented on the bottom of the report on 04/06/17 that she spoke with the family about getting a chair / bed alarm and the family was in agreement. The resident was on 15 minute checks.
-The Fall Risk Worksheet was blank.
-The assessment section to evaluate possible causes of the fall and document vital signs on the 72 Hour Follow-up form was incomplete.
-The 15 minute checks on the 72 hour form were not documented from 10:45 p.m. on 04/05/17 - 7:00 a.m. on 04/06/17 and from 11:15 p.m. on 04/06/17 - 2:00 a.m. on 04/08/17.

Review of accident / injury reports, progress notes and falls worksheets for Resident #1's fall on 04/10/17 revealed:
-04/10/17 (8:03 p.m.): The resident called for help

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and aides found him on the floor on his knees. No injuries were present.
-The Fall Risk Worksheet was blank.
-The assessment section to evaluate possible causes of the fall and document vital signs on the 72 Hour Follow-up form was incomplete.
-The 15 minute checks on the 72 hour form were not documented from 11:00 p.m. on 04/10/17 - 6:45 a.m. on 04/11/17, from 10:45 p.m. on 04/11/17 - 5:45 a.m. on 04/12/17, from 11:30 p.m. on 04/12/17 - 6:45 a.m. on 04/13/17, and from 6:00 p.m. - 8:00 p.m. on 04/13/17.

Review of a PCP visit summary dated 04/12/17 for Resident #1 revealed the resident was seen for follow-up to a fall and the PCP ordered a bed alarm.

Review of Resident #1's progress note dated 04/14/17 (10:16 a.m.) revealed the resident was seen by the PCP on 04/12/17 and he needs a bed and chair alarm.

Review of the Fall Management Team Meeting worksheets from 12/2016 - 04/2017 revealed no monthly evaluations had been completed for Resident #3 to assess causes and to determine interventions needed.

Review of Resident #1's current special care unit profile and care plan dated 04/24/17 revealed:
-The resident required limited assistance with ambulation and staff was to assist and supervise when the resident was up because he was a fall risk at times.
-The resident required limited assistance with transferring and staff would supervise him and assist him at all times because he was a fall risk.
-The resident had a bed alarm at bedtime when he was in bed and staff would check to make

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sure he had the alarm on and assist as needed.
-The resident did not have much control over his arms, hands, and legs which causes him to be a fall risk at times.
-Staff would assist the resident when needed and supervise to help keep him safe and redirect him when needed.

Interview with a PCA on 04/21/17 at 2:50 p.m. revealed:
-She tried to keep a constant check on Resident #1 and watch him frequently because his family wanted him to be watched.
-Resident #1 had fallen on third shift but she could not recall a date.

Interview with the Special Care Coordinator (SCC) on 04/24/17 at 6:15 p.m. revealed:
-Resident #1 would urinate in his trash can and slip on the urine on the floor or sometimes he tried to get up too fast.
-Resident #1 had abnormal movements and he was supposed to wait for help but he was impatient.

Interview with Resident #1 on 04/25/17 at 2:58 p.m. revealed:
-He had multiple falls and his buttocks were still tender from a recent fall.
-He had physical therapy recently which he thought helped.
-Staff checked on him every couple of hours.
-He had a bed alarm for when he was lying in bed.

Interview with a medication aide (MA) on 04/25/17 at 3:40 p.m. revealed:
-Resident #1 did not come out of his room except for meals and to use the bathroom.
-The resident had a lot of falls.

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D 270	Continued From page 49 -The resident had dark purple bruises on his bottom, the back of his legs and his scrotum after one of the falls. Interview with a personal care aide (PCA) on 04/25/17 at 6:10 p.m. revealed: -Staff could not get 15 minute or 30 minute supervision checks done because there was not enough staff to do it. -She thought staff could help prevent some falls in they had more staff to supervise the residents. -Resident #1 had falls because he had an unsteady gait. -The resident got agitated when his family left from visits and he would become more attention seeking. -The resident would urinate in his trash can and he would use the bed alarm as a call bell to get staff's attention when he was upset. Telephone interview with Resident #1's family member on 04/26/17 at 10:20 a.m. revealed: -There had been numerous incidents of Resident #1 falling. -The resident had dementia and forgot to wait for staff to assist him. -He had one severe fall with contusions on his buttocks, inner thigh, scrotum and penis. -The resident had a movement disorder and had received physical therapy recently. -Staff tell her they check on the resident every 15 minutes. -She visited one day and was in the resident's room for over an hour and no staff checked on the resident. -They did not have enough staff at the facility. Interview with Resident #1's primary care provider (PCP) on 04/26/17 at 12:30 p.m. revealed: -The resident had several falls and it had been	D 270		

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D 270	Continued From page 50 ongoing for the last few months. -The resident bruised his buttocks on occasion due to a fall. -The resident had tardive dyskinesia and gait dysfunction and was declining overall. -The resident had some falls at night when he stepped in urine on the floor. -PT had worked with the resident recently. -She had decreased his overactive bladder medication because of potential side effects that could contribute to falls. -Staff needed to remind the resident to call for help. -They could possibly move the resident to a room that was closer to the nurses' station so they could keep a closer eye on him and check him more frequently than the routine 30 minute checks. Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staffing. Refer to interview with the Administrator on 04/26/17 at 3:10 p.m. Refer to interview with the Special Care Coordinator (SCC) on 04/24/17 at 6:15 p.m. Refer to interview with the SCC on 04/26/17 at 1:15 p.m. _____ Interview with the Administrator on 04/26/17 at 3:10 p.m. revealed: -He was aware of the facility's Falls Management Program, including the worksheets that had to be completed and the 15 minute checks for 72 hours. -The Fall Risk worksheets were supposed to be filled out by the medication aides on duty and	D 270		

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D 270	Continued From page 51 once completed it was forwarded to the SCC. -They were supposed to have a Falls Management Team to meet monthly and fill out the team form but he did not have time to do it. -They did not have meetings or fill out the monthly forms to evaluate causes or interventions for falls. -The staff usually discussed issues with falls during daily stand up meetings. -He was not aware staff were not documenting on the falls forms as required or doing all 15 minute supervision checks as required. Interview with the Special Care Coordinator (SCC) on 04/24/17 at 6:15 p.m. revealed: -The facility's policy was to do 15 minute checks for 72 hours after a fall. -Other interventions she tried to do were physical therapy / occupational therapy, fall mats, bed/chair alarms, and always follow-up with the physician. -They always went back to routine 30 minute checks for all residents after the 72 hours. Interview with the Special Care Coordinator (SCC) on 04/26/17 at 1:15 p.m. revealed: -The SCC and the Administrator were responsible for filling out Falls Risk Worksheets but she had not had time to fill them out. -They did not have a Falls Management Team because the Administrator had not coordinated any meetings. _____ The facility failed to implement the facility's falls management policy and provide supervision in accordance with the policy for Resident #3 who had 11 falls from 12/08/16 - 04/20/17 including 3 visits to the emergency room (ER) for head injuries requiring staples or liquid sutures; and for Resident #1 who had 8 falls from 01/13/17 -	D 270		

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D 270	Continued From page 52 04/05/17 including 2 visits to the ER for bruising and pain in the buttocks. The facility failed to meet minimum staffing requirements at times when resident falls occurred. The failure of the facility to implement their falls management policy and provide adequate supervision for the safety and well-being resulted in substantial risk of serious neglect and physical harm to two residents and constitutes a Type A2 Violation. _____ Review of the facility's Plan of Protection dated 04/21/17 revealed: -All staff on duty would be re-educated on high fall risk residents and residents with aggressive behaviors to include all shifts going forward for 24 hours. The fall policy would be reviewed. -Fall risk and behavior mood forms would be reviewed with each shift and initialed. -Staff would also be directed to remain in their assigned areas. -Stand up meetings at the beginning of each shift would communicate high risk fall residents and residents with increased behaviors or other supervision needs that may require redirection. -Formal training on falls and behaviors would be held within 30 days and then at a minimum of once annually. -High risk falls and aggressive behaviors would be reviewed daily time two weeks, two times a week for 2 months, then weekly. This would be monitored by management/designee. -Staff would complete the 72 hour follow up to investigate factors contributing to the fall and document 15 minute checks for 72 hours after the fall. -Monthly team fall meetings would review interventions put in place and a reassessment completed after every fall.	D 270		

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D 270	Continued From page 53 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 26, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 3 of 5 residents (#1, #3, #4) sampled by failing to notify a resident's physician of multiple medication refusals (#4), failing to coordinate with a physical therapist or physician to obtain a new wheelchair for a resident with multiple falls with injuries (#3), and failing to coordinate a mental health referral for a resident with symptoms of depression, anxiety, and agitation (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 09/14/16 revealed: -The resident's diagnoses included history of cerebrovascular accident, diabetes mellitus, vascular dementia, hyperlipidemia, anemia, schizophrenia, depressive disorder, and Vitamin B12 deficiency. -The resident was intermittently disoriented. -The resident was a wanderer and verbally	D 273		

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abusive.
-The resident was non-ambulatory.
-The resident required assistance with bathing and dressing.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 02/27/96.

Review of Resident #3's current assessment and care plan completed 02/22/17 revealed:
-The resident was a wanderer and verbally abusive.
-The resident was in a wheelchair that required staff assistance at all times.
-The resident would sometimes pull herself down the hall in the wheelchair by the railing on the wall.
-There was times when the resident would pull herself out of the wheelchair to the floor.
-The resident was always disoriented, had significant memory loss, and must be redirected.
-The resident's vision was limited.
-The resident required extensive assistance with bathing, grooming, dressing, and toileting.
-The resident required limited assistance with ambulation and transferring.
-The resident required supervision with eating.

Review of accident / injury reports and progress notes from December 2016 - April 2017 for Resident #3 revealed:
-Resident #3 had 11 falls from 12/08/16 - 04/20/17.
-Five of the 11 falls required visits to the emergency room (ER) including 12/11/16, 01/29/17, 03/22/17, 04/05/17, and 04/13/17.
-Three of the ER visits required either staples or skin adhesive to close head wounds including 12/11/16, 03/22/17, and 04/13/17.

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-Five of the falls were documented the resident fell out of her wheelchair including 12/08/16, 01/29/17, 02/15/17, 04/05/17, and 04/13/17.

Observation of Resident #3 on 04/24/17 at 5:35 a.m. and 6:00 a.m. revealed:
-The resident was sitting in her wheelchair near the nurses' station.
-The resident was leaning forward in the wheelchair.
-The resident would not speak when asked questions.

Interview with a medication aide (MA) on 04/25/17 at 3:40 p.m. revealed:
-Staff had to hold Resident #3's shoulder when they were pushing her in the wheelchair because the resident would lean forward.
-The resident would rock forward in the wheelchair to self-propel it and she would lose her balance and fall forward.
-Staff had discussed Resident #3 in the stand-up meetings about getting a different wheelchair for her.
-She did know if anyone was working on getting a different wheelchair for Resident #3.

Interview with the Special Care Coordinator (SCC) on 04/24/17 at 6:15 p.m. revealed:
-Resident #3 reached for the handrail and leaned forward in the wheelchair causing her to fall out of the chair.
-She had talked with Resident #3's guardian about getting a different wheelchair (could not recall when).
-She could not recall if Resident #3 had physical therapy.

Telephone interview with Resident #3's legal guardian on 04/26/17 at 12:15 p.m. revealed:

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-The resident had a succession of falls because she pulled herself out of the wheelchair.
-The resident used the handrails on the walls to pull herself in the wheelchair.
-She recently had another fall last week and was sent to the ER.
-She had asked the SCC several times to have the resident evaluated by physical therapy (PT) for a different type of wheelchair.
-She last spoke to the SCC about a month ago about getting PT to see if the resident could benefit from a different type of wheelchair so the resident would not lean forward as much.
-The SCC was supposed to contact her back about it but she had not heard back from the SCC about the resident's wheelchair or a PT evaluation.
-She was concerned because the resident continued to have falls and had injuries from the falls.

Review of Resident #3's current special care unit quarterly profile and care plan dated 04/25/17 revealed:
-The resident required extensive assistance with ambulation.
-Staff assisted the resident in the wheelchair at times.
-The resident could pull herself with the railing while in the wheelchair to ambulate.
-The resident had a fall mat on the floor when she was in bed and staff made sure the mat was in place.
-The resident required extensive assistance with toileting, bathing, dressing, grooming, and transferring.

