Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HA1066019	A. BUILDING: _____ B. WING _____	R 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEWOOD MANOR	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Hertford County Department of Social Services conducted an annual and follow-up survey on May 17 through May 18, 2017 and May 22 through May 24, 2017.	D 000		
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 the walls and floors in 1 of 2 common shower rooms on the C Hall and 2 of 2 common shower rooms on the A Hall were kept clean and in good repair; to assure all baseboards on the C Hall hallway and 1 of 18 rooms on the A Hall were in good repair; to assure the 4 of 4 walls in the dining room on the Special Care Unit were clean; and to assure ceiling vents in 1 of 16 residents' rooms on the C hall and 6 of 18 residents' rooms on the A Hall were clean. The findings are: Observation of the C Hall on 5/17/17 between 10:30am-12:55pm revealed several black stains were seen along the baseboards throughout the hallways.	D 074	The facility Maintenance man will provide all material needed for walls, floor stains + all interior area that needs repaired The facility will provide maintenance workers work sheets for each shift to report any needed repairs for the day and repair immediately. The facility administrator maintenance repair man will monitor reports. The facility monitoring will take place daily, by the facility administrator housekeeper Supervisor RCC.	6/23/17 6/23/17 6/23/17 6/23/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Strayhorn — TITLE: administrator — (X6) DATE: 6/21/17

7/28/17 - Reviewed and accepted with documentation provided previously by the facility but not included with this POC. Other documentation to be added in the facility files. Jeffrey Sewell

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D 074	Continued From page 1 Observation of the common hall shower room between Room #12 and Room #13 on the C Hall on 5/17/17 at 10:35 am revealed: -There were 4 tiles on the right side wall of the shower with black stained grout. -The tiles inside the shower were covered with a white, sticky substance. -The grout and caulk on the shower walls was discolored with dark brown stained areas. -The shower floor had several dark brown stained areas. -The grout and caulk on the outside wall of the shower was covered with a sticky, white substance with black stained areas. Observation of Room #2 on the C Hall on 5/17/17 at 10:43 am revealed: -There was a thick layer of dust on the inside wall and window seal of the shared bathroom. -The entrance way into bathroom had chipped and broken tile at the base of the door frame. Observation of a shared bathroom between Room #9 and Room #10 on the C hall on 5/17/17 at 4:10 pm revealed there were missing baseboards on 2 of 4 walls. Observation of the dining room in the SCU on 5/17/17 at 10:45 am revealed four of four walls had numerous black, brown, and orange stains. Observation of Room #4 on the SCU on 5/17/2017 at 10:50am revealed: -The ceiling air vent next to the room entrance was dirty and had brown dust in between its dividers. -An approximately 3 inch semi-circle area with exposed drywall was under the soap dispenser in the bathroom. -The towel rack on the wall area to the right of the	D 074		

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D 074	Continued From page 2 bathroom sink and there were no brackets. Observation of Room #2 on the SCU on 5/17/2017 at 10:58am revealed: -There was white peeling paint over the sink inside the bathroom that measured approximately 2 feet long and exposed the green wall painted underneath. -Both towel racks were missing from the walls inside the bathroom and there were no brackets. -The paint was peeling around the door knob inside of the bathroom. -The two bottom slats of the right window covering of the bathroom window were broken. Observation of Room #14 on the A Hall on 5/17/17 at 3:45pm revealed: -The paint was peeling around the ceiling vent next to the door. -There were two areas of brown raised stains around the inside door knob that measured approximately 10 inches long. -There was a 2 foot long scraped area along the top of the left closet door on the wall. Observation of the shared bathroom between Room #13 and Room #14 on A Hall on 5/17/17 at 3:46pm revealed: -The bathroom door leading into Room #13 was covered with a white substance and had a hole that measured approximately 3 inches in diameter. -The door frame of the door leading into Room #13 had several rust spots and chipped white paint that measured approximately 3 feet up from the floor. -The white grab bar located next to the toilet tissue dispenser on the left wall had several rust spots. -The metal grab bar located on the right wall next	D 074		

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D 074	Continued From page 3 to the toilet was rusty. Observation of Room #13 on the A Hall on 5/17/17 at 3:50pm revealed: -There was a 2 foot long scraped area along the top of the left closet door on the wall. -There was a peeling white paint to the left wall area next to the closet that measured approximately 5 inches long. -The ceiling air vent next to the door was covered with brown dust. -There was an area of the black baseboard that was partially detached 1 foot from the right wall. -There were several brown linear stains on the floor next to detached baseboard area. -There was chipped, peeling paint along the upper right ceiling corner area that measured approximately 2 feet long. -There was a brown raised stain encrusted along the inside door knob that measured approximately 1and ½ feet long. Observation of the shared bathroom between Room #16 and Room #17 on A Hall on 5/17/17 at 4:05pm revealed: -The towel rack was missing from the right wall next to the sink and no brackets were present. -Both of the frames of the interior bathroom doors had chipped white paint with several areas of exposed metal and rust spots that extended approximately 4 inches from the floor. Interview with the resident in Room #16 on 5/17/17 at 4:07 pm revealed: -He had never noticed the towel rack was missing on the right wall in his shared bathroom. -The frame of the bathroom doors had chipped paint and rusty spots since he had been in the room. -He could not specify how long he had been living	D 074		

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D 074	Continued From page 4	D 074		

in Room #16.
-He had not reported the missing towel rack in his bathroom or the chipped paint and rust spots on the bathroom door frames.

Observation of Room #17 on A Hall on 5/17/17 at 4:10pm revealed the ceiling vent next to the room entrance was covered with brown dust.

Observation of Room #12 on A Hall on 5/17/17 at 4:18pm revealed:
-There were brown raised stains around the inside door knob that measured approximately 6 inches long along the perimeter of the door.
-There was a 5 foot puddle of yellow fluid that extended from inside the room into the shared bathroom floor.
-There was a strong urine smell in the room.

Attempted interview with resident in Room #12 on 5/17/17 at 4:20pm was unsuccessful due to the resident cognitive status.

Observation of Room #11 on A Hall on 5/17/17 at 4:23pm revealed the ceiling vent next to the door was covered with brown dust and the paint was peeling around all 4 sides of the ceiling fan.

Observation of the common hall shower room across from Room #19 on A Hall on 5/17/17 at 4:35pm revealed:
-The walls inside of the shower stall were covered with white stains.
-The grout of the shower stall had several areas with black and brown stains on the shower walls and floors.

Observation of Room #6 on A Hall on 5/17/17 at 4:40pm revealed the ceiling vent next to the door was covered with brown dust.

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D 074	Continued From page 5 Observation of Room #9 on A Hall on 5/17/17 at 4:45pm revealed: -There were no towel racks in the shared bathroom and the brackets were missing. -The ceiling vent next to the door was covered with brown dust and the frame of the ceiling vent was covered with duct tape. Interview with the resident in Room #9 on A Hall on 5/17/17 at 4:47pm revealed: -He just moved in the room within the last 2 months. -There were no towel racks in the bathroom when he arrived. -He had to hang is towel and bath cloth on hangers in his closet to dry. -The tape around the ceiling vent had been there since he moved into the room. -He did not complain about the towel racks or duct tape because it was like that when he got to the facility and he thought the staff already knew about. Observation of Room #7 on A Hall on 5/17/17 at 4:50pm revealed there was an area of peeling paint and drywall in the ceiling above the door over the resident's bed that measured approximately 12 feet long. Observation of Room #5 on A Hall on 5/17/17 at 4:55pm revealed: -Two of four walls had linear cracks along the ceiling molding that ranged 6 to 10 inches long. -The paint on the ceiling was peeling in several areas. -The ceiling vent next to the door was covered with brown dust. Observation of the common hall bathroom across	D 074		

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D 074	Continued From page 6 from Room #4 on A Hall on 5/17/17 at 5:00pm revealed: -The walls inside of the shower stall were covered with white stains. -The grout of the shower stall had several areas with black and brown stains on the shower walls and floors. -An L-shaped area of approximately nine -1 inch x 1 inch shower tiles were missing from the floor of the shower stall. -Gray and brown dust was inside of the tub area. -A bulb-like round ceiling fixture was covered with green and brown stains. -The paint around the bulb-like round ceiling fixture was cracked and had exposed rust spots around the frame of the fixture. Confidential interview with a resident revealed: -The resident did not use any of the common shower rooms on A Hall because "they are nasty". -He saw housekeeping staff go in to clean the shower rooms but they all still looked the same even after they are cleaned by the housekeeping staff. -The resident has seen green mold growing in the shower stalls several times. -The resident had complained several times about the cleanliness of the bathrooms on A Hall to housekeeping staff but there had been no improvements. -The resident could not remember which housekeeping staff that the complaint was made to. -The resident reported taking baths using a wash pan in the sink in the resident's room. Confidential interview with a second resident revealed: -The resident uses the common hall shower rooms on A Hall but the shower rooms are never	D 074		

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cleaned properly by staff.
-The resident reports the resident is careful not to let any skin touch the walls of the shower stalls.
-The resident wears sandals inside the shower due to lack of cleanliness of the shower room floors.
-The resident reported, "It don't do no good to complain because the shower rooms are never clean here unless the state is in the building".

Interview with a Housekeeper on 5/18/17 at 12:15 pm revealed:
-She cleaned the showers of the common bathrooms on the hall she was assigned every day.
-She cleaned all of the floors on the hall she was assigned every day.
-She did not clean the baseboards or walls in the facility.

Interview with the Housekeeping Supervisor on 5/22/17 at 4:44 pm revealed:
-He monitored housekeeping staff on a daily basis to ensure all resident rooms and bathroom areas were cleaned daily.
-Resident rooms and bathroom floors were swept and mopped every day.
-The toilets and sinks in the resident rooms and bathrooms were cleaned daily.
-Housekeeping cleaned the shower stalls in the common shower rooms every day on the hall they were assigned.
-He cleaned the facility as he was taught to do in training.
-He swept and mopped all of the floors in the residents' rooms every day when he worked the halls.
-He cleaned the shower stalls in the common bathrooms every day when he worked the halls.
-He swept and mopped the floors of the common

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bathrooms every day when he worked the halls.
-Deep cleaning was performed on a weekly basis and floors were stripped and waxed monthly.
-Deep cleaning at the facility included pulling out the residents' beds so that the floors under the beds were swept and mopped.
-Deep cleaning at the facility also included wiping all of the residents' mattresses down with disinfectant once every two weeks.
-He did not clean windows, walls, or baseboards in the facility.

Observations of the C hall on 5/23/17 at 10:40 am revealed all resident rooms and bathroom areas had not changed since the initial observations conducted on 5/17/17 from 10:30 am through 12:55 pm.

Interview with the Administrator on 5/24/17 at 2:15 pm revealed:
-She was in charge of the housekeeping staff.
-She had trusted her housekeeping staff to do their jobs as they were assigned.
-The facility did have a general housekeeping checklist and a deep cleaning checklist the housekeeping staff were supposed to go by for cleaning.
-She did not know if the housekeeping staff were using the checklists.
-The housekeeping staff were expected to follow those checklists to complete those housekeeping tasks.
-Deep cleaning was supposed to done every two days at the facility.
-She would have to check to see if the housekeeping staff was using the checklist for their cleaning schedules.
-It was expected for the housekeeping staff to clean all of the bathrooms in the facility every day.
-She would see what could be done to clean up

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D 074	Continued From page 9 the baseboard areas. -She would follow-up with maintenance regarding the areas of peeling paint on the walls and all other needed repairs.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure that 1 of 3 halls (the A Hall) was free of unpleasant and offensive odors that spread through the entire A Hall, the front sitting room, and dining room areas. The findings are: Observations on the A hall during the facility tour on 5/17/17 from 10:30am - 12:55pm revealed: -There was a strong foul odor upon entering the dining areas and the sitting area on the A hall. -The foul odor became stronger once entering the A hall hallway. -There was a strong foul odor of urine that could be smelt from all of the resident rooms on the A hall. Confidential interview with a resident revealed: -The A hall had a chronic urine smell for as long	D 075	The facility will provide a Contractor to come out and replace the tile in 2 bedroom & bathroom to ensure the chronic unpleasant odor is free from A Hall. 7/8/17 The facility housekeeping staff will continue to clean as scheduled and as needed. 7/8/17 The facility housekeeping supervisor, administrator, RCC, & staff members will monitor. 7/8/17 The facility environment will be monitored daily by housekeeping supervisor weekly by RCC & administrator. 7/8/17	