Interview with Resident #3's primary care provider (PCP) on 04/26/17 at 12:38 p.m. revealed:
-She was aware of Resident #3's falls.

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-The resident had been to the emergency room on a few occasions due to falls.
-The resident seemed to be having mechanical falls and sliding out of the wheelchair.
-The resident had advanced dementia and was always anxious.
-The PCP did not think the resident called for help when she needed it due to cognitive limitations.
-The resident was unable to do physical therapy because of cognitive limitations.

Interview with the Special Care Coordinator (SCC) on 04/26/17 at 1:15 p.m. revealed:
-She had asked a physical therapist (PT) who was in the facility for another resident about getting a different wheelchair for Resident #3 around the beginning of March 2017.
-There was discussion about whether the resident's insurance would pay for a new wheelchair.
-The PT was going to check on it and get back with her.
-She did not document her conversation with the PT.
-She had not heard back from the PT.
-The SCC had not contacted the PT or the agency back about getting a new wheelchair for the resident.
-The SCC had not contacted the PCP about getting a new wheelchair for the resident.

Attempts to contact the physical therapy agency by the end of the survey on 04/26/17 were unsuccessful.

2. Review of Resident #1's current FL-2 dated 08/03/16 revealed:
-The resident's diagnoses included Alzheimer's dementia, tardive dyskinesia, coronary artery disease, and Asperger's syndrome (autism).

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D 273	Continued From page 58 -The resident was constantly disoriented. -The resident was semi-ambulatory and had a wheelchair. -The resident required assistance with bathing and dressing. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/20/15. Review of Resident #1's current assessment and care plan completed 03/30/17 revealed: -The resident was verbally abusive and had developmental disabilities and mental illness. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required extensive assistance with bathing, grooming, dressing, and toileting. -The resident required limited assistance with transferring and eating. -The resident required supervision with ambulation. Interview with a medication aide (MA) on 04/25/17 at 3:40 p.m. revealed: -Resident #1 did not come out of his room except for meals and to use the bathroom. -When Resident #1's family visited and left, the resident would get depressed. -When the resident was depressed, he would have more attention seeking behavior like urinating more on himself and ringing his hand bell more often. Review of a primary care provider (PCP) visit summary dated 03/22/17 for Resident #1 revealed: -The resident was seen for follow-up to a fall, pain in hip and sacral area, and depression. -The PCP ordered a referral for the resident to	D 273		

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D 273	Continued From page 59 see a mental health provider for depression. Interview with Resident #1 on 04/25/17 at 2:58 p.m. revealed: -It was "depressing" living at the facility. -He had not seen a mental health therapist. -He did not know if he was supposed see a therapist. Interview with the Special Care Coordinator (SCC) on 04/25/17 at 10:18 a.m. revealed: -She could not recall if the mental health referral had been set up for Resident #1. -She usually called or emailed the mental health provider when they received referrals and she had to get consents from the family. Review of a mental health services consent for treatment form for Resident #1 provided by the SCC revealed: -The form was signed by the SCC indicating she received verbal consent from Resident #1's family member on 03/23/17 at 7:14 p.m.. -The SCC documented she emailed the form to the mental health provider on 03/23/17. -The SCC documented she re-emailed the form to the mental health provider on 04/25/17. Telephone interview with Resident #1's family member on 04/26/17 at 10:20 a.m. revealed: -She requested the resident's PCP to order a mental health referral about a month ago because the resident was agitated, anxious, and depressed. -No one at the facility had contacted her to get permission for the resident to receive mental health services. -She did not know why he had not seen a mental health provider.	D 273		

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D 273	Continued From page 60 Interview with the SCC on 04/25/17 at 12:10 p.m. revealed: -She got a verbal consent from the family member and emailed documentation of the consent to the mental health provider on 03/22/17. -She called the mental health provider today, 04/25/17, and they said they did not get the email. -She overlooked the referral after she emailed it and did not contact the mental health provider about the referral until today, 04/25/17. -She set up an appointment today for the resident to be seen in May 2017. -She would contact the PCP and let her know the mental health referral had not been done. Interview with Resident #1's primary care provider (PCP) on 04/26/17 at 12:30 p.m. revealed: -The resident was constantly depressed and had difficulty sleeping. -The resident got aggravated when his family visited and then left. -The resident's family member had asked about giving the resident some medication for depression. -The PCP decided to make a referral to mental health to try therapy first in March 2017. -The PCP did not want to start a medication for depression first because potential side effects could contribute to more falls for the resident. -The PCP was not aware the order for mental health referral for Resident #1 in March 2017 had not been followed up. Telephone interview with the Facility Coordinator for the Mental Health Agency on 04/25/17 at 1:30 p.m. revealed: -She was not on duty when the facility emailed the mental health referral for Resident #1 in March 2017.	D 273		

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-She could not recall what date the email was received.
-New staff printed out the email and put it in a stack of papers.
-Insurance and consent had to be verified.
-No one from the facility had contacted them about the referral or setting up an appointment since the email was sent other than today, 04/25/17.
-They set up a time today for the resident to be seen by a therapist and a provider on 05/17/17.

3. Review of Resident #4's current FL-2 dated 04/04/17 revealed:
-Diagnoses included dementia, congestive heart failure, gastric bypass, and Type 2 diabetes.
-The resident was ambulatory and constantly disoriented.
-There was an order for Gabapentin 300 mg every hour of sleep (used for nerve pain).
-There was an order for Levothyroxine 0.125mg daily (used for an underactive thyroid).
-There was an order for Melatonin 3 mg every evening (used to aid in sleep).
-There was an order for Pantoprazole 20 mg daily (used to decrease stomach acid).
-There was an order for Trazodone 50 mg at bedtime (used as a sedative and antidepressant).

Review of Resident #4's Resident Register revealed an admission date of 08/23/16.

Review of Resident #4's prior FL-2 dated 01/26/17 revealed:
-Diagnoses included dementia, diabetes type 2, hypertension, congestive heart failure, gout, coronary obstructive pulmonary disease, obstructive sleep apnea, hypothyroid, chronic venous insufficiency, and chronic low back pain.
-There was an order for Lipitor 10 mg at bedtime

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(used to treat high cholesterol).
-There was an order for Melatonin 3 mg every evening.
-There was an order for Terazosin 10 mg at bedtime (used to treat urine retention and high blood pressure).
-There was an order for Allopurinol 300 mg daily (used to treat gout).
-There was an order for Aspirin 325 mg daily (used as a blood thinner).
-There was an order for Levothyroxine 0.125mg daily.
- There was an order for Glipizide 10 mg twice daily (used to treat high blood sugar).
-There was an order for Metoprolol 50 mg twice daily (used to treat high blood pressure).
- There was an order for Pantoprazole 20 mg daily.

Review of the facility's Policy for Medication Refusal revealed:
-If a resident refused medications for 3 consecutive doses, the facility shall notify the prescribing practitioner.
-The prescribing practitioner would be asked the following questions concerning the medication being refused: should the medication be discontinued at this time or should the facility continue to offer the refused medication.
-The facility staff shall document the prescribing practitioner's response in the nursing notes and write a telephone order in the resident's chart.

Review of Resident #4's Medication Administration Record (MAR) for February 2017 revealed:
-The Medication Aides (MAs) had documented medication refusals in the exceptions section of the MAR.
-There was an entry for Allopurinol 300 mg daily,

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scheduled to be administered at 8:00 a.m. The MAs had documented the resident had refused Allopurinol 300 mg daily for 5 consecutive doses from 02/14/17 - 02/18/17 and 7 consecutive doses from 02/20/17 - 02/26/17.
-There was an entry for Aspirin 325 mg daily, scheduled to be administered at 8:00 a.m. The MAs had documented the resident had refused Aspirin 325 mg daily on 02/22/17 and 3 consecutive doses from 02/24/17 - 02/26/17.
-There was an entry for Lipitor 10 mg at bedtime, scheduled to be administered at 8:00 p.m. The MAs had documented the resident had refused Lipitor 10 mg at bedtime for 5 consecutive doses from 02/23/17 - 02/27/17.
-There was an entry for Glipizide 10mg twice daily before meals, scheduled to be administered at 7:00 a.m. and 4:30 p.m. The MAs had documented the resident refused Glipizide 10mg twice daily for 10 consecutive doses from the 7:00 a.m. dose on 02/14/17 through the 4:30 pm dose on 02/18/17, 7 consecutive doses refused from the 4:30 p.m. dose on 02/19/17 through the 4:30 p.m. dose on 02/22/17 and 3 consecutive doses refused at 7:00 a.m. on 02/27/17 through the 7:00 a.m. dose on 02/28/17. The MAs also documented the resident refused 2 doses of the 7:00 a.m. dose on 02/25/17 and 02/26/17.
-There was an entry for Levothyroxine 125mcg daily before meals, scheduled to be administered at 6:00 a.m. The MAs had documented the resident had refused Levothyroxine 125mcg daily for 3 consecutive doses from 02/26/17-02/28/17. The MAs also documented the resident refused doses on 02/15/17, 02/17/17, 02/18/17, and 02/22/17.
-There was an entry for Melatonin 3 mg at bedtime, scheduled to be administered at 8:00 p.m. The MAs had documented the resident had refused Melatonin 3 mg at bedtime for 5

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consecutive doses from 02/23/17 - 02/27/17.
-There was an entry for Metoprolol 50 mg twice daily, scheduled to be administered at 8:00 a.m. and 8:00 p.m. The MAs had documented the resident refused Metoprolol 50 mg twice daily for 3 consecutive doses from the 8:00 p.m. dose on 02/23/17 through the 8:00 p.m. dose on 02/24/17. The MAs also documented the resident refused the 8:00 am dose on 02/22/17 and the 8:00 p.m. dose on 02/25/17 - 02/27/17.
-There was and entry for Terazosin 10 mg at bedtime, scheduled to be administered at 8:00 p.m. The MAs had documented the resident had refused Terazosin 10 mg at bedtime for 5 consecutive doses from 02/23/17 - 02/27/17.

Review of Resident #4's computerized charting note dated 02/22/17 revealed:
-The resident had refused to take all of his morning medications today.
-The MA advised the resident that it would be in his best interest to take his medications but the resident said he was tired of taking medication not knowing what they were for.
-The family member had been notified.
-There was no further documentation of medication refusals and no documentation that the primary care provider had been notified.

Review of Resident #4's hospital discharge information from a local hospital revealed:
-The resident was admitted 03/04/17 - 03/06/17 with a primary diagnosis of chest pain.
-The discharge medications included Allopurinol 300 mg daily, Elavil 10 mg every night (used to treat mental/mood problems), Aspirin 325 mg daily, Lipitor 80 mg daily, Zytec 10 mg daily (used to treat allergy symptoms). Lasix 40 mg twice daily (used to treat fluid retention and swelling), Glipizide 10 mg twice daily 30 minutes before

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breakfast, Levothyroxine 125mcg daily at 6:00 a.m., Lisinopril 10 mg daily (used to treat high blood pressure and heart failure), Metoprolol XL 200 mg daily, Prilosec 20 mg twice daily 30 minutes before a meal (used to treat stomach ulcers), Lyrica 50 mg three times daily (used to treat nerve pain), and Terazosin 10 mg nightly.

Review of Resident #4's documentation from a local hospital revealed an admission date to an inpatient hospice unit on 03/27/17 with diagnoses that included gastrointestinal bleeding, anemia, melena and a desire for a natural death. The resident was discharged back to the facility on 04/05/17.

Review of Resident #4's initial assessment from a local hospice provider on 04/08/17 revealed and admission date to hospice services on 04/08/17.

Review of Resident #4's April 2017 MAR revealed:
-The MA had documented medication refusals in the exceptions section of the MAR.
-There was an entry for Gabapentin 300 mg daily, scheduled to be administered at 8:00 p.m. The MAs documented the resident had refused Gabapentin 300mg daily for 3 consecutive doses from 04/07/17- 04/09/17 and 9 consecutive doses from 04/11/17-04/19/17.
-There was an entry for Levothyroxine 125 mcg daily, scheduled to be administered at 6:00 a.m. The MAs documented the resident had refused Levothyroxine 125 mcg daily for 14 consecutive doses from 04/07/17 - 04/20/17.
-There was an entry for Melatonin 3mg daily, scheduled to be administered at 8:00 p.m. The MAs documented the resident had refused Melatonin 3 mg daily for 3 consecutive doses from 04/07/17 - 04/09/17 and 9 consecutive

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doses from 04/11/17 - 04/19/17.
-There was an entry for Pantoprazole 20 mg daily, scheduled to be administered at 8:00 a.m. The MAs documented the resident had refused Pantoprazole 20 mg for 4 consecutive doses from 04/07/17 - 04/10/17 and 9 consecutive doses from 04/12/17 - 04/20/17.
-There was an entry for Trazodone 50 mg at bedtime, scheduled to be administered at 8:00 p.m. The MAs documented the resident had refused Trazodone 50 mg at bedtime for 3 consecutive doses from 04/07/17 - 04/09/17 and 9 consecutive doses from 04/11/17 - 04/19/17.

Review of Resident #4's computerized charting note on 04/14/17 revealed:
-On 04/14/17 it was documented by a MA that the resident had been refusing is morning medications for the past week.
-The resident had been advised to take them repeatedly, however, the resident refused and stated that he would no longer take any of his medications because he wanted to die in peace.
-The MA made the resident's Power of Attorney aware of the resident's refusals and told the resident's hospice nurse who told the MA she would let the primary care provider know when the hospice nurse made a call to the provider.
-There was no further documentation of medication refusals and no documentation that the primary care provider had been notified.

Interview with Resident #4 on 04/19/17 at 10:58 a.m. revealed:
-The resident was upset because his roommate stole his clothes.
-The resident was leaving the facility soon to move out of state to be closer with his family.
-The resident didn't have much longer to live and just wanted to be with his family.

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D 273	Continued From page 67 Telephone interview with Resident #4's family member on 04/21/17 at 9:25 a.m. revealed: -The resident was receiving hospice care. -The resident liked the staff at the facility and had a very good relationship with the Administrator. -The family member was notified the first of April 2017 by a staff member that the resident was refusing to take his medication but was not aware of any issues of the resident refusing medications prior to April 2017. -The resident had a history of becoming verbally abusive and could be hard to get along with. -The resident had a very good relationship with the Administrator. -The resident had an outburst in December 2016 and had to be hospitalized for his behavior. -The resident was never physically abusive toward other people. -The resident wanted to move out of state to live with other family members but the resident had been estranged from the family for a long time. Interview with a Medication Aide on 04/21/17 at 8:30 a.m. revealed: -Resident #4 had been refusing his medications for the last few months. -The MAs were required to fill out a medication refusal form when a resident refused medications for 3 consecutive doses. -She had not contacted Resident #4's primary care provider regarding his medication refusals but did give the medication refusal information to Resident #4's family member on the days of the resident's medical appointments. -The resident had a history of becoming upset at times and wanted to leave the facility and could become verbally loud. -The resident wanted to go live with his family.	D 273		

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Interview with the Special Care Coordinator (SCC) on 04/24/17 at 2:23 p.m. revealed:
-The SCC was not aware of any medication refusals for Resident #4.
-The MAs were responsible to call the physician after 3 consecutive medication dose refusals, complete and fax the primary care provider the facility's medication refusal form and document the refusals in the charting notes.
-Stand up meetings were done every day with staff to discuss issues involving residents and Resident #4's medication refusals had not been mentioned.
-The SCC did chart audits and reviewed the MAR's exception lists but had not been able to do those reviews for the last 2 months.

Interview with a second MA on 04/26/17 at 2:30 p.m. revealed:
-The MA had documented Resident #4's medication refusals in the resident's computerized charting note on 02/22/17 and 04/14/17.
-The MA told Resident #4's hospice nurse about the resident's medication refusals on 04/14/17 and the nurse would have notified the primary care provider.

Telephone interview with Resident #4's Primary Care Provider's Nurse on 04/21/17 at 3:17 p.m. revealed:
-The resident was last seen at the primary care provider's office on 03/20/17.
-The resident was always brought into the office by a family member.
-The resident had been under the care of this provider for years.
-The facility had not communicated any issues of medication refusals for Resident #4.
-The primary care provider would want to be kept

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informed of any medication compliance issues with the resident.
-Some of the medications the resident was on had been discontinued recently; however some of the medications the resident was on was to decrease the workload on his heart, thyroid medications and a medication to control his blood sugar.
-In order to treat the resident effectively, the primary care provider should have been contacted regarding the resident's refusals of his medications.
-There were no records or any documentation from the facility related to the resident's refusal of medications.

A second interview with the SCC on 04/25/17 at 2:50 p.m. revealed there had not been any medication refusal forms completed for Resident #4 in February and April 2017. She had the MAs complete medication refusal forms for April 2017 yesterday for the medications refused for 3 consecutive days and sent those forms to the primary care provider.

A second telephone interview with Resident #4's family member on 04/25/17 at 4:00 p.m. revealed:
-The facility had never given the family member any documents to give to the primary care provider when the family member carried the resident to medical appointments.
-The Administrator had submitted a resignation with a projected last day of employment.
-The family member had requested for the resident not be informed of the Administrator's resignation; however the resident found out and became verbally disruptive and was involuntarily committed to an inpatient facility 04/24/17.

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D 273	Continued From page 70 Interview with the Administrator on 04/25/17 at 6:08 p.m. revealed: -Resident #4 started getting agitated some on 04/21/17 but he was not sure what caused it. -Resident #4 did calm down with no issues over the weekend. -Resident #4 became verbally agitated again on 04/24/17 on 2nd shift just before the dinner meal. -Resident #4 was admitted to an inpatient unit for evaluation and medication adjustments. -The Administrator was not aware of any prior issues with medication refusals at the facility, because the SCC took care of that. -The local mental health provider was contacted and assisted with Resident #4's transition to inpatient care. -The Administrator was unsure if an accident/incident report was completed for Resident #4's incident on 04/24/17, but would provide a copy if one was done. Telephone interview with Resident #4's hospice nurse on 04/26/17 at 9:10 a.m. revealed: -Resident #4 was admitted to hospice services on 04/08/17. -The hospice nurse was informed on 04/14/17 that the resident was refusing to take his medications. -The hospice nurse had spoken with the resident about not taking his medications but that was "where I left it". The hospice nurse had went on vacation shortly afterwards and had not yet reported the refusals to the primary care provider. -The resident did not want to take any medications that would prolong his life. The resident was critically ill during his last hospitalization and refused treatment and desired a natural death. -During the resident's hospitalization, the resident thought he was going to die and he had shared	D 273		

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D 273	Continued From page 71 this with his family. "Now he is mad he lived through it". -On the nurse's first visit with the resident he was "fine" and could be very "clear headed", but on the second visit the resident was very agitated and upset. He had a history of getting upset. -There was documentation on 04/21/17 that a call was received from the facility that the resident was out of control, was refusing his medications and they wanted him out of the facility. -There was documentation on 04/24/17 in the resident's record that a call was received from the facility to inform that the resident was involuntarily committed to an inpatient unit due to noncompliance and safety. _____ The facility failed to coordinate with a physical therapist or the PCP about obtaining a new wheelchair as an intervention for falls for Resident #3 who had multiple falls with injuries including 3 visits to the ER requiring staples or liquid sutures for head injuries; failed to coordinate a mental health referral for Resident #1 who had symptoms of depression, anxiety, and agitation; and failed to notify Resident #4's physician of multiple medication refusals including medications for diabetes, heart/blood pressure, hypothyroidism, chronic pain, acid reflux, high cholesterol, gout, depression, and insomnia. The failure of the facility to assure a system for the coordination of health care for the safety and well-being of the residents resulted in substantial risk of serious mental and physical harm to the 3 residents and constitutes a Type A2 Violation. _____ Review of a Plan of Protection dated 04/26/17 revealed:	D 273		

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D 273	Continued From page 72 -Auditing all resident charts for health care referral and follow up. Any discrepancies identified would be referred to the primary care physician (PCP) for review and follow up orders. -Physician orders forwarded to the PCPs for review and other recommendations. -The "Bucket system" of order processing would be reviewed with staff by the registered nurse. -The PCP would be notified about a residents' refusal of three consecutive medications and documentation would be maintained in the chart notes. -The transporter would be responsible for outside appointments and the Special Care Coordinator (SCC) would be responsible for making in house appointments for residents. -The appointment tickler would be maintained for in house and outside appointments. -The appointment tickler would be monitored by the SCC and the Administrator. -The Bucket System consisted of: yellow folder- once you receive an order and have faxed it to the pharmacy. Waiting on approval in Quick MAR then put in the orange folder. Waiting on the delivery of medication, check delivery sheet if completed put into green folder; if not delivered find out why, follow up and put in red folder. Red folder - order is complete, follow up immediately. Blue folder - all orders needing durable medical equipment (DME), labs, etc. required follow up from hospital visit. Continue to follow- place in green folder. Ready to file. -The SCC and Administrator in conjunction with Quality Assurance Nurse would monitor the "Bucket System", to ensure health care needs have been addressed by the PCP. -All orders or recommendations received from the health care provider would be processed through the Bucket System and facilitated by the SCC and monitored by the Administrator and Quality	D 273		

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D 273	Continued From page 73 Assurance Nurses. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 26, 2017.	D 273		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations, interviews and review of the facility's menus, the facility failed to maintain a 3 day supply of perishable food, including milk to serve to 52 residents according to the menu. The findings are: Observation of perishable foods on hand on 04/19/17 at 4:40 p.m. revealed there was approximately one gallon of milk plus a small amount of milk left in a second gallon milk container in the refrigerator. Review of the facility's supper menu for 04/19/17 revealed the supper meal included one cup of milk. Observation of the supper meal on 04/19/17 at 5:15 p.m. revealed: -The Dietary Manager (DM) walked through the first portion of the dining room holding a gallon	D 285		

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container of milk and asked in a tone of voice that could only be heard within the DM's immediate surroundings "does anybody want any milk?".
-Two residents were observed being served approximately 6 ounces of milk.
-The DM did not serve or offer milk to each resident.

Review of the facility's breakfast menu for 04/20/17 revealed the breakfast meal included one cup of milk.

Observation of the breakfast meal on 04/20/17 at 8:00 a.m. revealed:
-Some of the residents were served dry cereal with approximately 6 to 8 ounces of milk in addition to the planned breakfast menu.
-Approximately 8 ounces of milk was offered to 2 residents that did not receive the dry cereal.
-The dietary staff did not serve or offer milk to each resident.

Observation of the perishable milk in the refrigerator on 04/20/17 at 8:43 a.m. revealed there was a one gallon milk container with approximately ¼ of the milk remaining.

Observation of the refrigerator on 04/20/17 at 12:15 p.m. revealed there was no milk in the refrigerator.

Interview with two cooks on 04/20/17 at 12:15 p.m. revealed:
-The cook was aware that there was no milk in the refrigerator because all of the milk was served at breakfast.
-Milk was never served or offered to all the residents during a meal, but if they asked for milk, it was then given to them.
-The facility received food deliveries every Friday

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and milk would be delivered then.
-Milk would usually run out every week on Thursdays.
-Milk was not served to all of the residents, because they would not drink it.
-The cooks were trained to follow the dietary menus when preparing residents' meals.
-The DM was responsible for placing food orders weekly.

Confidential interview with a resident revealed:
-The resident liked milk.
-The resident would like to have milk during her meal, but milk was never offered or served.

Confidential interview with a second resident revealed:
-Milk was not served during meals to all residents.
-The resident did not drink milk, but there were some residents that wanted milk at meals.

Interview with the DM on 04/20/17 at 3:25 p.m. revealed:
-All of the residents were not served milk, because they wasted it.
-The DM ordered all of the food from an outside vendor and had to follow a budget for ordering food.
-The DM typically ordered 2 cases of milk a week which was a total of 8 gallons plus 2 cases of 8 ounce milk containers per week but was not sure how many 8 ounce containers were in a case without looking at the food delivery invoice.
-There were 2 or 3 residents that liked milk so it was always offered to them.
-It was not a common occurrence to run out of milk.
-The facility did not keep a 3 day supply of milk on hand at all times.