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D 075	Continued From page 10 as the resident could remember, but the resident could not specify a timeframe. -The terrible urine odor could be smelled from the dining room and sitting room areas of the facility. -The resident believed the smell came from Room #12. -Both residents in Room #12 "peed" on their bedroom floor and on the floor in the common bathroom. -The smell was so bad that sometimes the resident could not eat their food in the dining room or "sit in peace" in the sitting area. -The strong urine odors came from the common bathrooms on the A hall. -"Housekeeping cleaned, it smelled better for a little while, but the smell always returned". -It usually smelled worse early in the mornings and after 2:00 pm -The smell lingered in the A hall hallway most of the day. -The resident did not want family to visit because of the bad smell and would meet them outside or in a different area. -The resident did not feel the need to report the foul odor because "everyone could smell it." Attempted interviews with the two residents in Room #12 revealed the residents were not interview-able due to their cognitive status. Confidential interview with a second resident revealed: -There were chronic odors of urine in the facility all the time especially on the A hall, in the bathrooms on the A hall, near the dining/kitchen areas, and in the sitting area. -The resident usually smelled the odors all day long every day. -The urine smell was strongest in the mornings and after the lunch meal.	D 075		

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D 075	Continued From page 11 -The housekeeper cleaned the residents rooms and bathrooms everyday but "It doesn't do any good." -It smelled better after housekeeping had cleaned but the smell got stronger again after the cleaning had been done. -"Everybody could smell that bad smell." -The resident could smell the strong urine smell even in the dining room areas and sitting room. -The resident ate their meals even though it "smelled bad in the dining room, but "it wasn't a pleasant experience." -It had smelled that way for a long time, but could not specify how long. -The resident closed their bedroom door to help with the bad odors. Observation of the A hall throughout the day on 5/17/17 from initial tour at 10:30am - 6:00pm revealed: -There was a strong urine odor in the hallway starting at the dining/kitchen areas and in the sitting room area and going down the entire A hall hallway. -The odor was strong throughout the day, including in the morning and in the afternoon. Observation of Room #12 on 5/17/17 at 10:50am revealed: -The bedroom floor had been swept and mopped. -The residents' bedroom window was open. -There was a strong urine odor in the room. Interview with a Housekeeper on 5/18/17 at 12:15pm revealed: -She cleaned the sinks, toilets, and showers in the common hall shower rooms on the A Hall every day. -She cleaned all of the floors on the A Hall every day.	D 075		

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D 075	Continued From page 12 -She was aware of the strong urine smell. -The strong urine smell had been that way since she had been at the facility. -"Everyone couldn't help but smell that strong smell because it went from one end of the A hall to the other." -She cleaned the residents' rooms and bathrooms every day and "was doing the best she could, but the smell wouldn't go completely away." -The strong smell of urine came mainly from resident Room #12 and the common bathrooms on the A hall. -The urine must have saturated the cement floors of resident Room #12 and the bathrooms on the A hall because "it wouldn't ever completely go away." -The A hall smelled better after she had finished cleaning but "wouldn't stay that way for too long." -She had made the Housekeeping Supervisor aware of the foul smell on the A hall. Observation of the two common hall bathrooms on the A hall on 5/22/17 at 11:18 am revealed: -Both bathrooms had been cleaned and mopped. -There was a strong odor of urine in both bathrooms. Confidential interviews with three facility staff revealed: -The odor of urine could be smelled from the residents' dining and sitting areas near the A hall. -Some residents had gotten up from the dining table saying "they couldn't finish their food because of the bad odor." -Some residents who reside on the A hall kept their doors closed because of the bad smell. -Facility staff have kept the employee break room door closed because of the strong urine odor. -Some facility staff use air fresheners because of	D 075		

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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 075	Continued From page 13	D 075		

the strong smell.
-The urine odor gets worse a few hours after housekeeping has cleaned each day.

Interview with the Housekeeping Supervisor on 5/22/17 at 4:44 pm revealed:
-He monitored housekeeping staff on a daily basis to ensure all resident rooms and bathroom areas were cleaned daily.
-Resident rooms and bathroom floors were swept and mopped every day.
-The toilets and sinks in the resident rooms and bathrooms were cleaned daily.
-Housekeeping cleaned the shower stalls in the common shower rooms every day on the hall they were assigned.
-The floors of the common shower rooms were swept and mopped every day on the hall they were assigned.
-He was aware there were chronic urine odors on the A hall hallway, in the bathrooms on the A hall, and from the residents' rooms on the A hall.
-There was a very strong urine odor in Room #12.
-He thought the tile needed to be removed and replaced in order to get rid of the odor.
-Deep cleaning was performed on a weekly basis and floors were stripped and waxed monthly, but that smell would not fully go away.
-He had made the Administrator aware of the urine odor on the A hall but could not specify a timeframe.

Observations of the A hall on 5/24/17 at 10:00 am revealed the odors of urine were as strong as the previous days on 5/17/17, 5/18/17, 5/22/17, and 5/23/17.

Interview with the Resident Care Coordinator (RCC) on 5/24/17 at 2:05 pm revealed:
-There had always been a strong smell of urine

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D 075	Continued From page 14 on the A hall for as long as she could recall, but could not specify a timeframe. -All residents were encouraged by facility staff to take care of their toileting needs in the bathrooms. -The two residents in Room #12 did not always use the toilets in the bathrooms. -All the residents' rooms and bathroom areas were cleaned, swept, and mopped daily by the housekeeping staff, but the smell wouldn't go completely away. -She was unaware of any resident complaints about the smell on the A hall. Interview with the Administrator on 5/24/17 at 2:15 pm revealed: -She was aware of the strong odor on the A hall. -She couldn't smell the urine odor from the dining/kitchen areas or the sitting room area. -Housekeeping staff would continue to address the issue and ensure thorough cleaning occurred daily. -No residents had complained to her about the smell on the A hall. -She was unaware that the smell affected the residents and residents' complaints of not being able to eat their meals because of the smell. -She would follow-up with the housekeeping staff regarding the cleaning process of the residents' rooms, bathrooms, and common areas on the A hall. -She would follow-up with her corporate office to discuss options to resolve the issue. The facility failed to assure that 1 of 3 halls (the A Hall) was free of unpleasant and offensive odors that spread through the entire A Hall, the front sitting room, and dining room areas. This failure resulted in residents not being able to eat and enjoy meals in the dining room area; residents	D 075		

Division of Health Service Regulation

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D 075	Continued From page 15 having to visit with family members outside of the facility; and residents having to close their room doors to avoid the offensive odors. This failure was detrimental to the welfare of the residents and constitutes a Type B Violation. Review of a Plan of Protection dated 5/23/17 revealed: -The Administrator will put in a request to the corporate office to have the tile removed and replaced in 1 resident room. -The facility housekeepers will continue to monitor the rooms daily to assure the facility is odor free every shift. -The facility with check Room #12 at least 3 times before they leave to make sure the room is odor free. -The Housekeeping Supervisor will check behind the housekeeping staff daily. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 8, 2017.	D 075	The facility Maintenance crew will adhere to complete all exterior items that needs attention immediately.	7/8/17
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: FOLLOW-UP TO CONTINUING TYPE B	D 079	The facility housekeeper will ensure housekeeping crew clean accordingly when items are pointed out to them. The facility administrator will monitor the housekeeping crew on a regular basis to ensure each room is done accordingly. The facility administrator will monitor staff cleaning everyday and have them to redo if necessary.	7/8/17 7/8/17 7/8/17

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D 079	Continued From page 16 VIOLATION Based on these findings, the previously Unabated TYPE B VIOLATION was abated. Non-compliance continues. Based on observations and interviews, the facility failed to assure that 19 of 19 bedroom doors on the C Hall were in good repair, 2 of 19 light fixture covers in residents' rooms on the C Hall were clean and in good repair, 2 of 4 doors to the common shower rooms on the A Hall and the C Hall were in good repair and opened freely without obstruction; and to replace a missing toilet lid in the Special Care Unit. The findings are: Observation of the C hall on 05/17/17 between 10:30am -12:55pm revealed: -There were 19 doors scarred with dark brownish stains and scraped marks across the lower halves of the doors. Observation of the common hall shower room between Room #12 and Room #13 on the C hall on 05/17/17 at 10:40am revealed: -The entrance way into the common hall shower room doorframe had a large chipped tile area with missing molding and tile at the base of the doorframe. -The light fixture cover was dirty. -The ceiling vent was covered with dust. -The paper towel dispenser was dirty and covered with a sticky, white substance. -The toilet paper dispenser was covered with a sticky, white substance. -The sink was dirty and covered with grime. -The faucets on the sink were dirty and covered with a sticky, white substance.	D 079	The facility will provide more cleaning material to erase substance, provide material to repair all fixtures that needs repairing	7/8/17
			The facility Housekeeping dept will clean as scheduled as needed when staff has pointed out areas that needs attention.	7/8/17
			The facility will implement a work order sheet for housekeeping to complete.	7/8/17
			The facility extermination will continue to come as scheduled to spray for insect the administrator, RN, housekeeping will monitor daily.	7/8/17

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D 079	Continued From page 17 -The faucets to the bathtub were covered with a sticky, white substance. -The bathtub had discolored grout with dark brown stains. -The interior of the bathtub was dirty and had one black clothes hanger in it. -The non-slip tread strips were peeling away from the bottom of the bathtub. -The faucet and handrails inside of the shower were covered with a sticky, white residue. -The top of the white shower chair was covered with several dark brown and black marks. Observation of Room #2 on the C hall on 05/17/17 at 10:50am revealed: -The bottom of the bathtub was dirty with gray stains. -A shower chair in the tub had gray stains on the seat. -The sink was dirty and had a sticky, white substance. -The faucet of the sink was covered with a sticky, white substance. -The light switch cover had chipped, peeling paint. -The paper towel dispenser was covered with a sticky, white substance. -The toilet paper dispenser was covered with a sticky, white substance. Observation of Room #5 on the C hall on 05/17/17 at 11:00am revealed: -The window blind was broken and had missing slats. Observation of Room #9 and Room #10 on the C hall on 05/17/17 at 4:10pm revealed: -The bathroom had missing baseboards on two walls.	D 079		

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D 079	Continued From page 18 Observation of Room #11 on the C hall on 05/17/17 at 4:15pm revealed: -The door was very difficult to open and close. -The door scrapped against the door frame and floor when opened and closed. Observation of the common living room on the C hall on 05/17/17 at 11:20am revealed: -The carpet area was covered with several pieces of white paper and other white flaky materials. - Four vinyl-clothed chairs had cracked seating and armrests. -The television stand was dusty. Observation of the dining room on the C hall on 05/17/17 at 11:30am revealed: -The light switch cover had chipped/peeling paint. - The green cabinet in the dining room had chipped paint and the knob was missing to the right cabinet door. -The side of the green cabinet was stained with brown spots. -The areas to the base of the cabinets were dirty and corroded. Observation of Room #4 on the SCU on 5/17/2017 at 10:50am revealed: -The toilet tank lid was missing from the back of the toilet. -There was a 3-light fixture over the sinks covered with thick brown dust and the cover was missing to the middle light. Observation of Room #3 on the SCU on 5/17/2017 at 10:54am revealed: -The top drawer from a chest of drawers was missing and had exposed splinter wood. -The top sheet of the bed was covered with brown stains. -A protective white corner strip was pulled away	D 079		

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D 079	Continued From page 19 from the left corner at the foot of the bed from box string. Interview with a Personal Care Aide on the SCU on 5/17/17 at 10:55am revealed: -She did not realize the toilet tank lid or light fixture cover was missing in Room #4. -She did not know anything about the missing drawer, the stains on the sheets, or the pulled protective white corner strip on the bed in Room #3. -She reported needed repairs to the Housekeeping Supervisor when she saw them. Interview with the Housekeeping Supervisor on 5/17/17 at 11:40am revealed: -The staff normally told him when things needed to be fixed. -If it was something he couldn't handle then he got the maintenance person to fix it. -He was not aware of the toilet tank lid, missing light fixtures, or the ripped protective corner of the mattress box spring on the bed in the SCU but he would try to fix it as soon as possible. -He would find a drawer to replace the one missing from the chest of drawers in the SCU. Observation of Room #8 on A Hall on 5/17/17 at 4:15pm revealed the front 2 tabs under the toilet seat were broken and the toilet seat leaned forward. Attempted interview resident in Room #8 was unsuccessful due to the resident's cognitive status. Observation of Room #12 on A Hall on 5/17/17 at 4:18pm revealed: -There was a 5 foot puddle of yellowish liquid that extended from inside the room into the shared	D 079		

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D 079	Continued From page 20	D 079		

bathroom floor back toward the base of the toilet.
-The yellowish liquid had not dried.
-The length of time the yellowish liquid had been on the floor could not be determined.

Attempted interview with resident in Room #12 on 5/17/17 at 4:20pm was unsuccessful due to the resident cognitive status.

Observation of the common hall shower room across from Room #19 on A Hall on 5/17/17 at 4:35pm revealed:
-The door of the common hall shower room was difficult to open and required extreme force to open it.
-There were numerous brown stains on the base of the toilet.
-The back splash around the shower handle was missing.
-Two dirty white washcloths were hanging from the shower grab bar.