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D 285	Continued From page 76 -The DM had purchased a few gallons of milk from a local grocery store today (04/20/17). -Food orders were done every Wednesday and delivery of food was every Friday. -If he needed to make any substitutions to the menu served, he would write them in the substitution book. Interview with the DM on 04/21/17 at 9:45 a.m. revealed: -The DM looked back at the food delivery invoices and must have made a mistake when ordering milk on 04/14/17. -The DM felt confused about the rules and regulations regarding perishable foods and serving milk to residents Review of the supper menu on 04/20/17 revealed the menu included one cup of milk. Observation of the supper meal on 04/20/17 at 5:15 p.m. revealed: -The residents were served noodles with beef, one half cup of squash, one half cup of butterbeans, one piece of bread and one cookie, 8 ounces of water and tea. -Dietary staff walked around the dining room holding a gallon of milk and offered each one of the residents' milk. There were 12 residents that requested and served milk. Interview with the Administrator on 04/20/17 at 5:50 p.m. revealed: -The facility had a contract with a food delivery provider. -He understood the facility should have foods like milk on hand at all times. -The DM was supposed to communicate any needs with him before food ran out. -The Administrator was not aware that the facility	D 285		

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D 285	Continued From page 77 ran out of milk and expected to have all perishable foods such as milk on hand at all times in order to follow the menu.	D 285		
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 were of equal nutritional value and appropriate for 5 of 5 residents (#1, #3, #5, #12, #13) sampled including a regular diet for Resident #1 and #5, a regular diet with ground meats for Resident #3, a regular mechanical soft diet for Resident #12, and a regular pureed diet with nectar thick liquids for Resident #13. The findings are: 1. Review of Resident #1's current FL-2 dated 08/03/16 revealed: -The resident's diagnoses included Alzheimer's dementia, tardive dyskinesia, coronary artery disease, and Asperger's syndrome (Autism). -There was an order for a regular diet. Review of Resident #1's diet order sheet dated 12/28/16 revealed an order for a regular diet.	D 292		

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D 292	Continued From page 78 Review of the supper menu for 04/19/17 revealed the meal consisted of one crispy fish sandwich, ½ cup of grapes, ½ cup of coleslaw, 1 cup of milk and one sugar cookie. Observation of Resident #1 during the supper meal on 04/19/17 at 5:14 p.m. revealed: -The resident was served one piece of bread, one piece of fish, approximately 1/2 cup of cooked spinach, approximately ½ cup of boiled potatoes and one sugar cookie, tea and water. -The resident was feeding himself. -The resident was not served milk or any fruit. Refer to the observation of the food on hand on 04/19/17 at 4:30 p.m. Refer to the interview with the Dietary Manager on 04/20/17 at 8:50 a.m. Refer to the review of a Menu Substitution form dated 04/19/17. Refer to the confidential interview with a resident. Refer to the confidential interview with a second resident. Refer to the interview with two cooks on 04/20/17 at 12:15 p.m. Refer to the interview with the Dietary Manager on 04/20/17 at 3:25 p.m. Refer to the interview with the DM on 04/21/17 at 9:45 a.m. Refer to the interview with the Administrator on 04/20/17 at 5:50 p.m.	D 292		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 292	Continued From page 79 Refer to the interview with the Administrator on 04/24/17 at 2:10 p.m. 2. Review of Resident #5's current FL-2 dated 8/31/16 revealed: -Resident #5's diagnoses included vascular dementia, depression not otherwise specified, cerebral vascular accident in 2009, right sided hemiplegia, gastro-esophageal reflux disease (GERD), bronchial asthma, insomnia, and mood disorder. -There was an order for a regular diet. Review of a diet clarification order sheet dated 04/26/17 revealed the resident was on a regular diet. Review of the supper menu for 04/19/17 revealed the meal consisted of one crispy fish sandwich, ½ cup of grapes, ½ cup of coleslaw, 1 cup of milk and one sugar cookie. Observation of Resident #5 during the supper meal on 04/19/17 at 5:15 p.m. revealed: -The resident was served one piece of bread, one piece of fish, approximately 1/2 cup of cooked spinach, approximately 1/2 cup of boiled potatoes and one sugar cookie, tea and water. -The resident was feeding herself. -The Dietary Manager (DM) walked through the first portion of the dining room holding a gallon container of milk and asked in a tone of voice that could only be heard within the DM's immediate surroundings "does anybody want any milk". -Resident #5 requested milk and was served approximately 6 ounces of milk. -The resident was not served any fruit. Refer to the observation of the food on hand revealed on 04/19/17 at 4:30 p.m.	D 292		

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D 292	Continued From page 80 Refer to the interview with the Dietary Manager on 04/20/17 at 8:50 a.m. Refer to the review of a Menu Substitution form dated on 04/19/17. Refer to the confidential interview with a resident. Refer to the confidential interview with a second resident. Refer to the interview with two cooks on 04/20/17 at 12:15 p.m. Refer to the interview with the Dietary Manager on 04/20/17 at 3:25 p.m. Refer to the interview with the DM on 04/21/17 at 9:45 a.m. Refer to the interview with the Administrator on 04/20/17 at 5:50 p.m. Refer to the interview with the Administrator on 04/24/17 at 2:10 p.m. 3. Review of Resident #3's current FL-2 dated 09/14/16 revealed: -The resident's diagnoses included history of cerebrovascular accident, diabetes mellitus, vascular dementia, hyperlipidemia, anemia, schizophrenia, depressive disorder, and Vitamin B12 deficiency. -The area for a diet order on the FL-2 was blank. Review of Resident #3's diet order sheet dated 12/28/16 revealed an order for a regular diet with ground meats only.	D 292		

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D 292	Continued From page 81 Review of the supper menu for 04/19/17 revealed the meal consisted of one crispy fish sandwich, ½ cup of grapes, ½ cup of coleslaw, 1 cup of milk and one sugar cookie. Observation Resident #3 during the supper meal on 04/19/17 at 5:09 p.m. revealed: -The resident was served one piece of bread, ground fish, approximately 1/2 cup of cooked spinach, approximately 1/2 cup of boiled potatoes and one sugar cookie, tea and water. -The resident was feeding herself. -The resident was not served milk or any fruit. Refer to the observation of the food on hand on 04/19/17 at 4:30 p.m. Refer to the interview with the Dietary Manager on 04/20/17 at 8:50 a.m. Refer to the review of a Menu Substitution form dated on 04/19/17. Refer to the confidential interview with a resident. Refer to the confidential interview with a second resident. Refer to the interview with two cooks on 04/20/17 at 12:15 p.m. Refer to the interview with the Dietary Manager on 04/20/17 at 3:25 p.m. Refer to the interview with the DM on 04/21/17 at 9:45 a.m. Refer to the interview with the Administrator on 04/20/17 at 5:50 p.m.	D 292		

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D 292	Continued From page 82 Refer to the interview with the Administrator on 04/24/17 at 2:10 p.m. 4. Review of Resident #12's current FL-2 dated 12/28/16 revealed: -The resident's diagnoses included Alzheimer's disease unspecified, dementia encephalopathy without behavior, and malformation of coronary vessels, rhabdomyolysis weakness, essential hypertension, hyperkalemia, anemia, and mild dehydration. -There was an order for mechanical soft entire meal. Review of Resident #12's diet order sheet dated 04/20/17 revealed a regular diet, mechanical soft entire meal. Review of the supper menu for 04/19/17 revealed the meal consisted of one crispy fish sandwich, ½ cup of grapes, ½ cup of coleslaw, 1 cup of milk and one sugar cookie. Observation of Resident #12 during the supper meal on 04/19/17 at 5:19 p.m. revealed: -The resident was served one piece of bread, chopped fish, approximately 1/2 cup of cooked spinach, approximately 1/2 cup of boiled potatoes, lemon pudding, tea and water. -The resident was fed by a staff member. -The resident was not served milk or fruit. Refer to the observation of the food on hand revealed on 04/19/17 at 4:30 p.m. Refer to the interview with the Dietary Manager on 04/20/17 at 8:50 a.m. Refer to the review of a Menu Substitution form dated on 04/19/17.	D 292		

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D 292	Continued From page 83 Refer to the confidential interview with a resident. Refer to the confidential interview with a second resident. Refer to the interview with two cooks on 04/20/17 at 12:15 p.m. Refer to the interview with the Dietary Manager on 04/20/17 at 3:25 p.m. Refer to the interview with the DM on 04/21/17 at 9:45 a.m. Refer to the interview with the Administrator on 04/20/17 at 5:50 p.m. Refer to the interview with the Administrator on 04/24/17 at 2:10 p.m. 5. Review of Resident #13's current FL-2 dated 06/01/16 revealed: -The resident's diagnoses included Alzheimer's dementia, diabetes mellitus, hypertension, epilepsy and schizophrenia. -There was an order for a pureed diet with nectar thick liquids. Review of Resident #13's a diet order sheet dated 12/28/16 also revealed a pureed diet with nectar thick liquids. Review of a subsequent diet order sheet for Resident #13 dated 04/20/17 revealed a regular pureed diet with nectar thick liquids. Review of the breakfast menu for 04/20/17 revealed the meal consisted of one egg of choice, one slice of bacon, ½ cup of hash browns, ½ cup	D 292		

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D 292	Continued From page 84 of fresh fruit, 6 ounces of juice, ½ of an English muffin and one cup of milk. Observation of Resident #13 during the breakfast meal on 04/20/17 at 8:00 a.m. revealed: -Resident #13 was served eggs, bacon, and hash browns and bread pureed in a bowl and vanilla pudding. -Resident #13 fed herself with occasional verbal encouragement from staff to stay awake and eat during the meal. -Resident #13 completed her meal at 8:15 a.m. -Resident #13 was not offered any milk or any fruit during the breakfast meal. -The other residents in the dining room were served peaches with the breakfast meal. Review of the breakfast menu for 04/21/17 revealed the meal consisted of 2 pieces of French toast, one egg of choice or 1 ounce of sausage, ½ cup of fresh fruit, 6 ounces of 100% juice, and one cup of milk. Observation of Resident #13 during the breakfast meal at 8:14 a.m. at 04/21/17 revealed: - The resident had been served a bowl of pureed food and pudding, apple juice and water. -The dietary cook reported the resident was served French toast, sausage eggs and grits in the bowl. -The resident was not served any fruit. -The resident was offered milk by the dietary cook. Attempted interview with Resident #13 on 04/21/17 at 10:12 a.m. revealed the resident was not interviewable. Interview with the cook on 04/21/17 at 9:40 a.m. revealed:	D 292		

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-The dietary cook had worked at the facility since February 2017.
-The DM was not there when breakfast was prepared.
-The dietary cook had prepared the residents' breakfast meal today.
-Resident #13 liked pudding and yogurt.
-Resident #13 was given pudding instead of fruit because she was on a pureed diet.
-The cook should have pureed the fruit cocktail for Resident #1 but just didn't think about it.

Interview with the Dietary Manager (DM) on 04/21/17 at 9:45 a.m. revealed:
-The DM was not aware that Resident #13 was not served any fruit during breakfast.
-The DM expected the dietary staff to follow the menu for all residents.
-The cook that prepared breakfast on 04/21/17 was not use to serving breakfast.

Refer to the observation of the food on hand revealed on 04/19/17 at 4:30 p.m.

Refer to the interview with the Dietary Manager on 04/20/17 at 8:50 a.m.

Refer to the confidential interview with a resident.

Refer to the confidential interview with a second resident.

Refer to the interview with two cooks on 04/20/17 at 12:15 p.m.

Refer to the interview with the Dietary Manager on 04/20/17 at 3:25 p.m.

Refer to the interview with the DM on 04/21/17 at 9:45 a.m.

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D 292	Continued From page 86 Refer to the interview with the Administrator on 04/20/17 at 5:50 p.m. Refer to the interview with the Administrator on 04/24/17 at 2:10 p.m. Observation of the food on hand on 04/19/17 at 4:30 p.m. revealed there were several large containers of fruit that included peaches, pears, mixed fruits, pineapples and frozen strawberries. Interview with the Dietary Manager (DM) on 04/20/17 at 8:50 a.m. revealed: -The DM was aware that dietary staff had to follow the planned menu. -If there were any substitutions made in the menu the substituted food must be documented, of equal nutritional value and appropriate for the residents ordered diet. -The DM and dietary staff documented all food item substitutions on the Menu Substitution form. Review of the Menu Substitution form dated 04/19/17 revealed: -Spinach had been substituted for cole slaw. -There was no substitution for the 1/2 cup of fruit and the one cup of milk that was listed for the supper meal. Confidential interview with a resident revealed: -The resident liked milk. -The resident would like to have milk during her meal but milk was never offered or served. -Fruit was served sometimes at meals but not daily. Confidential interview with a second resident revealed:	D 292		

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D 292	Continued From page 87 -Milk was not served during meals to all residents. -The resident did not drink milk but there were some residents that would want milk at meals. -Fruit was served occasionally with meals. Interview with two cooks on 04/20/17 at 12:15 p.m. revealed: -Milk was never served or offered to all the residents during a meal but if they asked for milk it was then given to them. -The dietary cooks were aware that there was no milk in the refrigerator because it was all served at breakfast. -Milk would usually run out every week on Thursdays. -The cooks were trained to follow the dietary menus when preparing residents' meals. -The DM was responsible for placing food orders weekly. Interview with the DM on 04/20/17 at 3:25 p.m. revealed: -The menu for supper on 04/19/17 listed grapes to be served. -There were no grapes on the last delivery on 04/14/17. He was afraid to serve grapes to residents because of the choking risks. -Not serving the fruit on 04/19/17 was an oversight. Another fruit could have been served to the residents. -All of the residents were not served milk because they wasted it. -Some residents liked milk so it was always offered to them. Milk was served only if the residents asked for it. -If he needed to make any substitutions to the menu served, he would write them in the substitution book.	D 292		

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D 292	Continued From page 88 Interview with the DM on 04/21/17 at 9:45 a.m. revealed: -The DM looked back at the food delivery invoices and must have made a mistake when ordering milk on 04/14/17. -The DM felt confused about the rules and regulations regarding serving milk to residents. Interview with the Administrator on 04/20/17 at 5:50 p.m. revealed: -The facility had a contract with a food delivery provider. -He understood the facility should have foods like milk on hand at all times. -The DM was supposed to communicate any needs with him, before food ran out. -The Administrator was not aware that the facility ran out of milk and expected to have all perishable foods such as milk on hand at all times in order to follow the menu. Interview with the Administrator on 04/24/17 at 2:10 p.m. revealed the Administrator expected the dietary staff to prepare and serve meals by the residents ordered diet and follow the menu plan.	D 292		
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 B VIOLATION	D 338		

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Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to staff failing to provide assistance to a resident when asked and making an inappropriate comment (Resident #8); the way a resident was treated by staff in the dining room (Resident #9); the inappropriate manner staff interacted with an exit-seeking resident (Resident #10); staff failing to consider a resident's feelings about missing clothing and labeling her a hoarder (Resident #5); and the tone and manner staff spoke to and in front of residents at times.

The findings are:

1. Review of Resident #10's current FL-2 dated 02/13/17 revealed:
-The resident's diagnoses included senile dementia, anemia, hypothyroidism, failure to thrive, and constipation.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident required assistance with bathing, feeding, and dressing.

Review of Resident #10's special care unit pre-admission checklist and profile dated 01/30/17 and 01/31/17 revealed the resident had a history of falls but none in the last 6 months.

Review of Resident #10's Resident Register revealed:
-The resident was admitted to the facility on 02/20/17.
-The resident was forgetful and needed reminders.
-The resident required assistance with dressing, nail care, correspondence, hair/grooming, skin care, scheduling appointments, and orientation to

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time and place.

Review of Resident #10's assessment and care plan dated 02/20/17 revealed:
-The resident was ambulatory without assistive devices.
-The resident had limited strength in upper extremities.
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident required extensive assistance with bathing, grooming, and toileting.
-The resident required limited assistance with dressing, eating, and ambulation.

Review of a primary care provider (PCP) visit summary dated 04/05/17 for Resident #10 revealed:
-The resident was seen for agitation and wandering.
-The PCP started Ativan (anti-anxiety) for acute agitation / aggression and if she was not able to be redirected when wandering and attempting to escape out of the locked doors.
-The PCP noted the resident continued to remain a fall risk due to cognitive and physical debility.

Review of an accident / injury report dated 04/20/17 at 11:25 a.m. revealed:
-Resident #10 attempted to sit in a rolling chair when the chair rolled backwards, the resident tumbled and immediately got up.
-The resident was not injured.

Observation on 04/21/17 at 3:10 p.m. revealed:
-Two staff members ran very fast down the hall toward the door at the end of A Hall.
-Resident #10 was about halfway down the hall running quickly toward the two staff members.
-When the first staff person went out of the door,

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the second staff person (Staff A) slammed the door twice to close it as Resident #10 reached the door.
-Resident #10 hit Staff A on the back.
-Staff A turned around quickly and yelled loudly telling the resident not to hit her.
-A third staff person came and easily redirected Resident #10 down the hallway.
-Resident #10 was crying and her face was red.
-Staff A started walking back up the hall toward the nurses' station.

Interview with Staff A on 04/21/17 at 3:12 p.m. revealed:
-Resident #10 did that frequently and Staff A did not want the resident to get out of the door.
-Resident #10 was a problem because she followed everyone around.
-Staff A yelled in a loud voice in the hallway near the nurses' station, "She has no business doing that. It gets on my nerves. She shouldn't do that. It gets on my nerves. I am sick of it!"
-There were multiple residents sitting or standing in the hallway when Staff A made the statement.
-Staff A had dementia training but Resident #10 should not be following people around.

Interview with the Special Care Coordinator (SCC) on 04/21/17 at 3:20 p.m. revealed:
-Staff A had worked at the facility for less than 6 months.
-Staff A had the required dementia training.
-Staff were supposed to redirect the residents and not run from them.
-It was not safe for the residents to be running in the facility.
-Staff were not supposed to yell at the residents or talk about the residents.

Interview with a medication aide (MA) on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 92 04/21/17 at 4:15 p.m. revealed Resident #10 usually went to the doors but she was easy to redirect. Interview with a second MA on 04/21/17 at 4:20 p.m. revealed Resident #10 usually went to the main door of the facility but she was easy to redirect. Interview with a third MA on 04/21/17 at 4:22 p.m. revealed Resident #10 should be redirected to a different location when she went to the doors. Interview with Resident #10's PCP on 04/26/17 at 12:45 p.m. revealed the resident was "pretty mobile" but would be at risk for falls if she were running. Review of the Punch Detail Report revealed Staff A worked on 04/22/17 and 04/23/17. Interview with the Administrator on 04/24/17 at 5:45 p.m. revealed: -He and the Regional Director of Operations talked with Staff A after the incident on 04/21/17. -Staff A did not understand what she did wrong. -They sent Staff A home on 04/21/17 pending an investigation. -He did not realize that Staff A came to work over the weekend. -She was not supposed to come back until after the facility conducted an investigation. -He spoke with Staff A today on 04/24/17 and she told the Administrator that she did not realize she was not supposed to come back to work until she was contacted. -Staff A was aware of that now. Interview with the Special Care Coordinator (SCC) on 04/24/17 at 6:15 p.m. revealed:	D 338		

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D 338	Continued From page 93 -Staff A was not supposed to work this past weekend. -Staff A was told she was suspended until the Administrator called her and told her she could come back to work after an investigation was done. -Staff A knew she was not supposed to come back until she was contacted by the Administrator. -She was not aware Staff A worked over the weekend until today, 04/24/17. 2. Review of Resident #5's current FL-2 dated 8/31/16 revealed diagnoses included vascular dementia, depression nos, cerebral vascular accident in 2009, right sided hemiplegia, gastroesophageal reflux disease (GERD), bronchial asthma, insomnia, and mood disorder. Review of Resident #5s Resident Register revealed the resident was admitted to the facility on 07/15/14. Interview with Resident #5 on 4/19/17 at 9:50 a.m. revealed: -Resident #5's clothes were bagged up and removed due to a bedbug problem in her bedroom about a month ago. -She had asked staff and the Administrator to return her clothes several times but no one had returned her clothing. -She wanted her clothes back because they were her clothes. (She began to cry as she shared about her clothes). Observation of Resident #5's room on 4/19/17 at 9:55 a.m. revealed eight dress outfits hanging in her closet and six drawers filled with casual clothing.	D 338		

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D 338	Continued From page 94 Interview with Resident #5's guardian on 4/21/17 at 4:20 p.m. revealed: -She was aware there was an incident with bedbugs about a month or so ago. -She was not aware Resident #5's clothes had been removed as a result of the infestation. -No one had informed her Resident #5 had not had her clothes returned. -She thought the facility could have dried the clothes in a dryer and returned them after treating them to Resident #5. -She would visit Resident #5 within the next couple of days and check on the status of her clothing that had been removed. Interview with the Special Care Coordinator (SCC) on 4/21/17 at 5:30 p.m. revealed: -Resident #5's clothing was removed as a result of the bedbug infestation over a month ago. -She was unaware of where Resident #5's clothes were and said she had plenty of clothes to wear in her dresser and closet. -Resident #5 was a "hoarder" and collected and piled things in her room. -She had not informed Resident #5's guardian about her clothing being removed and did not specify why she had not informed the guardian. Interview with the Administrator on 4/21/17 at 5:56 p.m. revealed: -Resident #5 had mentioned to him she wanted her clothes back that had been removed. (He was able to specify a timeframe). -He explained to Resident #5 that she had a lot of nice clothes to wear but could not "hoard" things in her room. -Resident #5 did not need her clothes back because she was a "hoarder" and there was a potential to cause another infestation of bedbugs if she got those clothes back.	D 338		

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-He was unsure how many bags of clothes were removed about a month ago but he thought it might have been "two or more" bags.
-He had not informed Resident #5's guardian of the removed clothing and did not specify why he did not.
-He was not sure of the location of Resident #5's clothing that was removed but believed the clothing was in the facility or in the outbuilding of the facility.
-He would check to see where Resident #5's clothing was located.

Interview with the Administrator on 4/21/17 revealed he had not located Resident #5's clothing, because Resident #5 may have already gotten her clothes back and was not aware she had.

3. Review of Resident #8's current FL-2 dated 03/29/17 revealed:
-The resident's diagnoses included Alzheimer's, hypertension, unspecified glaucoma, coronary artery disease involving bypass graft, history of falls, history of malaise and fatigue, history of diabetes, and psychosis.
-The resident was intermittently disoriented and semi-ambulatory with a wheelchair.

Review of Resident #8's Resident Register revealed and admission date of 12/24/12.

Review of Resident #8's care plan dated 10/28/16 revealed:
-The resident was ambulatory in her wheelchair from time to time, staff assisted her with all activities of daily living.
-The resident required limited assistance from staff to transfer to and from a bed or chair.
-The resident required extensive assistance from

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D 338	Continued From page 96 staff to ambulate room to room. Observation on 04/19/17 at 9:45 a.m. revealed: -Resident #8 was rolling herself in a wheelchair down the B Hall. -Resident #8 stopped rolling herself in the wheelchair and complained of her back hurting and asked the surveyor to please help her to her room which was located at the end of the hall. -Notification was given to Staff A that Resident #8 had requested some help to get back to her room. -Staff A stood in front of Resident #8 and questioned the resident. "You want me to do what?" -Staff A did not assist Resident #8 and walked away leaving Resident #8 in the same position in the hallway. Staff A proceeded toward the nurse's station then back down to the activity room door which was in close proximity to where Resident #8 had stopped. -Resident #8 shook her head and proceeded to roll herself down the hallway toward her room at 9:50 a.m. Interview with the Special Care Coordinator (SCC) and the Administrator on 04/19/17 at 2:00 p.m. revealed they would talk with Staff A about the incident with Resident #8. 4. Review of Resident #9's current FL-2 dated 04/05/17 revealed: -The resident's diagnoses included Alzheimer's disease with behavioral disturbances, pacemaker, hypertension, acute kidney failure, unspecified atrial fibrillation, non-traumatic intra cerebral hemorrhage in hemisphere, and hypothyroidism. -The resident was constantly disoriented and semi ambulatory with a wheelchair.	D 338		

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D 338	Continued From page 97 Review of Resident #9's Resident Register revealed an admission date of 03/31/17. Attempted interview with Resident #9 on 04/19/17 at 10:07 a.m. revealed the resident was not interviewable. Observation in the dining room on 04/21/17 during the lunch meal at 12:30 p.m. revealed: -Resident #9 was sitting in the dining room at a table with 3 other residents. -The other 2 female residents began to complain that Resident #9 was reaching and placing her hands into their plates. Resident #9 responded in an upset tone of voice, "I can't do anything right here". -Upon notification, the Administrator instructed the Dietary Manager to move Resident #9 to another table. -The Dietary Manager (DM) moved Resident #9 to the 2nd dining room section then retrieved Resident #9's plated food and beverages, and placed the plated food and beverages down in front of Resident #9 firmly which caused a loud noise when the plate and glasses made contact with the table. The loud noise caused Resident #9 to slightly tense up as noted by a slight jump in her shoulders when the food and beverages were placed in front of her. The DM walked back to the kitchen without a response to the resident. Interview with the Administrator on 04/21/17 revealed: -The Administrator did not observe the incident between Resident #9 and the DM. -Staff were supposed to always maintain a courteous and helpful manner when assisting residents. -The Administrator would talk with the DM about	D 338		

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the incident with Resident #9.