Observation of the common shared bathroom across from Room #4 on A Hall on 5/17/17 at 5:00pm revealed there was a green vinyl bath mat with brown stains on the floor in front of the shower.

Interview with a PCA on the A Hall on 5/17/17 at 5:05pm revealed she did not know about the vinyl bath mat in the common hall shower room.

Observation in the SCU dining room on 5/18/17 at 7:55am revealed 2 small brown roaches crawling along the back wall during breakfast.

Observation of Room #3 on 5/18/17 on the C Hall at 11:20am revealed 1 small brown roach crawling on the floor by the resident's bed.

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D 079	Continued From page 21 Interview with a resident in Room #3 on the C Hall on 5/18/17 revealed she was not aware that the facility had any problems with roaches. Observation of Room #7 on the A Hall on 5/18/17 at 12:39pm revealed 2 small roaches crawling across the bottom of the bedspread. Interview with a resident in Room #7 on the A Hall on 5/18/17 at 12:39pm revealed: -The facility "has a problem with roaches". -He had seen roaches crawling from the cracks in the walls and across on the floor. -He was not sure if the facility was sprayed by an exterminator. Interview with the Housekeeping Supervisor on 05/22/17 at 4:44pm revealed: -He monitored housekeeping staff on a daily basis to ensure all resident rooms and bathroom areas were cleaned daily. -Resident rooms and bathroom floors were swept and mopped every day. -He was unaware of the leaning toilet seat in Room #8. -The toilets and sinks in the resident rooms and bathrooms were cleaned daily, but the faucets with calcium deposits wouldn't come off those faucets. -He had told the administrator about the faucets with calcium deposits. -The floors of the common hall shower rooms were swept and mopped every day on the hall they were assigned. -The facility was sprayed by the exterminator at least once a month to control the roaches. Review of exterminator records for the facility revealed the facility was sprayed monthly from March 2017 through May 2017.	D 079		

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D 079	Continued From page 22 Maintenance was not available for interview prior to survey exit. Interview with the Administrator on 05/24/17 at 2:15pm revealed: -She was not aware the repairs had not been completed to the resident bathrooms and rooms. -It was her responsibility to call maintenance with any needed repairs for the facility. -The facility used a corporate maintenance crew and she would check the list to see what had been done and report all the needed repairs. -She would have maintenance complete the repairs still needed. -There was a new maintenance worker on staff but he was on leave from the facility.	D 079		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure curtains, drapes or window coverings were in 5 of 6 common hall shower rooms, to provide for the privacy of the residents, when used for their personal care needs.	D 083	The facility has provided blinds/curtains for the common hall showers. 5/24/17 The facility housekeeping staff will be made attentive to all the rooms as they clean and report any work area items needed to the room during personal that day. 5/24/17 The facility housekeeping supervisor will monitor housekeeping staff's work behind them for correction. 5/24/17 The facility administrator/DCC or designee will monitor daily to ensure areas that are cleaned out accordingly. 5/24/17	

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D 083	Continued From page 23 The findings are: Observation of the C Hall on 5/17/17 between 10:30am - 12:55pm revealed: -Two of two common hall shower rooms did not have blinds or curtains at the exterior windows to provide residents' privacy when used. -Both shower room windows opened into the rear courtyard facing toward the A Hall. -This area was accessible to both staff and residents. Observation of the Special Care Unit on 5/17/17 between 10:45am-10:58am revealed: -One of two common hall shower rooms did not have blinds or curtains at the exterior windows to provide residents' privacy when used. -The shower room window opened into the rear courtyard facing toward a field and a side road adjacent to the facility. -This area was accessible to both staff and residents. Observation of the A Hall on 5/17/17 between 4:05pm - 4:35pm revealed: -Two of two common hall shower rooms did not have blinds or curtains at the exterior windows to provide residents' privacy when used. -Both shower room windows opened into the rear courtyard facing toward the C Hall. -This area was accessible to both staff and residents. Interview with a resident on 5/17/17 at 5:55pm revealed: -There had not been any curtains on the windows in the C hall bathrooms since she had been at the facility. -She wished the two common hall shower rooms' windows had some type of covering and she	D 083		

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D 083	Continued From page 24 would like to have curtains or blinds to cover the windows on the C hall. -Anyone could look in at you while you're using the bathroom and she didn't like to think about it that happened. -She was unsure if anyone had looked in on her when used the common hall shower rooms. -She had not made "a big deal" about the windows not having any curtains or blinds, but didn't like it. -She just "worked with it like it was" and covered herself up as much as she could when she was in the shower rooms on C hall. -She had not made anyone aware because there weren't any blinds or curtains at the windows in the shower rooms on the C Hall before she had gotten to the facility. -"Staff knew there were no curtains or blinds at the shower room windows before she got there". Interview with second resident on 5/17/17 at 5:54pm revealed: -There were two common hall shower rooms on the C Hall but none had a curtain or blinds on the windows. -She wanted a blind or curtain to be on the windows in the C hall shower rooms. -She didn't know why there wasn't anything ever on the C hall shower rooms' windows, but "it had always been that way." -She hadn't complained to anyone, but could not explain why. -She had a gown and a robe she wore when having to go to the shower rooms on the C hall. -She tried not to "think too much" about the windows not being covered and tried to "hurry up and finish when she used those shower rooms. -She could recall if anyone had ever looked in on her while she used the shower rooms.	D 083		

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D 083	Continued From page 25 Confidential interview with a third resident revealed: -The resident had noticed that there were no curtains or blinds in the common shower rooms. -The resident would have preferred to have something to cover the windows in the shower rooms when bathing. -"If I were home, I would have curtains at my bathroom window". -The resident had not complained about the lack of the blinds or curtains to the Administrator. Interview with a fourth resident on 5/18/17 at 12:05pm revealed: -He did not use the common shower rooms because they did not have any curtains and anybody could see in the shower rooms when you had to shower. -He had not complained about it to the Administrator because the Administrator wasn't going to do anything. Interview with the Administrator on 5/18/17 at 5:05pm revealed: -She was not aware that the blinds or curtains were missing in the common hall shower rooms. -She always thought blinds were supposed to be at those windows in the shower rooms. -Blinds or curtains should have been at the common bathroom windows but she could not explain why blinds or curtains were not there. -No residents had complained about it to her. -The administrator said, "Getting blinds and curtains to those windows is an easy fix". The facility failed to assure curtains, drapes or window coverings were in 5 of 6 common hall shower rooms used by residents for their personal care needs. This failure resulted in residents not being able to utilize the toilet, the	D 083		

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D 083	Continued From page 26 sink, the bathtub, and shower areas in the bathrooms of the facility in private, in comfort, and free from the view of others outside of the facility. This failure of the facility was detrimental to maintaining the dignity, respect, and welfare of the residents and constitutes a Type B Violation. Review of a Plan of Protection dated 6/08/17 revealed: -The facility will provide a blind and/or curtain for all common hall shower rooms windows to provide privacy for the residents on the A Hall, C Hall, and Special Care Unit (SCU). -The facility will continue to protect each residents' right to privacy. -The facility will monitor all rooms on the A Hall, C Hall, and SCU for privacy. -The Administrator, Resident Care Coordinator, and Housekeeping staff will check daily and weekly to ensure that all residents are provided privacy and a safe environment in the facility. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 8, 2017.	D 083	The facility administrator will meet with Kitchen staff to ensure all task are done accordingly. The facility will reimplement the importance of the daily cleaning list to be done or checked off accordingly. The facility administrator will check daily as one often do to ensure everyone is actually completing the task and sign off on it. The facility Resource monitor daily the task as well to ensure all is done accordingly.	7/8/17 7/8/17 7/4/17 7/8/17
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure the food preparation countertop area, two reach-in	D 282		

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	HAL046019	A. BUILDING: _____ B. WING _____	R 05/24/2017

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PINEWOOD MANOR	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

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D 282	Continued From page 27 coolers, and two reach-in freezers were clean and protected from contamination. The findings are: Observation of the food preparation countertop area in the kitchen area on 05/17/17 at 12:35 p.m. revealed: -There were several dried food particles covering the food preparation surface. -The food preparation countertop was very sticky and covered in a dried white substance. Observation of the two reach-in coolers and two reach-in freezers on 5/17/17 at 12:45 p.m. revealed: -There were large, white spider webs hanging in the corners above the doors of reach-in cooler and reach-in freezer. -There was thick dust and sticky grime above the doors of the reach-in coolers and reach-in freezers. -The door handles of the reach-in coolers and reach-in freezers were sticky and covered in dark brown and black grime. -The door handles of the reach-in coolers and reach-in freezers had several dried food particles on them. Interview with a Cook on 05/17/17 at 3:50 p.m. revealed: -She and a dietary aide had worked in the kitchen at the facility the longest and cleaned before they left each day. -There were two new dietary staff who worked days opposite of them. -She was aware of a cleaning schedule for the kitchen posted on the bulletin board. -She did not always remember to initial when she had finished a task.	D 282		

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D 282	Continued From page 28 -The entire kitchen was to be cleaned daily by the dietary staff working that day. -She was not aware of when the last time the area above the reach-in coolers and reach-in freezers had been cleaned or the door handles. -She accidentally had overlooked those areas but would take care of it. Interview with a Dietary Aide on 05/18/17 at 3:45 p.m. revealed: -All of the dietary staff worked together to get all of the cleaning done on a daily basis. -She was aware of the cleaning schedule but did not always initial her completed tasks daily. -She tried to clean the food preparation areas, including the countertop, between meals. -She was not aware there were spider webs and several dirty areas above the reach-in coolers and reach-in freezers and on the handles. Review of the Dietary Cleaning Schedule posted on the kitchen small bulletin board on 05/17/17 revealed: -The sheet was dated for an entire week at a time. -Each day had cleaning tasks listed but were not initialed. -After each task was completed, the dietary staff were to place their initials beside each task completed. -There were no signed entries noted for the months of March 2017, April 2017, or May 2017. Observation of the kitchen preparation countertop area and the two reach-in coolers and two reach-in freezers on 05/22/17 at 11:45 a.m. revealed: -There were several dried food particles covering the food preparation surface. -The food preparation countertop was very sticky	D 282		

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	HAL045016	A. BUILDING: _____ B. WING _____	R 05/24/2017

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D 282	Continued From page 29 and covered in a dried white substance. -There were large, white spider webs hanging in the corners above the doors of reach-in cooler and reach-in freezer. -There was thick dust and sticky grime above the doors of the reach-in coolers and reach-in freezers. -The door handles of the reach-in coolers and reach-in freezers were sticky and covered in dark brown and black grime. -The door handles of the reach-in coolers and reach-in freezers had several dried food particles on them. Interview with the Administrator on 05/23/17 at 4:55 p.m. revealed: -There was a cleaning schedule for the kitchen. -The cleaning schedule was posted in the kitchen on the bulletin board. -All of the dietary staff knew there was a cleaning schedule. -There was no particular person responsible for cleaning the food preparation areas or the reach-in coolers. -She would follow-up with the dietary staff regarding ensuring cleaning occurred as scheduled.	D 282	The facility will provide a dietary class for all kitchen staff to ensure the importance of serving portion size to the Resident.	7/8/17
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by:	D 297	The facility administrator will make sure our proper menus are carried out accordingly. The facility administrator will also check daily with dietary dept to ensure each resident gets what according to their diet.	7/8/17 7/8/17

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D 297	Continued From page 30 Based on observations, interviews, and record review, the facility failed to assure residents were served a minimum of three palatable meals per day. The findings are: Observation of the dinner meal on 05/17/17 at 5:34 p.m. revealed: -Cook A and the Dietary Aide 1 had prepared chicken dumplings, cooked sliced carrots, cabbage, and cornbread. -The chicken dumplings covered nearly half of the plates for most of the residents, none of the residents had been served chicken dumplings. -The cabbage and cooked sliced carrots covered a quarter sized section each on the residents' plates. -All residents who had mechanical soft diets had the food on their entire plate ground and the bread looked like bread crumbs. Confidential interviews with twelve residents revealed: -When Cook A and Dietary Aide 1 were working, there was plenty of food served and seconds of food were given when requested. -If the new Cook B and new Dietary Aide 2 were cooking, there were "very small portions" of food on their plates. -When the new Cook B and the new Dietary Aide 2 were there, no one would get seconds of food when they asked for it. -The food tasted good when Cook A and Dietary Aide 1 worked, but did not taste good and there was not enough when the new Cook B and new Dietary Aide 2 worked. -Some residents purchased snacks from the vending machines or ate their own snacks when the new Cook B and new Dietary Aide 2 had	D 297	The facility will ensure all three palatable meals are served daily and accordingly by menu.	7/8/17

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D 297	Continued From page 31 cooked that day. -If you do not get to the dining rooms first, there would not be enough food left when the new Cook B and new Dietary Aide 2 were cooking. -When the new Cook B and the new Dietary Aide 2 prepared their food, the food tasted "bad, had no taste, and looked overcooked." -Residents only get one piece of meat when the new Cook B and new Dietary Aide 2 were working. When a resident asked for another piece of meat, the residents were told there "wasn't anymore." -Residents had complained about how the food tasted and that there were very small portions of food placed on their plates when the new Cook B and new Dietary Aide 2 were working in the kitchen to them and to the Administrator "too many times to count," but nothing changed. Observation of the lunch meal on 05/18/17 at 11:49 a.m. revealed: -Cook A and Dietary Aide 1 had prepared beef tips in gravy with noodles, cooked broccoli, and wheat roll. -The beef tips in gravy with noodles covered nearly half of the plates for most of the residents, none of the residents had been served beef tips in gravy with noodles. -The cooked broccoli covered a quarter sized section on each residents' plate. -All residents who had mechanical soft diets had the food on their entire plate ground and the wheat roll looked pureed. Interview with Cook A on 05/17/17 at 3:50 p.m. revealed: -She had prepared the residents' meals as listed on the dietician's menu with specified portion sizes but sometimes, she would serve more food than specified.	D 297		

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D 297	Continued From page 32 -She gave all residents seconds of food when they asked for it. -No resident had complained to her about the food when she was off from the facility. Interview with Dietary Aide 1 on 05/18/17 at 3:45 p.m. revealed: -She prepared all meals by following the Dietician's menu with portion sizes. -She wanted the residents to get enough to eat so sometimes, she gave a little more of each portion of food. -She gave the residents seconds of food if they wanted it. -The residents had commented to her that they were glad to see her when she came in to work. -The residents liked her food and complimented her cooking a lot. -No resident had complained to her about the portion sizes or the taste of the food when she was not working. Interview with the new Cook B on 05/22/17 at 5:00 p.m. revealed: -She started working at the facility as a Cook in January 2017. -She was recently hired and worked mainly with the other new Dietary Aide 2 at the facility. -She did not follow the dietician's menu with specified portion sizes. -She followed the weekly menu and facility list of residents without portion sizes when preparing all resident meals. -She knew how much food to serve on each residents' plate because she would go by how it looked to determine if she had served enough of each food item. -She fixed all the food together and served the food items from the pot or container it was prepared in.	D 297		

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D 297	Continued From page 33 -She did not measure the food portions when preparing the meals or when fixing the residents' plates. -She would not give seconds of food when residents asked because she thought she had to serve only one serving of each food item as listed on the weekly menu. -She grinded up all the food for the residents who received mechanical soft diets. -The mechanical soft foods did not look good but neither did the pureed food. -No resident had complained to her about not liking the food or not getting enough to eat. Attempted telephone interviews with the new Dietary Aide 2 were unsuccessful prior to survey exit. Confidential interview with three facility staff revealed: -The residents had complained about the food tasting "bad" especially when the new Cook B and the new Dietary Aide 2 had prepared the food. -Residents complained out loud that there was not enough food on their plates when the new Cook B and new Dietary Aide 2 were there. -The residents got "very small" portions of food on their plates. -When residents asked for seconds of food especially meat, they were told "no or we're out of food." -The residents received "extra-large sized portions of food and even seconds of food" when Cook A and Dietary Aide 1 had worked. -The residents went to the vending machines and into the kitchen looking for extra food when the new Cook B and new Dietary Aide 2 had worked. -The residents ate well and did not complain about their meals when Cook A and Dietary Aide	D 297		

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D 297	Continued From page 34 1 had worked because they got "plenty of food on their plates." Interview with the Administrator and the Resident Care Coordinator (RCC) on 05/18/17 at 5:02 p.m. revealed: -The Administrator was aware the residents complained about the portion sizes and the taste of the food especially when the new Cook B and new Dietary Aide 2 had prepared the meals. -Residents could ask for a sandwich if they did not like the food that was prepared or wanted more food. -The Administrator was aware Cook A and Dietary Aide 1 gave the residents "large portions" of food and would give seconds of food to the residents when they asked as long as those residents were not diabetic. -The Administrator was not aware the residents were purchasing additional snacks because they were still hungry on the days the new Cook B and new Dietary Aide 2 had prepared meals. -The Administrator was not aware the residents did not receive seconds on food when requested especially when the new Cook B and new Dietary Aide 2 worked. -The Administrator addressed the residents' concerns with all four dietary staff. -Some residents would "complain no matter what" but she had talked with the dietary staff about the residents' concerns on a few occasions but was unable to specify when. -The RCC was not aware the residents disliked the food and were not getting enough food when the two new cooks worked. -Cook A and Dietary Aide 1 worked together and the new Cook B and new Dietary Aide 2 worked primarily together but on different days. -The facility did not have a Dietary Manager. -The Administrator would follow-up with all of the	D 297		

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D 297	Continued From page 35 dietary staff to ensure they were following the dietician's menu with specified portion sizes and were giving seconds when requested.	D 297		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to offer 8 ounces of milk at least twice a day to residents. The findings are: Review of Weekly Menu on 05/17/17 revealed each resident should receive 8 ounces of milk twice a day. Observation of the refrigerator on 05/17/17 at 12:55 p.m. revealed there were 10 gallons of milk. Observation of the dinner meal on 05/17/17 at 5:34 p.m. revealed no resident was served or offered milk. (One gallon of milk was brought out to the dining room and placed on the counter	D 299		

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D 299	Continued From page 36 when the dinner meal was nearly completed). Observation of the breakfast meal on 05/18/17 at 8:45 a.m. revealed milk was served to all residents at the breakfast meal. Observation of the lunch meal on 05/18/17 at 11:49 a.m. revealed no residents were served or offered milk. Observation of the dinner meal on 05/22/17 at 5:50 p.m. revealed no milk was served or offered to the residents. Review of the Dietician's Menu on 05/17/17 revealed 8 ounces of 2% milk were to be served to all residents at the breakfast and dinner meals. Interview with Cook A on 05/17/17 at 3:50 p.m. revealed: -She offered milk at least three times a day to all residents. -Some resident's didn't like milk but she offered it anyway. -She gave extra milk and other beverages to those residents who wanted it. -She was not aware of any resident being told "no" when they asked for milk. Interview with Dietary Aide 1 on 05/18/17 at 3:45 p.m. revealed: -She was not aware all residents should be offered and served milk twice a day. -She only served milk at the breakfast meal. -She thought the residents received milk with their evening snack but could not explain why. -She served extra milk during the breakfast meal when residents asked for it. -She served additional water or other beverages when residents requested milk.	D 299		

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D 299	Continued From page 37 Interview with Cook B on 05/22/17 at 5:00 p.m. revealed: -She had been working as a Cook since January 2017 at the facility. -She only served 8 ounces of milk at the breakfast meal to all residents. -No one had told her to serve milk differently and she thought that was okay. -When residents asked for milk, she would offer them more water because she thought milk was for the breakfast meal. -She asked the residents to wait because they would get milk with their breakfast. Confidential interviews with twelve residents revealed: -They wanted milk but only got it at breakfast. -Milk was only offered during the breakfast meal. -Residents have asked for milk and were told they would get some at breakfast the next morning. -No one had asked them if they wanted any milk at the lunch or dinner meals. -When we questioned why we couldn't have milk during the lunch or dinner meals, we were told we could only get milk at breakfast. -"Since I would not get milk when I asked, I stopped asking." -We have been told "no" too many times when we wanted milk "so why keep asking?" Confidential interview with three facility staff revealed: -The residents were only served milk during the breakfast meals. -No resident had been served milk for as long as they could remember at the lunch or dinner meals. -Residents have asked for milk during the dinner	D 299		

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D 299	Continued From page 38 meal but were told to wait until breakfast. -We don't know why the residents didn't receive milk twice a day when there was plenty of milk in the kitchen. -A few residents have been observed asking for milk at the dinner meal and were told "no" by the newer dietary staff. -Some residents were told they could have more water but not milk. -We thought there must have been a physician's order in place that we weren't aware of since milk was only given out at the breakfast meal, so we didn't question it. Interview with the Administrator and the Resident Care Coordinator (RCC) on 05/18/17 at 5:02 p.m. revealed: -All residents should be offered and served milk twice a day in accordance with the Dietician's Menu. -Milk should be served at the breakfast and dinner meals. -They were not aware the residents were not receiving milk twice daily. -Some residents did not like milk but should be offered milk anyway. -They did not know the residents were being told "no" when they asked for milk or were told to wait until breakfast the next morning to get milk. -The Administrator would follow-up with the dietary staff to ensure all residents received milk at least twice daily per the Dietician's Menu.	D 299		
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	D 338		

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D 338	Continued From page 39 and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure every resident's rights were maintained as related to residents not being treated with dignity and respect; free of physical abuse, and free of fear of retaliation. The findings are: 1. Based on reviews and interviews, the facility failed to assure residents were treated with respect and dignity as evidenced by the residents being subjected to disrespectfulness by the way the Administrator, the Resident Care Coordinator, Staff A, Staff C, Staff D, Staff E, and Staff F yelled and/or cursed at the residents [Refer to Tag D 911 G.S. § 131D-21 (1) Declaration of Resident Rights (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled residents was free of physical abuse that resulted in both physical harm and emotional distress to Resident #7 by Staff G [Refer to Tag D 914 G.S. § 131D-21 (4) Declaration of Resident Rights (Type A1 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure residents had the right to voice complaints and be free of retaliation as evidenced by an attempt by staff to have Resident #6 involuntarily committed based on false allegations that Resident #6 exhibited	D 338	The facility will continue to have ongoing inservices as needed to ensure all resident are treated accordingly. The facility administrator/RCC will monitor daily to assure each resident has voiced any Concerns. The facility administrator will continue to have the Complaint Book go around for the resident to voice their Concerns & address them accordingly.	6/23/17 6/23/17 6/23/17

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	HAL046019	A. BUILDING: _____ B. WING _____	R 05/24/2017

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D 338	Continued From page 40 aggressive and combative behaviors and other residents subjected to threats of discharge from the facility by the Administrator and Staff A for expressing their complaints[Refer to Tag D 921 G.S. § 131D-21 (11) Declaration of Resident Rights (Type A1 Violation)].	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the ingestion of medications for 1 of 5 sampled residents (#3) who had a known history of hiding medications in her cheeks and later spitting them out. The findings are: 1. Review of Resident #3's current FL-2 dated 03/16/17 revealed: -Resident #3's diagnoses included vascular dementia, type 2 diabetes, chronic kidney disease - stage 3, malignant hypertension, cerebral vascular accident, coronary artery disease.	D 358	The facility has held a medication training on 6/5/17 on the importance of administering meds properly The facility med Techs were retrained on med administering to ensure all meds are taken accordingly. The facility RCC will check behind the med tech to make sure all meds are taken accordingly. The facility RCC will monitor daily as needed to ensure all meds are Dar accordingly.	7/8/17 7/8/17 7/8/17 7/8/17

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D 358	Continued From page 41 dysphagia, and herpes simplex virus 2. -Resident #3 was intermittently disoriented and wandered. -Resident #3's level of care was for the Special Care Unit (SCU). Review of the Resident Register revealed an admission date of 6/25/2014 for Resident #3. Review of the Resident #3's Care Plan dated 8/24/16 revealed the resident was always disoriented and had significant memory loss. Review of a physician's order for Resident #3 dated 03/16/17 revealed: -An order for Aggrenox 25/200mg twice a day (Aggrenox is a medication used to reduce the risk of stroke in patients with a previous history of stroke). -An order for Bentyl 10mg four times daily with meals and bedtime (Bentyl is a medication used to treat irritable bowel syndrome). -An order for Seroquel - 1 tablet twice daily (Seroquel is used a medication used to treat depressions). -An order for Trazodone 50mg as needed at bedtime once daily for insomnia (Trazodone is a medication used to treat depression). Review of the SCU Quarterly Profile for Resident #3 dated 4/28/17 revealed: -Resident #3 had a history of spitting her medications back out after medication administration. -Staff needed to make sure Resident #3 swallowed her medications and was not tucking medications in her cheeks during medication administration. Observation of a Resident #3's room on the	D 358		

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D 358	Continued From page 42 Special Care Unit (SCU) on 05/17/17 at 10:58am revealed: -Resident was lying in her bed with her eyes closed. -A medicine cup that contained 5 pills on the nightstand next to Resident #3's bed. -There were 1 blue capsule, 2 white oval tablets, 1 white tablet, and 1 tan and red capsule inside the medicine cup on the Resident #3's nightstand. -There was no one else in the room with Resident #3. Interview with Resident #3 on 5/17/17 at 10:59am revealed: -Resident #3 was oriented to person only. -She did not realize there was a medicine cup that contained medications on her nightstand. -She wasn't sure where the medications came from. -Resident #3 reported a family member had brought the medications in the room and left them on her nightstand. -Resident #3 then reported she had dropped her medications on the floor and asked her family member to leave it at her bedside in the medicine cup. -She planned to rinse off the medications in the cup and save it for later in case she ran out of medications. -She believed she had already taken her medications on the morning of 5/17/17. Observation of the SCU on 05/17/17 at 11:04am revealed: -Eleven residents were in the sitting area in the SCU. -One PCA was assisting a resident in the bathroom. -Resident #3 and another resident were in their	D 358		