Interview with the Administrator on 04/21/17 at 7:30 p.m. revealed:
-The Administrator talked to the DM after the incident during the meal on 04/21/17.
-The DM was not aware he displayed this type of behavior while assisting Resident #9.

Interview with the DM on 04/24/17 revealed:
-The DM did not realize he startled Resident #9 when he transferred her plated food and beverages to another table and placed them in front of her during the meal on 04/21/17.
-The DM would be more mindful of body movements and actions while interacting and assisting residents.

5. Confidential interview with a staff member revealed:
-The Special Care Coordinator (SCC) and the facility Transporter/Activity Director had a verbal incident in the presence of 5 to 6 residents at the nurse's station about a month ago after the residents' breakfast that day.
-The verbal incident occurred after the Transporter/Activity Director had questioned a note that the SCC had written regarding a resident's appointment. The SCC overheard the Transporter/Activity Director questioning the note the SCC had written.
-The SCC started yelling at the Transporter/Activity Director by telling her that she should do her job and mind her own business while using curse words.
-The Transporter/Activity Director never raised her voice or cursed back at the SCC.
-The SCC was reminded by a staff member that there were residents around.
-The SCC was observed on a separate incident

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D 338	Continued From page 99 yelling at a resident telling the resident to "get out of my office". Confidential Interview with a second staff member revealed: -The SCC raised her voice and cursed in front of residents while talking to the facility's Transporter/Activity Director at the nurse's station. -The incident occurred over a comment the Transporter/Activity Director made aloud about a note the SCC had written regarding a resident's medical appointment. -The SCC and the Transporter/Activity Director both ended up behind the nurse's station. -The SCC told the Transporter/Activity Director she had already handled the resident's appointment and the Transporter should go back down the hall and do her job and should not be behind the nurse's station. The Transporter/Activity Director questioned the SCC "why don't you do your job?". -The Transporter/Activity Director never raised her voice or got upset. -The SCC got upset and raised her voice. - A staff member started to remove some of the residents from the area since the verbal incident continued to escalate between the SCC and the Transporter/Activity Director. -None of the residents seemed to have been upset over the incident and no comments were made by the residents. -The Administrator was not present during the verbal incident but the staff member thought that the SCC called the Administrator into her office when he arrived. The staff member also thought that the Transporter/Activity Director told the Administrator. -The staff member remembered an incident about 3 weeks ago where the SCC was "getting	D 338		

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loud" with a resident during a stand up meeting. The resident thought a family member was outside during the meeting and came into the SCC's office. The SCC told the resident by yelling "get out of my office". Another staff member redirected the resident. The Administrator was present in the meeting.

Interview with the Transporter/Activity Director on 04/26/17 at 9:50 a.m. revealed:
-There was a verbal incident between her and the SCC.
-The Transporter/Activity Director was down the hall with residents and was told by a staff member that the SCC was "cursing you out", and said "keep you're [expletive] in activities and not in her job".
-The incident occurred over a sticky note that the Transporter/Activity Director seen in the "hot box" at the nurses station. The Transporter/Activity Director said out loud speaking to another staff member "why would she write this; just make appointment". The SCC overheard the comment.
-The SCC responded "why do you [expletive] care about what I do". One of the staff members responded "because she does the transporting". The SCC stated that she had already made the appointment for the resident "for your information".
-The SCC told the Transporter/Activity Director "Why don't you take your [expletive] to activities because that is what you are supposed to be doing and if you don't like it, clock out and leave".
-The Transporter/Activity Director was mad but never cursed.
-There were at least 7 residents/staff around the nurse's station where the verbal incident occurred.
-One of the staff members told the SCC that there were residents around so she would calm

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down.
-One of the staff members brought the Transporter/Activity Director back down the hallway and the SCC stayed at the front of the facility.
-She was unsure what the response was from residents.
-The Transporter/Activity Director told the Administrator about the incident and he replied to the Transporter/Activity Director "what do you think she has done now?".
-The Administrator never said anything to her about the incident.

Interview with the SCC on 04/26/17 at 8:30 p.m. revealed:
-There was a verbal incident between her and the Transporter/Activity Director.
-The Transporter/Activity Director were behind the nurse's station and made a comment "I don't know why she didn't make this appointment; this is crap".
-The SCC told the Transporter/Activity Director that she thought she needed to keep her nose out of her business and the Transporter/Activity Director responded "yeah right, go tell a lie on something else".
-The SCC tried to explain that the resident's "legal" person had to be notified about the appointment.
-The verbal incident continued and the residents had started coming down the hallway from the dining room after breakfast so the SCC went into her office.
-The Transporter/Activity Director was using foul language a couple of times "you're not my [expletive] boss" and had raised her voice. The SCC stated she used the same tone and volume of voice that she was using right now.
-The Administrator knew about the incident but

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D 338	Continued From page 102 could not remember how. The SCC thinks she called him to "give him a heads up". -There had been no further incidences with the Transporter/Activity Director. Interview with the Administrator on 04/26/17 at 5:55 p.m. revealed: -He was aware of "arguing in the hallway" between the SCC and the Transporter/Activity Director. -The incident occurred in March 2017. -He did not know the specifics about the incident and told them (SCC and the Transporter/Activity Director) to settle their differences and work as a team. -He did not do an investigation. -Staff vented to him. -He did not know if there was any foul language or yelling involved. _____ The facility failed to assure residents were treated with respect, consideration, and dignity as related to staff failing to provide assistance to a resident when asked and making an inappropriate comment; the way a resident was treated by staff in the dining room; the inappropriate manner staff interacted with an exit-seeking resident; staff failing to consider a resident's feelings about missing clothing and labeling her a hoarder; and the tone and manner staff spoke to and in front of residents at times. The facility's failure to treat residents with dignity, respect, and consideration directly impacted the wellfare and safety of the residents and constitutes a Type B Violation. _____ Review of a Plan of Protection dated 04/21/17 revealed:	D 338		

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D 338	Continued From page 103 -Due to the incident that occurred today, the employee was coached in memory care behaviors and suspended during investigation. -All employees would receive the resident right policies and procedures to review and sign an acknowledgment. -Immediately, management would hold an in-service on "Resident Rights" for all shifts starting on 04/21/17. -Management would monitor staff behavior on a daily basis and in the event this occurred again, staff would be coached and suspended pending investigation. -Staff would be instructed on the process of reporting "Resident Right" concerns to management. -The Special Care Coordinator (SCC) or designee would contact the Ombudsman to setup training for staff covering topics of Resident Rights, approach and communication. Again staff would be coached and suspended during investigation. -The SCC or designee would contact the Ombudsman to schedule within 30 days to setup "Resident Rights" training and ongoing training thereafter. -The SCC would continue to monitor staff by random observations. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 10, 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,	D 358		

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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:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#2, #11) observed during the medication passes including errors with a medication used to treat high blood pressure (#2) and a topical ointment used to treat a skin rash (#11).

The findings are:

The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 4:00 p.m. - 5:00 p.m. medication pass on 04/19/17 and the 8:00 a.m. and 11:00 a.m. - 11:30 a.m. medication passes on 04/20/17.

1. Review of Resident #2's current FL-2 dated 11/22/16 revealed:
-The resident's diagnoses included hypertension, Alzheimer's dementia, history of ischemic cerebrovascular accident 2010 and 2013, lung cancer, arthritis, and hypothyroidism.
-There was an order for Hydralazine 25mg twice daily with food. (Hydralazine is used to treat high blood pressure.)

Review of a physician's order dated 12/28/16 for Resident #2 revealed a subsequent order for Hydralazine 25mg twice daily with meals.

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Review of the April 2017 medication administration record (MAR) for Resident #2 revealed:
-There was an entry for Hydralazine 25mg twice daily with meals.
-Hydralazine was scheduled to be administered at 7:00 a.m. and 5:00 p.m.

Interview with the medication aide on 04/19/17 at 4:40 p.m. revealed:
-She was going to start the 5:00 p.m. medication pass because she could administer the medications one hour before and one hour after the scheduled time.
-Supper was served at 5:00 p.m. and it was usually served on time.

Observation of the medication pass on 04/19/17 revealed:
-Hydralazine 25mg was administered to Resident #2 at 4:44 p.m.
-The resident was in the hallway at the medication cart.
-Hydralazine was not administered with a meal as ordered.

Observation of Resident #2 on 04/19/17 revealed the resident was served the supper meal at 5:10 p.m.

Based on observation, interview, and record review, Resident #2 was not interviewable due to diagnoses of Alzheimer's dementia.

Review of Resident #2's monthly vital signs log revealed her blood pressure was 122/60 on 03/27/17 and 124/69 on 04/01/17.

Interview with the medication aide on 04/19/17 at 6:05 p.m. revealed:

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-The medications scheduled for 5:00 p.m. usually "popped up" on the computer screen around 3:30 p.m.
-She thought it was okay to administer the medication one hour before or after the scheduled time.
-She was not aware medications ordered with meals should be given with the meal or up to one hour after the resident had eaten the meal.

Interview with the Special Care Coordinator (SCC) on 04/19/17 at 6:30 p.m. revealed:
-The facility's policy was to administer medications ordered with meals while the resident was eating the meal.
-The medication aides had been trained and they knew medications ordered with meals should be given with the meal.

2. Review of Resident #11's current FL-2 dated 02/01/17 revealed:
-The resident's diagnoses included diabetes, Alzheimer's dementia, hyperkalemia, hypertension, chronic kidney disease - stage 3, muscle weakness, history of left hip fracture with left hip replacement, and repeated falls.
-There was an order for Zinc Oxide 20% ointment, apply topically to groin folds 3 times a day until healed. (Zinc Oxide ointment is used to treat and prevent skin irritations and rashes.)

Review of Resident #11's April 2017 medication administration record (MAR) revealed:
-There was an entry for Zinc Oxide 20% ointment, apply topically to groin folds 3 times a day until healed.
-Zinc Oxide ointment was scheduled to be applied at 8:00 a.m., 2:00 p.m., and 8:00 p.m.