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D 358	Continued From page 43 rooms with their doors open. -Two residents were wandering the hallway of the SCU. -One resident was standing by the medication cart with the MA at the entrance of the dining room. Observation of Resident #3's room at 11:06am revealed: -The MA promptly removed the medicine cup from the Resident #3's room. -The medications in the medicine cup were identified as 1 Bentyl capsule, 2 Seroquel tablets, 1 Trazodone tablet, and 1 Aggrenox capsule. Interview with the MA in the Special Care Unit on 5/17/17 at 11:07am revealed: -She was the MA who administered medication on the Special Care Unit today. -She was not aware there was a medicine cup with medications on Resident #3's nightstand. -The medications in the medicine cup looked like they were part of Resident #3's night time medications. -Resident #3 had a history of "squirreling" medications in her cheeks and then hiding the medications in her room. -She never gave medications to Resident #3 in her room. -She always had Resident #3 to come out of her room and administered medications to Resident #3 in the hallway next to the medication cart. -The MA had Resident #3 to open her mouth and stick her tongue to ensure Resident #3 had swallowed all of her medications after medication administration. -The SCU did have several residents who were known wanderers in the SCU. -It was possible for wandering patients in the SCU to get access medications if they were left at	D 358		

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D 358	Continued From page 44 the bedside or if Resident #3 hid medications in her room. Interview with the Personal Care Aide (PCA) in the Special Care Unit on 5/17/17 at 11:10am revealed: -She came in at 7:00am on 5/17/17. -She had not seen the medicine cup with the medications on Resident #3's nightstand when she went in the resident's room earlier on 5/17/17. -She was unable to specify what time she had been in Resident #3's room on the morning of 5/17/17. -She did not know how long the medications had been in Resident #3's room. -Resident #3 had a history of hiding her medications in her mouth during medication administration. -She would try to pay better attention to monitor if Resident #3 was trying hide medications in her room. Interview with the Special Care Coordinator (SCC) in the Special Care Unit on 05/17/17 at 11:15am revealed: -She was not aware a medicine cup that contained medication was on Resident #3's nightstand. -She did not know how long the medications had been in the medicine cup in the Resident #3's room. -Resident #3 would hide the medications in her room behind her bed or inside her bed and the MAs were supposed to watch and make sure Resident #3 took her medications because Resident #3 had a habit of holding medications in her cheeks. -All the MAs were supposed to check Resident #3's mouth after medication administration to	D 358		

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D 358	Continued From page 45	D 358		

make sure Resident #3 had swallowed all of her medications.
-She would have to re-educate the all MA staff on medication administration precautions with Resident #3 and she would notify the Administrator of the medications found in Resident #3's room.
-She was concerned that other wandering residents could get to medications that may have been hidden by Resident #3 in her room.
-She would also have staff to check Resident #3's room every day to check for any hidden medications.

Interview with the Administrator on 05/17/17 at 2:55pm revealed:
-The SCC had told her about the medications that were found in Resident #3's room.
-It was expected for the MAs to make sure Resident #3 took her medications and no medications were left in the resident's room.
-She understood "it was possible for other residents in the SCU to wander in to [Resident #3's] room and get to any medications that may have been left in the room".
-She would talk with the SCC and the MAs would be re-educated on assure Resident #3 took all of her medications.

Review of a facility Medication Aide In-Service Report revealed:
-An inservice was held on 05/17/17 with 3 MAs, the Resident Care Coordinator, and the Administrator in attendance.
-The agenda was titled "Medication" but there was no summary of what agenda items were discussed.

Review of an Employee Notification from the facility revealed a mandatory medication

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D 358	Continued From page 46 administration inservice was scheduled for 6/5/17 at 11:00am and all MAs were required to attend. Review of the facility's Medication Administration Policy revealed the MA should always observe the resident after medication administration to ensure the medication dose is completed ingested. Observation of a second MA in the SCU on 05/18/17 at 8:19am revealed: -The MA administered 8 medications to Resident #3 with approximately 120 milliliters of water. -The MA did not attempt to check inside Resident #3's mouth to ensure the resident had ingested all medications. -The MA proceeded with medication administration with a second resident at 8:22am. -Resident #3 walked back down the SCU hallway toward her room. -No attempts were made by the MA to ensure Resident #3 had actually ingested all of the medications during her medication administration. Interview with the second MA in the SCU on 05/18/17 at 8:30am revealed: -She had been nervous and forgot to check Resident #3 to make sure the resident actually took all of her medications. -She would go back and check Resident #3 mouth and she would keep a check in Resident #3's room for any hidden medications on 5/18/17. -She had not been re-trained yet on medication administration with Resident #3 but she knew she needed to check Resident #3's mouth thoroughly to make the resident took her medications. Interview with the SCC on 05/18/17 at 8:40am revealed: -The second MA had not been re-trained in	D 358		

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D 358	Continued From page 47 medication administration. -She planned to re-emphasize all MAs monitor Resident #3's mouth and cheeks during medication administration to ensure Resident #3 actually swallowed all medications. -She would make the Administrator aware of that the second MA did not check Resident #3 to ensure the resident had swallowed her medications during the medication administration. Attempted telephone interviews with the Primary Care Provider (PCP) for Resident #3 were unsuccessful 3 times during the survey process. The facility failed to ensure the ingestion of medications was witnessed by staff during medication administration of 1 of 5 sampled residents (#3) in a Special Care Unit with a known history of hiding medications in her cheeks and later spitting them out. This failure resulted in Resident #3 missing doses of medications used for mood stabilization and stroke prevention. This failure was detrimental to the health, safety and welfare of the resident which constitutes a Type B Violation. Review of the Plan of Protection dated 5/17/17 revealed: -The RCC will have staff meeting for all oncoming MAs to re-education on medication administration. -The Administrator will contact the regional registered nurse to set up an inservice on medication administration. -A daily check by the RCC, SCC, and Administrator will be done to check all rooms, dressers, and any other areas that may be use to hide medications in the SCU. -The MAs will ensure each resident has taken their medication before leaving them.	D 358		

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D 358	Continued From page 48 -The facility will continue to schedule inservice on medication administration as needed. -The SCC/RCC will monitor all medication passes to assure all medications are given correctly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 8, 2017.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to investigate and report known allegations of abuse for 3 residents (#5, #6 and #8) by 2 staff members (Staff A and Staff C) to the Health Care Personnel Registry (HCPR). The findings are: Interview with the Administrator on 5/18/17 at 5:05pm revealed: -She knew that Resident #8 had written a complaint stating that "Staff C needed to back off" in 2/2017. -The Administrator did not talk with Resident #8 about his written complaint. -She was not aware that Staff C had been verbally abusive to Resident #8.	D 438	The facility administrator will immediately report any abuse noted from any residents. 6/23/17 The facility had an inservice on Abuse by our ICAA ombudsman to give current information on resident abuse. 6/23/17 The facility will continue to have an 30 day inservices as needed to assure all resident are free from abuse. 6/23/17 The facility administrator, RCC and other staff members will monitor daily for any type of abuse. 6/23/17	

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D 438	Continued From page 49 -A 24 hour report was not sent to the HCPR and she had not completed a 5 day investigation report regarding Staff C. -She was not aware Staff A had been verbally abusive to Resident #5 and Resident #6. -She would complete a 24 hour report to HCPR for Staff A and Staff C by 5/19/17. -Staff A nor Staff C had never been suspended from employment from the facility and continued to work. Review of HCPR paperwork on 5/22/17 revealed the Administrator had reported Staff C to HCPR on 5/19/17 but did not report Staff A. Interview with the Administrator on 5/24/17 revealed Staff A had been reported to the HCPR on 5/24/17 and she was unable to give a reason why she had not reported Staff A to the HCPR. [Refer to Tag D 921 G.S. § 131D-21 (4) Declaration of Resident Rights (Type A1 Violation)]. The failure of the facility to investigate and report known allegations of abuse to three residents (#5, #6 and #8) by 2 staff members (Staff A and Staff C) to the Health Care Personnel Registry resulted in alleged perpetrators of abuse being allowed to continue to work around residents at the facility, putting Residents #5, #6, #8 and all other residents at substantial risk of abuse, which constitutes a Type A2 Violation. Review of the facility's Plan of Protection dated 5/18/17 revealed: -The Administrator will forward a 24 hour and 5 day working report to the HCPR to investigate the reported resident abuse immediately. -The Administrator will immediately investigate	D 438		

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D 438	Continued From page 50 any report of resident abuse and forward the 24 hour report to the HCPR for investigation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 23, 2017	D 438		
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: TYPE A1 VIOLATION Based on reviews and interviews, the facility failed to assure residents were treated with respect and dignity as evidenced by the residents being subjected to disrespectfulness by the way the Administrator, the Resident Care Coordinator, Staff A, Staff C, Staff D, Staff E, and Staff F yelled and/or cursed at the residents; residents being subjected to unpleasant and offensive odors in the A Hall, the front sitting room, and dining room areas; and the failure of the facility to provide drapes or window coverings for the privacy of the residents in 5 of 6 common hall shower rooms created an unpleasant living environment within the facility. The findings are: Review of a confidential note from a resident revealed: -Staff were "disrespectful to residents as to yelling	D911	The facility will assure the administrator, RCC, staff will continue treating all resident with respect. The facility will have a in service on the respect & dignity toward our residents The facility staff will monitor each other behavior toward the resident to assure each resident is treated with dignity. The facility administration, RCC will monitor daily.	6/23/17 6/23/17 6/23/17 6/23/17

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and saying 'I don't care'.
-Staff wanted residents to go by the facility rules but the staff do not follow the state Bill of Rights rules.
-When resident said something to staff, some staff would change their words to something the resident did not say.

An interview with Resident #6 on 5/17/17 at 4:50pm revealed:
-"They (Staff A and Administrator) want me out of here because I know my rights and they know I will speak up".
-"I see a lot of stuff that staff here are doing wrong to the residents and when I try to say something about it, then they (Staff A and Administrator) tell me it's none of my business and tell me I am going be discharged if I start trouble".

Confidential interview with a resident:
-"I always have problems with Staff A, Staff E, and Staff F".
-"Staff A, Staff E, and Staff F are always yelling at me and make me feel disrespected."
-Staff A, Staff E, and Staff F often told the resident to "shut up" or "get out of my face" when the resident asked for assistance.
-When the resident voiced complaints about the facility, Staff A and Staff F told the resident "I don't care".
-Staff F cursed at the resident a lot.
-The resident had complained to the Administrator about Staff A, Staff E, and Staff F several times but nothing was ever done.
-Staff E argued with the resident a lot and misconstrued the resident's words to the Administrator.
-Staff E told the Administrator that resident said, "All the Administrator wanted was the residents'

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money" and that made the Administrator angry.
-The Administrator told the resident, "You can pack [expletive] stuff and go".

Confidential interview with a second resident:
-"I am tired of staff being sarcastic with me and it makes me feel uncomfortable".
-The resident reported that the Administrator, the RCC, Staff A, and Staff C always talked mean to the residents.
-Staff C cursed at the resident when the resident asked for cigarettes.
-If the resident asked for something or if the resident asked for help, Staff A and Staff C would yell at the resident and "say why you keep asking for the same thing over and over".
-If the resident complained about being talked mean to the Administrator or the RCC then the staff would say, "Well, you asked for it".
-"If you catch the Administrator in a mood she will yell and curse at you too" but the resident did not specify how often that happened.
-The RCC said to the resident, "Your family doesn't want you and the only reason you are here is because of the Administrator".
-That statement made the resident "feel bad" and the resident did not believe staff should to talk to the resident that way.

Confidential interview with a third resident revealed:
-"I like to have peace of mind and peace in my spirit".
-"I don't like it here because I can't get any peace here".
-'I am not happy here".
-"Staff is always fussing and upset with the residents here".
-The resident witnessed Staff D cursing at residents at the facility.

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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
D911	Continued From page 53 -"I just try to stay out of crazy stuff here'. Confidential interview with a staff member revealed: -The staff member knew that staff did not treat the residents right at the facility. -Staff yelled at residents a lot. -The staff member witnessed Staff D cursing at residents. -The staff member did not report anything to the Administrator because the staff member was afraid of losing their job. -Staff who had previously complained about the mistreatment of residents or the conditions of the facility were soon terminated by the Administrator. Confidential interview with a second staff member revealed: -Residents did complain a lot about staff who worked on second shift. -Residents complained that second shift did not treat them right. -The staff member had heard several staff curse at residents. -The staff member did not specify who the staff were who cursed at the residents when asked by the survey team. -The staff member had witnessed Staff A jump at a resident when Staff A got angry with the resident. -That resident was no longer in the facility. -The staff member did not report any of the cursing or when Staff A jumped at the resident. -The staff member reported, "You already know it's kind of hard to complain about a staff member who is the Administrator's family member". -The staff member reported that staff who complained about residents being treated badly to the Administrator were soon terminated by the Administrator.	D911		

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D911	Continued From page 54 Review of the resident complaint book revealed Resident #8 wrote "Staff C needed to back off" in 2/2017. Interview with the Administrator on 5/18/17 at 5:05pm revealed: -She knew about the complaint in the resident complaint book but she never investigated what it meant. -She had spoken with Staff C and Staff C reported that Resident #8 made an inappropriate gesture with his tongue at Staff C. -She told Staff C to stay away from Resident #8. -She believed that was why Resident #8 put that complaint in the resident complaint book. Interview with the Administrator on 5/18/17 at 6:40pm revealed: -She was not aware of any verbal abuse of the residents by the staff. -"I am quite sure the residents had a lot to say about the staff because they can't get their way". -She did not recall any residents making any complaints about being verbally abused by residents. -She had never been verbally abusive to any residents. Interview with Resident #8 on 5/22/17 at 1:15pm revealed: -He confirmed he wrote the complaint in the resident complaint book in 2/2017. -He wrote the complaint because Staff C kept hollering at him and he was tired of it. -The Administrator never talked to him about his complaint. -He tried to talk with the Administrator about Staff C but nothing was ever done. -"Staff C kept hollering at me and the RCC does	D911		

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D911	Continued From page 55 too". -Staff C and the RCC cursed and said such things as, 'you're stupid', 'you're a stupid bastard', and 'you ain't got nothing in your head' to the residents. -The Administrator had told another resident "you need find yourself some [expletive] where else to go, pack your stuff". -He saw when the same resident got into an argument with Staff A and Staff A told the same resident "to pack her [expletive] stuff and get out. -He knew it wasn't right for the staff to talk to the residents like that but it never did any good if the residents tried to complain to the Administrator. Review of a handwritten notes given to the survey team by the Administrator on 5/22/17 revealed the RCC, Staff C, Staff E, and Staff F all denied being verbally abusive to any residents at the facility. Two attempted telephone interviews were unsuccessfully with Staff A on 5/22/17 and 5/23/17. Interview with the Executive Officer on 5/24/17 at 10:45am revealed: -He was not aware of the residents' allegation of verbal abuse or staff being disrespectful to the residents. -He planned to make changes in the facility as of 5/24/17. -He was there to protect the residents at the facility. -He would be submitting a report to the Health Care Personnel Registry (HCPR) on 5/24/17 regarding the allegations against the Administrator and Staff A. 2. Based on observations and interviews, the	D911		

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D911	Continued From page 56 facility failed to assure that 1 of 3 halls (the A Hall) was free of unpleasant and offensive odors that spread through the entire A Hall, the front sitting room, and dining room areas [Refer to Tag D 075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings (Type B Violation)]. 3. Based on observations and interviews, the facility failed to assure curtains, drapes or window coverings were in 5 of 6 common hall shower rooms, to provide for the privacy of the residents, when used for their personal care needs [Refer to Tag D 083, 10A NCAC 13F .0306(a)(9) Housekeeping and Furnishings (Type B Violation)]. The facility failed to assure residents were treated with respect and dignity as evidenced by the way the Administrator and 5 other staff yelled and/or cursed at the residents. The failure resulted in residents suffering feelings of powerlessness and the creation of an unpleasant living environment. This failure constitutes a Type A1 Violation. Review of a Plan of Protection dated 5/18/17 revealed: -The Administrator will review residents' rights regarding physical, verbal, and mental abuse with all staff immediately. -The Resident Care Coordinator, Special Care Coordinator, and Administrator will assure all residents' right are reviewed daily and meet accordingly to the Residents' Bill of Rights -The facility will schedule an inservice on physical, verbal, and mental abuse for all staff. -The Resident Care Coordinator, Special Care Coordinator, and Administrator will be responsible to report any allegation of abuse to the Health Care Personnel Registry within 24 hours. -The facility will have ongoing in-services as	D911		

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D911	Continued From page 57 needed by the regional nurse and ombudsman. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 23, 2017.	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 medication administration and health care personnel registry reporting. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure the ingestion of medications for 1 of 5 sampled residents (#3) who had a known history of hiding medications in her cheeks during medication administration and later spitting them out. Based on observations, record reviews, and interviews, the facility failed to ensure the ingestion of medications for 1 of 5 sampled residents (#3) who had a known history of hiding medications in her cheeks during medication administration and	D912	The facility had an in service on Residents Right's rule addressing, to assure all residents Rights are in compliance. 6/23/17 The facility will continue to have on going classes regarding the resident to ensure all staff are following rules as required. 6/23/17 The facility administrator Rec. Staff will monitor daily all activity's report found the resident to ensure all resident rights are in compliances. 6/23/17	

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D912	Continued From page 58 later spitting them out. [Refer to Tag 358, 10A NCAC 13F Medication Administration .1004(a)(2) (Type B Violation)].	D912		
	2. Based on record reviews and interviews, the facility failed to investigate and report known allegations of abuse for 3 residents (#5, #6 and #8) by 2 staff members (Staff A and Staff C) to the Health Care Personnel Registry (HCPR) [Refer to Tag 438 10A NCAC 13F Health Care Personnel Registry .1025 (Type A2 Violation)].		The facility will schedule an inservice on mental & physical abuse to train staff to do in compliance with Resident rights	6/23/17
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A1 VIOLATION: Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled residents was free of physical abuse that resulted in both physical harm and emotional distress to Resident #7 by Staff G. The findings are: Confidential interview with a resident revealed: -The resident saw Staff G "push" Resident #7 down on the smoking porch floor. -Resident #7 hadn't started anything, but was upset about a soda. -Resident #7 shouldn't have been "pushed down" like that, he didn't bother anyone. -The "fight" occurred around late April 2017 or early May 2017.	D914	The facility will continue to have ongoing inservices as needed for the benefit of the residents. The facility administrator RSC & other staff members will monitor daily.	6/23/17 6/23/17

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D914	Continued From page 59 -Staff G assisted Resident #7 outside to the smoking porch area and pushed Resident #7 down to the porch floor "hard." -Resident #7 yelled, but the resident wasn't sure what Resident #7 had said. -Staff came outside after Staff G pushed Resident #7. -The resident couldn't remember which staff had come outside. -Resident #7 had a bruise on "his rib cage, stomach area." -The resident had not told anyone about what had happened because the resident "didn't want any trouble." -Staff G was known as "the enforcer" because he made sure things were taken care of at the facility when any of the residents had behaviors. -Staff G was called on by other facility staff when residents got upset to assist. Confidential interview with a second resident revealed: -The resident saw Staff G "hit" Resident #7 and "push" him down to the cement on the smoking porch of the facility. -Resident #7 hadn't done anything to Staff G that the resident saw. -The incident occurred in early May 2017 but the resident could not remember the exact date. -Resident #7 was upset because he wanted a soda. -No other staff were on the porch when the incident occurred. -The resident could not remember what other residents were on the porch that day. Interview with Resident #7 on 5/22/17 at 3:20 pm revealed: -Staff G had pushed him down on the front porch of the smoking area.	D914		

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D914	Continued From page 60 -They use to be friends but aren't anymore. -He didn't know why Staff G had pushed him down, but he was upset that day because he wanted a soda. -This incident happened late April 2017. -The facility staff wouldn't let him have a soda. -Staff G pushed him down after he had gone out to the smoking porch and then hit him. -Resident #7 pushed and hit Staff G back because Staff G had push and then hit him first. -Resident #7 told Staff B and the Resident Care Coordinator (RCC) about the incident. -Resident #7 had a bruise on his side, but couldn't remember which side. -He wished that Staff G and him were friends again, but hadn't been since that incident. Confidential interview with a third resident revealed: -Resident #7 was upset about not getting a soda. -Resident #7 went outside to the smoking porch. -Staff G was outside by the door on the smoking porch. -Staff G pushed Resident #7 down to the floor and put his arm across his chest. -Resident #7 hadn't started anything, but was only upset and fussing about wanting a soda. -The resident was not sure who yelled out but staff did come outside. -Staff B, Staff C, and the RCC came outside to the front porch. -The resident was not sure what else happened after that. Telephone interview with Staff G on 5/22/17 at 4:44 pm revealed: -He was not aware of any resident being physically abused. -He had not abused any resident. -He knew that "if he had put his hands on any	D914		

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D914	Continued From page 61	D914		

resident, he would be fired and put out of the facility."

Review of a progress note on 5/22/17 at 5:00pm for Resident #7 dated 5/4/2017 revealed:
-The progress note was written by the RCC.
-Resident #7 became very agitated because he wanted a soda.
-Resident #7 was informed by the staff that the Administrator was not there to give him a soda.
-Resident #7 began yelling and threatening staff (no specification on what the threats were).
-The Administrator came in the building and tried to talk with the resident.
-Resident #7 tried to hit the Administrator.
-Resident #7 did hit the Staff G twice (no specification on where Staff G was hit).
-Resident #7 continue to threaten staff (no specification on what the threats were).
-Resident #7 apologized after he had calmed down and cooled off outside.
-No time was documented in the progress note for the incident.

Second telephone interview with Staff G on 5/22/17 at 5:15pm revealed:
-He was not aware of any resident having hit staff or being aggressive towards facility staff.
-No resident had been yelling at or threatening any facility staff to his knowledge.
-He remembered that Resident #7 had "charged at him" and "he had pushed him away."
-Resident #7 continued to charge at him after he had pushed Resident #7 away.
-The incident happened sometime in May 2017.
-"I had put my elbow, no my forearm, across Resident #7's chest, to stop him."
-He had yelled for facility staff to come out there and get Resident #7.
-Staff B, Staff C, and the RCC came outside to

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D914	Continued From page 62 the smoking porch on the front side of the facility. -Resident #7 calmed down and Staff G bought Resident #7 a soda. -Resident #7 had initially charged at Resident #6, but then charged at him. -He didn't write an incident report because "he doesn't write incident reports." -Resident #7 was upset because he wanted a soda and his brother hadn't brought him any yet. -He had no idea why Resident #7 continued to charge at him. -He was on the smoking porch leaning against the entrance door prior to Resident #7 coming outside and charging at him. -Other residents were outside too, but he couldn't remember who or how many. -Resident #7 had grabbed his arm and scratched him, but he did not complete an incident report. -The whole situation "wasn't nothing really at all." -Resident #7 drank the soda he had bought and he remained calm. Interview with the Administrator on 5/22/17 at 5:27 pm revealed: -She was not aware of any incident or altercation between facility staff or any resident. -After being shown the Progress Note in Resident #7's record regarding the 5/04/17 incident, the Administrator said "RCC had left for today and "we'd have to ask her about that." -"Resident #7 had charged at Staff G, but she didn't know because she wasn't outside and didn't observe it, but she knew Staff G hadn't come at Resident #7 first." -Resident #7 got upset when he wanted a soda and could not get one when he wanted it. -She was at the facility the day of the incident but only heard the residents yelling and talking loudly outside. -She was not sure which residents were outside	D914		

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D914	Continued From page 63 or how many. -The incident occurred around early May 2017, but she was unsure of a specific date. -Resident #7 had not been aggressive toward her nor had tried to hit her. -She wasn't not sure what all had happened that day and informed the survey team to ask Staff G and the RCC what had happened. -Staff G remained employed at the facility following the incident with Resident #7. Interview with Resident Care Coordinator (RCC) on 5/23/17 at 10:10 am revealed: -She was at the facility when the incident occurred between Staff G and Resident #7 on 5/04/17. -She did not witness the incident but was told by Staff G what had happened. -The incident happened before lunch that day. -Resident #7 became upset while in the facility because he wanted a soda. -Sodas for Resident #7 were locked up in the Administrator's office but she was not there at that time to get a soda for Resident #7. -Resident #7 tried to hit Staff B first before going outside to the smoking area. -She was not sure when exactly Staff G went outside, but said 2 or 3 residents yelled out that Staff G was being hit by Resident #7. -It was Resident #7's history to be aggressive toward staff but that had occurred at a previous facility. -There were no documented behaviors for Resident #7 at the current facility. -Staff B and herself went outside to see what was going on and talked with Resident #7. -She did not observe the incident but said Staff G was not hurt. -She asked Staff G to complete an incident report.	D914		