Observation during the 8:00 a.m. medication

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D 358	Continued From page 107 pass on 04/20/17 revealed: -The medication aide (MA) administered Resident #11's morning medications at 8:38 a.m. -The MA clicked on the electronic MAR that all of the 8:00 a.m. medications for Resident #11 were administered, including the entry for Zinc Oxide ointment. -The MA did not apply any Zinc Oxide ointment to Resident #11. Interview with the MA on 04/20/17 at 8:40 a.m. revealed: -She could not locate the Zinc Oxide in the medication cart for Resident #11. -She did not apply the Zinc Oxide to the resident because she saw a personal care aide (PCA) apply the ointment after she changed the resident's incontinence brief earlier that morning. -She documented the Zinc Oxide was applied on the MAR because she had observed the PCA do it that morning. -She would find the tube of ointment. Interview with a PCA on 04/20/17 at 10:35 a.m. revealed: -She had not changed Resident #11 today and she had not applied any Zinc Oxide to his groin area today. -She last saw the resident's groin area a couple of days ago and it was pinkish red. Interview with a second PCA on 04/20/17 at 10:38 a.m. revealed: -She had come in late that morning and had just changed Resident #11's incontinence brief a few minutes ago. -She did not apply any Zinc Oxide to the resident because it was not scheduled to be administered next until 2:00 p.m. -She did not know if anyone applied the 8:00 a.m.	D 358		

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D 358	Continued From page 108 dose because she came in late that day. Interview with Resident #11 on 04/20/17 at 10:40 a.m. revealed the resident did not remember if anyone had applied any ointment to his groin area that morning. Interview with the MA on 04/20/17 at 10:44 a.m. revealed: -She thought she had seen a PCA apply the Zinc Oxide ointment that morning but she may have gotten her days mixed up. -She found the resident's tube of Zinc Oxide ointment in the medication room. Interview with the MA on 04/20/17 at 11:20 a.m. revealed: -She remembered a third shift PCA reported to a first shift PCA during change of shift that the third shift PCA had applied the Zinc Oxide ointment to Resident #11. Interview with the third shift PCA on 04/21/17 at 8:37 a.m. revealed: -She did not apply any Zinc Oxide ointment to Resident #11 on third shift. -She did not have access to the medication cart and no one had asked her to apply any ointment to the resident. -The resident's groin area was currently light red and it looked like it was getting better. Observation of Resident #11 on 04/21/17 at 6:38 p.m. revealed: -A PCA was providing incontinence care to Resident #11. -The resident's groin area was light pink with some areas of redness on both sides of the groin. -The resident denied pain or itching.	D 358		

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D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 31 of 63 shifts sampled in March 2017 and April 2017. The findings are: Interview with the Special Care Coordinator (SCC) on 04/19/17 at 11:37 a.m. revealed: -First shift staff hours were from 7:00am to 3:00pm. -Second shift staff hours were from 3:00pm to 11:00pm. -Third shift staff hours were from 11:00pm to 7:00am. Review of the Daily Census Report dated 03/01/17 revealed: -The census for the SCU was 51 residents.	D 465		

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D 465	Continued From page 110 -51 hours of staff time was required for first shift. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 03/01/17 revealed: -There was 41.32 staff hours provided on first shift. -There was 38.4 staff hours provided on third shift. Review of the Daily Census Report dated 03/17/17 revealed: -The census for the SCU was 53 residents. -53 hours of staff time was required for first shift. Review of the "Punch Detail" Report dated 03/17/17 revealed there was 51.82 staff hours provided on first shift. Review of the Daily Census Report dated 03/18/17 revealed: -The census for the SCU was 53 residents. -53 hours of staff time was required for second shift. Review of the "Punch Detail" Report dated 03/18/17 revealed there was 51.48 staff hours provided on second shift. Review of the Daily Census Report dated 04/05/17 revealed: -The census for the SCU was 52 residents. -52 hours of staff time was required for second shift. -41.6 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 04/05/17 revealed:	D 465		

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D 465	Continued From page 111 -There was 46.38 staff hours provided on second shift. -There was 35.02 staff hours provided on third shift. Review of the Daily Census Report dated 04/07/17 revealed: -The census for the SCU was 51 residents. -51 hours of staff time was required for first and second shifts. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 04/07/17 revealed: -There was 44.02 staff hours provided on first shift. -There was 50.52 staff hours provided on second shift. -There was 39.3 staff hours provided on third shift. Review of the Daily Census Report dated 04/08/17 revealed: -The census for the SCU was 51 residents. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 04/08/17 revealed there was 24.43 staff hours provided for third shift. Review of the Daily Census Report dated 04/09/17 revealed: -The census for the SCU was 51 residents. -40.8 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 04/09/17 revealed there was 32.93 hours	D 465		

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provided on third shift.

Review of the Daily Census Report dated 04/10/17 revealed:
-The census for the SCU was 51 residents.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/10/17 revealed there was 39.53 staff hours provided on third shift.

Review of the "Daily Census Report" dated 04/11/17 revealed:
-The census for the SCU was 51 residents.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Reports dated 04/11/17 revealed there was 39.54 staff hours provided on third shift.

Review of the "Daily Census Report" dated 04/12/17 revealed:
-The census for the SCU was 51 residents.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" reports dated 04/12/17 revealed there was 31.47 staff hours provided on third shift.

Review of the "Daily Census Report" dated 04/13/17 revealed:
-The census for the SCU was 51.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/13/17 revealed there was 31.75 staff hours

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provided on third shift.

Review of the "Daily Census Report" dated 04/14/17 revealed:
-The census for the SCU was 51.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/14/17 revealed there was 39 staff hours provided on third shift.

Review of the "Daily Census Report" dated 04/15/17 revealed:
-The census for the SCU was 51.
-51 hours of staff time was required for second shift.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/15/17 revealed:
-50.32 hours of staff time was provided on second shift.
-38.75 hours of staff time was provided on third shift.

Review of the "Daily Census Report" dated 04/16/17 revealed:
-The census for the SCU was 51.
-51 hours of staff time was required for second shift.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/16/17 revealed:
-40.87 hours of staff time was provided on second shift.
-23.25 hours of staff time was provided on third

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shift.

Review of the "Daily Census Report" dated 04/17/17 revealed:
-The census for the SCU was 51.
-51 hours of staff time was required for first shift.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/17/17 revealed:
-49.84 hours of staff time was provided for first shift.
-30.78 hours of staff time was provided for third shift.

Review of the "Daily Census Report" dated 04/18/17 revealed:
-The census for the SCU was 51.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/18/17 revealed 20.36 hours of staff time was provided for third shift.

Review of the "Daily Census Report" dated 04/19/17 revealed:
-The census for the SCU was 51.
-40.8 hours of staff time was required for third shift.

Review of the "Punch Detail" Report dated 04/19/17 revealed 38.03 hours of staff time was provided for third shift.

Review of the "Daily Census Report" dated 04/21/17 revealed:
-The census for the SCU was 50.
-40 hours of staff time was required for third shift.

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D 465	Continued From page 115 Review of the "Punch Detail" Report dated 04/21/17 revealed 31.27 hours of staff time was provided for third shift. Review of the Daily Census Report dated 04/22/17 revealed: -The census for the SCU was 48 residents. -48 hours of staff time was required for first and second shifts. -38.4 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 04/22/17 revealed: -There was 45.08 staff hours provided on first shift. -There was 41.1 staff hours provided on second shift. -There was 24.67 staff hours provided on third shift. Review of the Daily Census Report dated 04/23/17 revealed: -The census for the SCU was 50 residents. -50 hours of staff time was required for first and second shifts. -40 hours of staff time was required for third shift. Review of the "Punch Detail" Report dated 04/23/17 revealed: -There was 45.3 staff hours provided on first shift. -There was 39.0 staff hours provided on second shift. -There was 32.17 staff hours provided on third shift. Interview with a personal care aide (PCA) on 04/19/17 at 9:33 a.m. revealed: -Second and third shift were usually understaffed.	D 465		

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-She worked on second shift sometimes to help out.

Interview with a PCA on 04/19/17 at 10:45 a.m. revealed:
-She had to stay over on second shift sometimes because they were short staffed.
-They had always been short staffed since she started working there about a year ago.
-About a month ago, there was only 2 staff working on third shift when she arrived to work at 6:58 a.m. one morning.

Confidential staff interview revealed:
-First shift was the only shift covered with enough staff but second and third shift were almost always short staffed.
-It was difficult to meet all of the residents needs when shifts were short staffed, "It's a lot". Management had instructed staff to wake the residents up at 5:00 a.m., but the staff member did not understand why. Some residents were up at 5:00 a.m. and some liked to sleep later and did not like to get up at 5:00 a.m. "I wouldn't either".
-The Special Care Coordinator (SCC) stayed late on 04/19/17 until approximately 12 midnight, but she did not work on the floor. "She stayed in her office".

Confidential interview with a second staff member revealed:
-There was a staffing shortage on second and third shift.
-The staff member could not respond to resident needs as quickly when shifts were worked short.
-Residents had more falls and behavioral outbursts when shifts were short staffed.

Confidential interview with a third staff member revealed second and third shifts needed more

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staff because a lot of the residents at the facility had "sun downing syndrome" (a symptom of Alzheimer's disease where confusion and agitation worsen in the late afternoon and evening).

Confidential interview with a fourth staff member revealed:
-Third shift was never fully staffed.
-Some staff members worked double shifts to help out.

Confidential interview with a fifth staff member revealed:
-The SCC and the Administrator alternated call days/weekends.
-Staff knew of an incident when they were short staffed. A call was placed to the SCC who referred the staff member to call the Administrator, but after calling the Administrator was told the SCC was on call. "We had to do the best we could".
-Shifts were short sometimes related to staff calling out, and at other times because the shifts were scheduled with short staffing. "We just don't have the numbers (staff)".
-The SCC does the schedule but never helps on the floor.
-Adequate staff on each shift could prevent occurrences of resident accidents, incidents and behaviors.
-Staff were expected to get the residents up at 5:00 a.m. If the resident did not want to get up at that time, she would get the resident dressed and the resident would lay back down.

Confidential interview with a sixth staff member revealed:
-There was an ongoing storage of staff on second and third shift.

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D 465	Continued From page 118 -The last time the SCC covered second or third shift was "months ago". Observation on 04/24/17 at 5:30 a.m. revealed there were two PCA's and one medication aide (MA) working as an aide. No other staff were present Observation on 04/24/17 at 5:46 am on B Hall revealed: -There was one MA on B Hall assisting residents. -There were 2 residents walking up and down B Hall. -There were two linen savers soiled with urine and feces laying on the floor in front of the toilet in the last stall of the common restroom. -Upon notification, the MA removed the soiled linens off the floor. -The MA did not know the linen savers were on the floor. Observation on A Hall on 04/24/17 at 6:14 a.m. revealed: -There were residents walking up and down the hall. -The floor in front of resident room 104 was wet. The wet area was approximately 2 to 3 feet long. -There was not a staff who was on A Hall. -Upon notification, a PCA at the front of the building cleaned the area up and stated that one of the residents [named] who used a wheelchair had urinated on the floor. Interview with the SCC on 04/25/17 at 5:35 p.m. revealed: -The SCC was responsible for scheduling staff on each shift. -The staffing ratio on first and second shift was one staff person to 8 residents and one staff person to 10 residents on third shift.	D 465		

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D 465	Continued From page 119 -The SCC would schedule 7 staff members (PCAs/Nurse Aides (NAs)/Medication Aides) on first and second shifts and 6 staff members on third shift, but that all depended on the number of residents in the facility. -There were times second and third shifts were short staffed. -Short staffing had been an ongoing issue for a while, "for about 6 months". "We hire but the turnover is high". -The SCC and the Administrator were responsible to assure adequate staff were maintained in the facility at all times. -When a staff member called in and was not able to work after the SCC and Administrator left for the day, the Medication Aide (MA) would be responsible to call other staff to come in to cover the shift. The MA was also responsible for notifying the SCC and the Administrator of the call out and they would call staff as well. -When the SCC called staff to cover a shift she could usually get some staff members to cover a partial shift. -Staff were supposed to stay over their scheduled work time if needed, until the "floor was covered". -When there was no volunteer staff members, staff had to work short. -The SCC would fill in and help on the floor when needed. -When the SCC did not have enough staff to cover all the shifts, she would report this to the Administrator but no feedback would be given. -The facility continued to actively hire new staff. Interview with the Administrator on 04/26/17 at 5:55 p.m. revealed: -Staffing issues were reviewed in "stand up meetings". -The staffing ratio on first and second shift was one staff person to 8 residents and one staff	D 465		

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person to 10 residents on third shift
-The Administrator was always on call but rotated weekends with the SCC.
-The facility was actively hiring staff.

Interview with the Regional Director of Operations (RDO) on 04/24/17 at 3:30 p.m. revealed:
-Staffing schedules were sent to the facility's corporate office for log in purposes but the corporate office did not check scheduling.
-The RDO expected the Administrator to assure all scheduling needs were met.

The facility failed to assure the minimum number of staff were present at all times on all 3 shifts to meet the needs of residents residing in the Special Care Unit (SCU) for 31 of 63 shifts sampled in March 2017 and April 2017. The facility failed to meet minimum staffing requirements at times when resident falls occurred. The facility's failure to provide sufficient staffing to meet the needs of the residents in the SCU was detrimental to the health, safey, and welfare of the residents and constitutes a Type B Violation.

Review of a Plan of Protection received on 04/24/17 revealed:
-The facility would immediately review staffing for all shifts to ensure that shifts are staffed according to state guidelines per community current census.
-Management would review daily schedules for adequate coverage and approved by administrator.
-The Manager on duty would assure shifts were adequately covered according to state guidelines.
-Staff scheduled were not to leave the facility at

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D 465	Continued From page 121 the end of their shift until their relief had arrived or until a manager was relieved by staff of their shift. -A rotation for the manager on duty would be implemented covering 7 day rotations. When staff were required to stay to ensure coverage they would be awarded by the company incentive program. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 10, 2017.	D 465		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, consideration, dignity, and full recognition of his or her individuality. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to staff failing to provide assistance to a resident when asked and making an inappropriate comment (Resident #8); the way a resident was treated by staff in the dining room (Resident #9); the inappropriate manner staff interacted with an exit-seeking resident (Resident #10); staff failing to consider a resident's feelings	D911		

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D911	Continued From page 122 about missing clothing and labeling her a hoarder (Resident #5); and the tone and manner staff spoke to and in front of residents at times. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation).]	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to personal care and supervision, health care, special care unit staffing, and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 5 residents (#1, #3) sampled including a resident with multiple falls resulting in 3 visits to the emergency room (ER) for head injuries requiring staples or liquid sutures (#3) and a resident with multiple falls resulting in two ER visits for bruising and pain in the buttocks (#1). [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and	D912		

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D912	Continued From page 123 Supervision (Type A2 Violation).] 2. Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 3 of 5 residents (#1, #3, #4) sampled by failing to notify a resident's physician of multiple medication refusals (#4), failing to coordinate with a physical therapist or physician to obtain a new wheelchair for a resident with multiple falls with injuries (#3), and failing to coordinate a mental health referral for a resident with symptoms of depression, anxiety, and agitation (#1). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 3. Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 31 of 63 shifts sampled in March 2017 and April 2017. [Refer to Tag D465 10A NCAC 13F .1308(a) SCU Staffing (Type B Violation).] 4. Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to physical environment, housekeeping and furnishings, other requirements, other staff qualifications, tuberculosis test, personal care and supervision, health care, nutrition and food service, residents' rights, medication administration, special care unit staffing, adult care home infection prevention requirements, and examination and screening of controlled substances. [Refer to G.S. 131D-25 Implmentation (Type A2 Violation).]	D912		

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D934	Continued From page 124	D934		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide mandatory, annual state approved infection prevention training for 2 of 3 medication aides (B, F) sampled that had been employed for more than one year. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired on "3/12". -There was a job description for supervisor dated 01/18/12 and medication aide and personal care aide dated 05/22/12. -Staff B completed the Medication Aide Clinical Skills checklist on 04/05/12. -Staff B passed the written Medication Aide Exam on 10/04/06.	D934		

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D934	Continued From page 125 -There was documentation the annual state approved infection control training was completed on 11/26/13. -There was no documentation the annual state infection control training had been completed since 11/26/13. Observation on 04/24/17 at 5:00 a.m. revealed Staff B was working as a medication aide on third shift. Interview with the Business Office Manager (BOM) on 04/26/17 at 7:50 p.m. revealed: -She started working at the facility in 2015. -She was responsible for setting up the annual state infection control for staff. -She was not sure of Staff B's exact hire date but she thought "3/12" meant she was hired on 03/12/12. -They had a mandatory class for the annual state infection control course on 03/28/17. -Staff B did not show up for the scheduled training on 03/28/17. -She had not rescheduled the training for Staff B. 2. Review of Staff F's personnel file revealed: -Staff F was hired as a Personal Care Aide on 10/16/10. -Staff F's job description was changed on 05/22/12 to a Medication Aide. -Staff F had completed the medication clinical skills checklist on 10/24/13. -Staff F had passed the state written medication aide exam on 05/17/12. -There was documentation Staff F had completed the state mandated annual infection control training on 07/22/15. Observation of Staff F revealed Staff F worked as a Medication Aide (MA) on 04/24/17 from 8:00	D934		

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D934	Continued From page 126 a.m. - 3:00 p.m. Staff F was not available for interview. Interview with the Business Office Manager (BOM) on 04/26/17 at 8:45 p.m. revealed she would try and locate Staff F's 2016 infection control training. The BOM was unable to locate evidence that Staff F had completed the 2016 infection control training by the end of the survey.	D934		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to physical environment, housekeeping and furnishings, other requirements, other staff qualifications, tuberculosis test, personal care and supervision, health care, nutrition and food service, residents' rights, medication administration, special care unit staffing, adult care home infection prevention requirements, and examination and screening of controlled substances.	D980		

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D980	Continued From page 127 The findings are: Interview with the Administrator on 04/26/17 at 5:55 p.m. revealed: -He had worked at the facility for about 2 and ½ years and his job responsibilities were to oversee the facility and make sure each department was functioning. -They had stand up meetings each day and he usually participated in the meetings. -Each department would report to the Administrator if they were having staffing issues or hiring needs. -He did marketing for the facility by recruiting new residents and going offsite to assess potential new residents. -His routine schedule was to work Monday through Friday about 8 hours a day and he was always on call. -He usually did 1 to 4 potential new resident assessments offsite each week. -He and the Special Care Coordinator (SCC) rotated weekends so he was on call every other weekend. -He did not "micromanage" the staff. -He relied on the department managers to let him know if there were any issues or concerns. -He would monitor things like the food order or if staff were getting overtime. -He did not monitor residents' records or staff records because it was impossible to do it all. -Even if he monitored everything, there was still going to be "holes in it". -It was the role of the department managers to monitor their areas. Noncompliance identified during the survey included:	D980		

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D980	Continued From page 128 1. Based on observations, interviews, and record reviews, the facility failed to assure the door at the end of A Hall of the special care unit (SCU) was equipped with a sounding device that activated when the door mag lock malfunctioned leaving the door unlocked and able to be opened from the inside leading to the staff lounge, which had a door leading to the outside that was unlocked and not equipped with a sounding device. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment] 2. Based on observations and interviews, the facility failed to assure walls and floors were kept clean and in good repair for residents' bedrooms and restrooms on the B and C Halls of the facility. [Refer to Tag D074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings] 3. Based on observations and interviews, the facility failed to have furniture in good repair in the residents' living areas which included chairs, 3 sofas, and a television stand in the television room on A Hall, chairs in the Quiet Room on C Hall, a bench on C Hall, and the wooden tables and chairs in the residents' dining room. [Refer to Tag D076 10A NCAC 13F .0306(a)(3) Housekeeping and Furnishings] 4. Based on observations and interviews, the facility failed to assure a resident's room (room 309), the residents' shower room and handicapped bathroom on C Hall, and the television room on A Hall were maintained in an uncluttered, clean and orderly manner, and were free of all obstructions and hazards. [Refer to Tag D079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings] 5. Based on observations, record reviews, and	D980		

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interviews, the facility failed to assure the facility's water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 3 of 15 fixtures, including three sinks in the shower room and handicapped bathrooms on C Hall and in resident room 306. [Refer to Tag D113 10A NCAC 13F .0311(d) Other Requirements]

6. Based on observations, interviews, and review of personnel files, the facility failed to assure 2 of 7 staff (D,F) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry upon hire to the facility. [Refer to Tag D137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications]

7. Based on observations, interviews, and review of personnel files, the facility failed to assure 3 of 6 staff (B, D, F) sampled had a criminal background check upon hire in accordance with G.S. 114-19.10 and 131D-40. [Refer to Tag D139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications]

8. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 6 sampled residents (#5) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag D234 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Examination and Immunizations]

9. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 5 residents (#1, #3) sampled including a resident with multiple falls resulting in 3 visits to the

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emergency room (ER) for head injuries requiring staples or liquid sutures (#3) and a resident with multiple falls resulting in two ER visits for bruising and pain in the buttocks (#1). [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]

10. Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 3 of 5 residents (#1, #3, #4) sampled by failing to notify a resident's physician of multiple medication refusals (#4), failing to coordinate with a physical therapist or physician to obtain a new wheelchair for a resident with multiple falls with injuries (#3), and failing to coordinate a mental health referral for a resident with symptoms of depression, anxiety, and agitation (#1). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]

11. Based on observations, interviews and review of the facility's menus, the facility failed to maintain a 3 day supply of perishable food, including milk to serve to 52 residents according to the menu. [Refer to Tag D285 10A NCAC 13F .0904(a)(4) Nutrition and Food Service]

12. Based on observations, interviews, and record reviews, the facility failed to assure any substitutions made in the menu were of equal nutritional value and appropriate for 5 of 5 residents (#1, #3, #5, #12, #13) sampled including a regular diet for Resident #1 and #5, a regular diet with ground meats for Resident #3, a regular mechanical soft diet for Resident #12, and a regular pureed diet with nectar thick liquids for Resident #13. [Refer to Tag D292 10A NCAC 13F .0904(c)(3) Nutrition and Food Service]

13. Based on observations, interviews, and

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record reviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to staff failing to provide assistance to a resident when asked and making an inappropriate comment (Resident #8); the way a resident was treated by staff in the dining room (Resident #9); the inappropriate manner staff interacted with an exit-seeking resident (Resident #10); staff failing to consider a resident's feelings about missing clothing and labeling her a hoarder (Resident #5); and the tone and manner staff spoke to and in front of residents at times. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation).]

14. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#2, #11) observed during the medication passes including errors with a medication used to treat high blood pressure (#2) and a topical ointment used to treat a skin rash (#11). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration]

15. Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 31 of 63 shifts sampled in March 2017 and April 2017. [Refer to Tag D465 10A NCAC 13F .1308(a) SCU Staffing (Type B Violation]

16. Based on observations, interviews, and record reviews, the facility failed to provide mandatory, annual state approved infection prevention training for 2 of 3 medication aides (B, F) sampled that had been employed for more

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D980	Continued From page 132 than one year. [Refer to Tag D934 G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements] 17. Based on observations, interviews, and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was performed for 1 of 3 staff (C) sampled who was hired after 10/01/13. [Refer to Tag D992 G.S. § 131D-45. Examination and Screening for the Presence of Controlled Substances.] The Administrator failed to assure the management, operations, and policies of the facility were implemented including implementation of residents' rights. The Administrator failed to assure residents were treated with respect and dignity as evidenced by staff failing to provide assistance to a resident when asked and making an inappropriate comment; the way a resident was treated by staff in the dining room; the inappropriate manner staff interacted with an exit-seeking resident; staff failing to consider a resident's feelings about missing clothing and labeling her a hoarder; and the tone and manner staff spoke to and in front of residents at times. The Administrator failed to assure appropriate care and services were provided by the failure to maintain substantial compliance with rules and statutes related to physical environment, housekeeping and furnishings, other requirements, other staff qualifications, tuberculosis test, personal care and supervision, health care, nutrition and food service, medication administration, special care unit staffing, adult care home infection prevention requirements, and examination and screening of controlled substances, which is the responsibility	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051041	A. BUILDING: _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

(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
D980	Continued From page 133 of the Administrator. The failure of the Administrator to implement rules and regulations resulted in substantial risk of serious neglect and mental and physical harm for all residents, which constitutes a Type A2 Violation. _____ Review of a Plan of Protection dated 04/26/17 revealed: -The Administrator had resigned effective today 04/26/17 and another corporate Executive would assume management of the facility under the direction of the Regional Director of Operations. -A certified Administrator would be assigned to the facility effective 04/27/17 until the permanently assigned Administrator assumed duties by May 31, 2017. -A certified Administrator assigned to manage the facility and oversee all departments within the facility. -A team would conduct audits of each department and address any areas of concern. Refer to the plan of Protection for Resident Rights 04/21/17, Personal Care and Supervision 04/21/17, Special Care Unit staffing 04/24/17, and Health Care 04/24/17. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 26, 2017.	D980		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D992	Continued From page 134 licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was performed for 1 of 3 staff (C) sampled who was hired after 10/01/13. The findings are: Review of Staff C's personnel file revealed:	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D992	Continued From page 135 -The hire date for Staff C was 09/30/16. -Staff C was hired as a personal care aide (PCA). -There was no documentation of a urine controlled substance exam and screening being completed for Staff C. Observation on 04/25/17 revealed Staff C was working as a PCA on second shift. Interview with the Business Office Manager (BOM) on 04/26/17 at 7:50 p.m. revealed: -She started working at the facility in 2015. -She usually did orientation with new employees including the urine drug screens. -There should be a urine drug screen on file for Staff C. -She thought Staff C's orientation may have been done by the Special Care Coordinator. -She did not recall if a urine drug screen was done for Staff C.	D992		