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D914	Continued From page 64 -It was common practice for facility staff to move out of the way when any resident was aggressive. -She believed Staff G had moved out of Resident #7's way when he went outside. -Staff G helped handle some of the residents who were of a larger size. -Staff G brought Resident #7 a soda after the incident and Resident #7 was calm. Review of Resident #7's Register revealed the resident was admitted to the facility on 2/10/2017. Review of Resident #7's FL-2 dated 2/20/17 revealed: -Diagnoses of schizoaffective disorder, mild intellectual disability, diabetes, and hypertension. -Resident #7 had a history of being verbally abusive and a history of being injurious to others. -Resident #7 took Haldol 10mg twice a day and Zoloft 100mg once a day (Haldol is used to treat schizophrenia and Zoloft is used to treat depression. Review of Resident #7's record revealed there was no documentation that the resident had been abusive or aggressive toward staff or residents from February 10, 2017 through May 3, 2017. Review of handwritten note written by Staff G dated 5/23/17 revealed: -On 5/4/17 Resident #7 charged and grabbed Staff G twice. -Staff G shoved Resident #7 twice off of him with his forearm and called for assistance. -Resident #7 then turned and walked toward the bench in the front courtyard and sat down. -Staff G was not injured during the altercation. -There was no documentation of any other staff members being present during the altercation or who witnessed the altercation.	D914		

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D914	Continued From page 65 Review of handwritten note written by the Administrator dated 5/23/17 revealed: -The Administrator wrote "Resident #7 was very agitated that morning "walking back and forward fussing cussing about a soda". -Resident #7 went from the hallway to the outside yelling, cussing what he was going to do. -The Administrator wrote, "Staff G was charged". -The Administrator wrote, "Resident #7 came to him". -Staff G didn't allow Resident #7 to hit him during the charge. -Staff G used his forearm to push Resident #7 away. -Resident #7 walked away and later Resident #7 came and apologized. -Resident #7 stated, "He didn't mean any harm." Telephone interview with Resident #7's primary care provider's nurse revealed on 5/23/17 at 11:50am. -Resident #7 did have a history of being verbally abusive and injurious to others. -There was no reports from the facility that Resident #7 had been verbally abusive or injurious to others since he was admitted to the facility. -She was not aware of the incident on 5/4/17 and their office had received no notification from the facility. The facility failed to assure 1 of 6 residents sampled was free from physical abuse that resulted in Resident #7, with a diagnosis of mild intellectual disability, being physically harmed by Staff G. Resident #7 suffered continued emotional distress when the incident was not investigated by the Administrator and Staff G was allowed to continue working at the facility. This	D914		

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D914	Continued From page 66 failure of the facility to protect the resident's rights to be free from physical abuse resulted in serious neglect and constitutes a Type A1 Violation. Review of a Plan of Protection dated 5/23/17 revealed: -The Administrator will review residents' rights regarding physical abuse with all staff immediately. -The Resident Care Coordinator, Special Care Coordinator, and Administrator will assure all residents' right are reviewed daily and meet accordingly to the Residents' Bill of Rights -The facility will schedule an in-service on physical abuse for all staff. -The Resident Care Coordinator, Special Care Coordinator, and Administrator will be responsible to report any allegation of physical abuse to the Health Care Personnel Registry within 24 hours. -The facility will have ongoing in-services as needed by the regional nurse and ombudsman. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 23, 2017.	D914	The facility will exercise in accordance with rules to allow each resident as they do speak accordingly.	6/23/17
D921	G.S. 131D-21(11) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 11. To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.	D921	The facility administrator has an open door policy, where all residents are at liberty to come as they do daily to voice any concern & problems.	6/23/17
	This Rule is not met as evidenced by: TYPE A1 VIOLATION			

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D921	Continued From page 67 Based on observations, interviews and record reviews, the facility failed to assure residents had the right to voice complaints and be free of retaliation as evidenced by an attempt by staff to have Resident #6 involuntarily committed based on false allegations that Resident #6 exhibited aggressive and combative behaviors and other residents subjected to threats of discharge from the facility by the Administrator and Staff A for expressing their complaints. The findings are: Review of Resident #6's FL-2 dated 7/19/16 revealed: -Diagnoses included a single episode of major depression, sequela of spinal cord injury, cocaine abuse, and marijuana abuse. -Not applicable was documented for sections regarding Resident #6 being disoriented, verbally abusive, injurious to self, or injurious to others. Review of Resident #6's Care Plan dated 8/10/16 revealed: -Resident #6 did not have a history of being verbally abusive, physically abusive, exhibiting disruptive or inappropriate behaviors. -Resident #6 was not injurious to self, others, or property. -Resident #6 have a diagnoses of a single episode of major depression, sequela of spinal cord injury, cocaine abuse, and marijuana abuse. -Resident #6 was receiving mental health services. -He was oriented and his memory was adequate. Review of Resident Register for Resident #6 revealed an admission date of 7/27/16. An interview with Resident #6 on 5/17/17 at	D921	The facility staff members will be more attentive to Residents suggestions around without them in fear of any retaliation. 6/23/17 The facility staff nurses will monitor their actions daily to ensure each resident is treated accordingly. 6/23/17	

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D921	Continued From page 68 4:50pm revealed: -"They (Staff A and Administrator) want me out of here because I know my rights and they know I will speak up". -"I see a lot of stuff that staff here are doing wrong to the residents and when I try to say something about it, then they (Staff A and Administrator) tell me it's none of my business and tell me I am going be discharged if I start trouble". -He did not get along with Staff A and Staff A had threatened several times to have her family member (the Administrator) to discharge him when he complained about Staff A. -The Administrator had threatened him several times to give him a 30 day notice of discharge when he complained about Staff A or voiced any complaints about the facility. -He was unable to give specific dates or the number of times he had been threatened to be discharged from the facility by the Administrator or Staff A. -The residents at the facility were afraid to complain about conditions at the facility or complain about Staff A to the Administrator. -The Administrator had threatened other residents with discharge from the facility if residents' complaints were going to cause her problems at the facility. -"Most of the residents won't complain about Staff A to the Administrator either because they have been threatened to be discharged from the facility by the Administrator". -Resident #6 felt that "the Administrator retaliates against residents that try to speak up for themselves". Interview with the Administrator on 05/18/17 at 8:40 a.m. revealed: -"The bottom fell out last night" regarding a	D921		

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D921	Continued From page 69 resident who became very agitated and was out of control but she refused to disclose which residents were involved. -She "wasn't going to have to deal with any of this much longer and she have taken care of one resident and she was working on taking care of the other resident" when she referred to the agitated resident(s) Interview with Resident #6 on 5/18/17 at 12:05pm revealed: -Resident #6 reported that the Administrator had him taken out of the facility by the police on 5/17/17 because he threatened to call the state and complain about what was going on in the facility. -"I am tired of it and somebody needs to know what is really going on in here". -He had gotten into an argument with Staff A on the afternoon of 5/17/17 because he witnessed another resident fall two times in the dining room while Staff A was on the phone in the front office. -He had to go and find help for the resident who fell because no staff was available and it upset him. -He found Staff A and told her about the resident who had fallen in the dining room. -Staff A told him, "That's none of your business in an angry tone". -Resident #6 reported he was also upset because another staff member had a child at the facility during work hours on the afternoon of 5/17/17. -It was really upsetting because staff were not taking care of the residents as they should be. -"How can you take care of residents here if you are on the phone or watching your child, that's just not right." -He and Staff A argued off and on during the evening of 5/17/17 while he was sitting in the front sitting room of the facility.	D921		

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D921	Continued From page 70 -He told the staff on the evening of 5/17/17 that he was going to report the facility to the state because "they weren't doing nothing to take care of the residents" at the facility. -Staff A told him, "You ain't have a [expletive] thing to do with it" and called Resident #6 "a crack head". -Staff A told him that she was going to call her family (the Administrator) and the police to get him out of the facility. -"The Administrator came to the facility and she was upset because he was arguing with Staff A (the Administrator's family member). -Resident #6 was not sure what time the Administrator returned to the facility on the evening of 5/17/17. -The Administrator and Staff A were both in Resident #6's face yelling at the resident. -The Administrator told Resident #6, "You are always in somebody's [expletive] business". -The Administrator told him, "Go get your stuff before I go and throw it out". -The Administrator repeatedly threatened to throw Resident #6 out of the facility because the police had been called. -The Administrator gave clear trash bags to Staff H to pack up Resident #6's belongings. -Two police officers arrived at the facility around 10:00pm on 5/17/17. -"Staff A went off and told the police Resident #6 had a bad record and Resident #6 was a crack head". -The police asked Resident #6 why he was upset and he told them what had happened earlier. -Resident #6 was not arrested, handcuffed or escorted out the facility at that time. -The police told him to go his room and he went to his room per the policeman's request. -The police left the facility but returned to the facility a second time around 2:00am.	D921		

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D921	Continued From page 71 -He was not exactly sure about the time but he was in his bed asleep. -Three policemen woke him up and told Resident #6 that he had to go with them to the hospital to be checked out. -He did not know about the involuntary commitment papers served on him until after he went to the hospital for a mental health evaluation. Confidential interview with a resident revealed: -The resident saw Staff A and Resident #6 arguing in the front sitting room on the evening of 5/17/17 around 8:00pm or 8:30pm. -Staff A called and told the Administrator that "Resident #6 was at it again and bothering Staff A" so the Administrator came to the facility. -The resident was not sure what time the Administrator arrived. -The resident saw Staff A and the Administrator "fussing" with Resident #6. -The resident saw the police come up but was not sure what time the police arrived. -The resident left for their own room once the police arrived and did not know what happened after that. -The resident did not observe Resident #6 being aggressive or combative with staff or other residents. Review of Resident #6's Record on 5/18/17 at 12:40pm revealed: -There was no documentation of any incidents on 5/17/17. -The last entry in the progress notes was dated 4/21/17. -There was no documentation of Resident #6 being combative or aggressive since his admission on 7/27/16.	D921		

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D921	Continued From page 72 Interview with the Administrator on 5/18/17 at 5:05pm revealed: -Staff A had called her on 5/17/17 around 9:00pm and reported that Resident #6 and Resident #5 were being disruptive at the facility. -Staff A reported that Resident #6 insinuated that he was going to call social services because a staff member had a child at the facility earlier on the afternoon of 5/17/17. -The child had already been picked up about 4:00pm on 5/17/17 so the Administrator did not understand why Resident #6 was concerned about that. -Resident #6 accused the staff of not doing their jobs and was fussing with staff as he followed the staff around the A and C Halls. -The Administrator told Staff A to try to resolve the situation. -Resident #6 always had issues with the 3-11 staff and was argumentative. -Staff A called the police because Resident #6 was fussing with the staff and coming up to the staff in his wheelchair. -The staff on the 3-11 shift were tired of Resident #6 because the resident thought "he was running stuff in the facility". -The police advised the Administrator to get Resident #6 out of the building. -The Administrator was unable to specify which police officer advised to get Resident #6 out of the building. -"The police officers said it was out of their hands" and left the facility a little before 11:00pm. -Resident #6 was still not calm when the police left the facility. -The Administrator did call 2 family members of Resident #6 to see if they could come and get the resident. -Neither of family members of Resident #6 would agree to come get the resident.	D921		

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D921	Continued From page 73 -"Resident #6 was just fussing with the 3-11 staff and was acting like he was running things here". -"He (Resident #6) had to go so I had involuntary commitment papers taken out for him because I did not know what else to do". -"Resident #6's behavior on 5/17/17 was disruptive" but she was unable to specify any disruptive behaviors other than Resident #6 was arguing with staff. -"He (Resident #6) needed to get out of here with all that mouth". -The Administrator denied three times that Resident #6 was combative or aggressive to staff or residents on the afternoon or evening of 5/17/17. Review of an Affidavit and Petition for Involuntary Commitment for Resident #6 dated 05/17/17 revealed: -Staff H swore that Resident #6 was mentally ill and dangerous to self and others. -Staff H swore that Resident #6 was combative to staff and other residents. -Resident #6 was hearing voices and was talking to himself. -Resident #6 had a history of depression and was taking his meds. -Resident #6 had poor insight and his judgment in his actions with other residents was he was aggressive with his talking with other residents and attempted to harm them with his cane or his wheelchair showed danger to himself and others. Review of an Examination and Recommendation to Determine the Necessity for Involuntary Commitment for Resident #6 dated 05/17/17 revealed: -In the emergency room, Resident #6 was calm and cooperative. -Resident #6 was oriented to person, place and	D921		

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D921	Continued From page 74	D921		

situation.
-Resident #6 did not verbalize any thoughts of delusions.
-Resident #6 was not held for involuntary commitment after evaluation in the emergency room.

Interview with Staff H on 5/18/17 at 6:15pm revealed:
-She worked on the A Hall on the 3-11 shift on 5/17/17.
-She had been off the two nights prior to 5/17/17.
-Resident #6 was sitting in the front sitting room near the business office most of the afternoon on 5/17/17 and he was fussing with the 3-11 staff.
-Resident #6 was mainly fussing with Staff A because he was upset that a resident had fallen in the dining room while Staff A was doing something else.
-She did not know what Staff A was doing when the other resident fell but the resident's fall was handled appropriately by the staff.
-The resident that had fallen didn't get hurt.
-Resident #6 was saying disrespectful things about an employee's child who was briefly at the facility on the afternoon of 5/17/17.
-"The child had been gone but he (Resident #6) was still talking about the child around 8:00pm".
-"He (Resident #6) shouldn't have been talking about her kid like that because it was none of his business".
-She could not specify what Resident #6 said that was disrespectful.
-She could hear Resident #6 fussing under his breath but he was not loud.
-Resident #6 "was still talking junk" when she returned from her lunch break around 9:00pm.
-Resident #6 and Staff A kept arguing off and on as he was sitting in the front sitting room
-Resident #6 stated, "I am going to call the state

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D921	Continued From page 75 because ya'll aint doing nothing. The state told me to keep a diary and ya'll are going to have to go back to work at McDonald's". -Resident #6 told Staff A that he was going to call the state on the facility because something needed to be done about how staff was treating the residents. -Resident #6 was going to report to the state about the child being at the facility and how he had to get help for the resident who fell. -"I just tried to stay out of it because he (Resident #6) wasn't fussing with me". -Staff A got fed up and she called her family (the Administrator). -The Administrator came to the facility around 10:00pm and the arguing continued between Staff A and Resident #6. -The police were called but she was not sure who called the police. -The police came but there was nothing the police could do because Resident #6 had only fussed with Staff A. -Resident #6 was calm when the police left and the resident had gone to bed. -"Look, I am going to tell you the truth that Resident #6 had not threatened any staff or residents on the evening of 5/17/17". -The Administrator was angry and wanted Resident #6 out of the facility. -She was instructed by the Administrator to go to the magistrate's office and complete a petition for Resident #6 to be involuntarily committed. -She told the magistrate that Resident #6 was combative and aggressive but Resident #6 had not been combative or aggressive on the evening of 5/17/17. -She did the petition because she feared she would lose her job if she did not do what the Administrator wanted. -She had documented in Resident #6's record	D921		

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D921	Continued From page 76 about 30 minutes before the 5/17/17 entry as she was instructed by the Administrator and signed a blank incident report form for Resident #6. Review of a Progress Note dated 05/17/17 on 5/18/17 at 5:30pm for Resident #6 revealed: -Staff H documented Resident #6 was watching staff and constantly telling them what they should be doing. -Resident #6 was talking inappropriately and indirectly acting with authority. -Resident #6 continued his harassment all during the night -He picked with other residents and made them feel threatened. -Resident #6 continued these actions all day and night. -Resident #6 had been acting out for the last 3 days. -Staff tried to calm the problem but Resident #6 was unwilling to listen and cops were called. Review of Facility Staffing Records revealed Staff H worked on the 3-11 shift on 5/17/17 but did not work on 5/15/17 or 5/16/17. Interview with the Administrator on 5/18/17 at 6:40pm revealed: -She had Resident #6 sent out for involuntary commitment evaluation because he would not calm down. -Resident #6 was not sent out for involuntary commitment because he made complaints about the facility to state or county. -She was not aware that residents feared retaliations from her and Staff A if they voiced complaints. -She had never threatened any residents with a 30 day notice discharge if they complained.	D921		

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D921	Continued From page 77 Telephone Interview with Police Officer on 5/22/17 at 12:00pm revealed: -He was one of the officers who came to the facility on 5/17/17 and 5/18/17. -The police were called to the facility for a report of a resident being combative and aggressive with staff and other residents. -Resident #6 wasn't displaying any type of aggressive or combative behaviors toward staff when the police were called out to the facility on their two visits. -Resident #6 was sitting in the front sitting area and came up to the policemen as they entered the facility. -"He (Resident #6) just wanted to tell his side of the story". -Resident #6 told police officers that he was upset that another resident had fallen at the facility and staff was not available to help the resident. -The police officer did not feel threatened by Resident #6 at any time. -"The staff appeared upset and looked like they wanted to leave". -Administrator stated "I am tired of him (Resident #6) causing trouble here. I know what to do; I am going to have him (Resident #6) committed". -He did not recall any other comments from other staff. -He did not observe any staff using any foul language while he was there. -He asked the Resident #6 to go to his room and the resident complied. -The police left the facility because there was nothing they could do. -Resident #6 was calm when the police left the facility on the first visit. -The police returned to the facility a second time around 2:00am on 5/18/17 because they had an involuntary commitment order for Resident #6. -Resident #6 was in his bed asleep and the police	D921		

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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
D921	Continued From page 78 officers had to wake Resident #6 for transport to the emergency room because of the involuntary commitment order. -Resident #6 asked, "What did I do wrong; why do I have to go out to the hospital?" -He told Resident #6 that "he needed to go out with the officers to the hospital to be checked out". -Resident #6 went calmly with the police officers and he did not resist leaving the facility with the police officers. -Resident #6 repeatedly kept asking the police officers, "what did I do wrong?". -The involuntary commitment order stated that Resident #6 was aggressive and combative with staff and other residents but the police officer said, "I did not observe any of those behaviors by Resident #6 on either visit". -The police officer said, "the statements on the involuntary commitment orders about Resident #6 being aggressive and combative did not coincide with the behaviors he observed for Resident #6". Interview with the Primary Care Provider (PCP) for Resident #6 on 5/24/17 at 9:36am revealed: -There was no documentation of Resident #6 being aggressive or combative in his previous medical history. -There was no documentation of Resident #6 being aggressive or combative since he was admitted at the facility. -The PCP had not been contacted by any staff from the facility about Resident #6 being aggressive or combative. -The PCP had not been contacted by any staff from the facility about the petition for involuntary commitment for Resident #6 being aggressive or combative on 5/17/17. Interview with the Mental Health Provider for	D921		

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	HAL046019	A. BUILDING: _____ B. WING _____	R 05/24/2017

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D921	Continued From page 79 Resident #6 on 5/24/17 at 9:36am revealed: -There was no documentation of Resident #6 being aggressive or combative in his previous medical history. -There was no documentation of Resident #6 being aggressive or combative since he was admitted at the facility. -The Mental Health Provider had not been contacted by any staff from the facility about Resident #6 being aggressive or combative. -The Mental Health Provider had not been contacted by any staff from the facility about the petition for involuntary commitment for Resident #6 being aggressive or combative on 5/17/17. -Resident #6 was last seen in his office on 4/21/17 for depression and his next appointment was scheduled in August 2017. Observation of two residents who appeared apprehensive and declined to speak with the survey team on 5/22/17. Two attempted telephone interviews were unsuccessfully with Staff A on 5/22/17 and 5/23/17. Two attempted telephone interviews were unsuccessfully with family members on 5/24/17. Confidential interview with a staff member revealed: -The staff member had heard the Administrator threaten several times to discharge residents from the facility if residents voiced complaints. -She could not specify the number of residents or specific dates or times. -The Administrator and Staff A did not like Resident #6 because he would try to get help for other residents and he complained a lot. -Staff tried to avoid any conflicts with Staff A and	D921		

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D921	Continued From page 80 not complain about things going on at the facility because they wanted to remain employed at the facility. Confidential interview with the same resident revealed the resident overheard the Administrator tell staff members not to talk with the survey team and to let the Administrator know what residents spoke with the survey team. Confidential interview with a second resident revealed: -The resident had been threatened to be discharged from the facility by the Administrator when the resident complained that there were not enough condiments served with meals. -The resident was not able to give a specific time frame when this occurred. -The resident reported feeling powerless in making any complaints at the facility. An interview with a third resident on 5/18/17 at 10:05am revealed: -She was admitted to the facility in the later part of March 2017. -She has gotten into several arguments with Staff A. -On 2 separate occasions, she complained about Staff A to the Administrator since she was admitted to the facility. -The Administrator told her "if she couldn't get along with Staff A to pack her [expletive] and get out on both occasions. -The Administrator had also threatened her several times to be discharged from the facility. -She was fearfully to complain about anything because she did not have any other place to go. Confidential interviews with two previous residents revealed the Administrator said, "I don't	D921		

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D921	Continued From page 81 care what the state says, I am going to keep on doing what I want to do here, just watch and see". Confidential interview with a fourth resident revealed: -The resident felt intimidated by the Administrator when they voiced their concerns. -The resident had seen when other residents complained a lot that these residents were quickly discharged from the facility. Interview with the Administrator on 5/18/17 at 6:40pm revealed: -She was not aware that residents feared retaliations from her and Staff A if they voiced complaints. -She had never threatened any residents with a 30 day notice discharge if they complained. -She had never told any residents that they had to get out of the facility. -She would go around and talk with the residents to see what was going on. The facility failed to assure residents were allowed to voice complaints without fear of retaliation as evidenced by an attempt by staff to have Resident #6 involuntarily committed based on false allegations of aggressive and combative behaviors and the threatening to discharge other residents of discharge from the facility. This failure constitutes a Type A1 Violation. Review of the Plan of Protection dated 05/22/17 revealed: The Administrator will immediately review Resident Rights with all staff. -The facility will have the regional nurse to come and provide an inservice to all staff related not taking any retaliation actions against residents. -The Administrator will contact the ombudsman to	D921		

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D921	Continued From page 82 come and talk with staff on Resident Rights. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 23, 2017.	D921		
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 A1 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 housekeeping and furnishings, medication administration, health care personnel registry, and residents' rights. 1. Based on observations and interviews, the facility failed to assure that 1 of 3 halls (the A Hall) was free of unpleasant and offensive odors that spread through the entire A Hall, the front sitting room, and dining room areas [Refer to Tag D 075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations and interviews, the facility failed to assure curtains, drapes or window coverings were in 5 of 6 common hall shower rooms, to provide for the privacy of the residents,	D980	The facility administrator will continue to operate daily today and provide appropriate training to staff to ensure each resident is treated accordingly The facility will continue to have daily, weekly & monthly training as scheduled to cover all aspect of the resident right to ensure we are in compliance The facility administrator, RCC, SCH will monitor daily their day to day to K-to ensure all residents are equally cared for according to need.	6/23/17 6/23/17 6/23/17

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D980	Continued From page 83 when used for their personal care needs. [Refer to Tag D 083, 10A NCAC 13F .0306(a)(9) Housekeeping and Furnishings (Type B Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to assure every resident's rights were maintained as related to residents not being treated with dignity and respect; free of physical abuse, and free of fear of retaliation. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation).]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure the ingestion of medications for 1 of 5 sampled residents (#3) who had a known history of hiding medications in her cheeks and later spitting them out [Refer to Tag 358, 10A NCAC 13F Medication Adminstration .1004(a)(2) (Type B Violation)]. 5. Based on record reviews and interviews, the facility failed to investigate and report known allegations of abuse for 3 residents (#5, #6 and #8) by 2 staff members (Staff A and Staff C) to the Health Care Personnel Registry (HCPR) [Refer to Tag 438 10A NCAC 13F Health Care Personnel Registry .1025 (Type A2 Violation)]. 6. Based on reviews and interviews, the facility failed to assure residents were treated with respect and dignity as evidenced by the residents being subjected to disrespectfulness by the way the Administrator, the Resident Care Coordinator, Staff A, Staff C, Staff D, Staff E, and Staff F yelled and/or cursed at the residents [Refer to Tag D 911 G.S. § 131D-21 (1) Declaration of Resident Rights (Type A1Violation)].	D980		

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D980	Continued From page 84 7. Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled residents was free of physical abuse that resulted in both physical harm and emotional distress to Resident #7 by Staff G [Refer to Tag D 914 G.S. § 131D-21 (4) Declaration of Resident Rights (Type A1 Violation)]. 8. Based on observations, interviews and record reviews, the facility failed to assure residents had the right to voice complaints and be free of retaliation as evidenced by an attempt by staff to have Resident #6 involuntarily committed based on false allegations that Resident #6 exhibited aggressive and combative behaviors and other residents subjected to threats of discharge from the facility by the Administrator and Staff A for expressing their complaints[Refer to Tag D 921 G.S. § 131D-21 (11) Declaration of Resident Rights (Type A1 Violation)]. 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 being verbally disrespectful to residents, speaking inappropriately to residents, subjecting residents to physicial abuse, and staff retaliation against residents for voicing complaints. The Administrator failed to assure appropriate care and services were provided by the failure to maintain substantial compliance with rules and statutes related to housekeeping and furnishings, medication administration, and health care personnel registry, which is the responsibility of the Administrator. This failure to implement rules and regulations resulted in the serious neglect to all residents which constitutes a Type A1	D980		

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D980	Continued From page 85 Violation. Review of the Plan of Protection dated 5/23/17 revealed: -The Administrator will implement and recreate a better managment system to make us of available resources to improve the management of the facility. -The facility will continue to monitor the day to day operation of the facility and assure all tasks are carried out accordingly to provide patient care. -The Administrator will continue to meet with residents to make sure their issues and concerns are addressed. CORRECTION DATE FOR THE A1 VIOLATION SHALL NOT EXCEED JUNE 23, 2017.	D980		