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
	FCL079089	A. BUILDING: _____ B. WING _____	08/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN # 2	157 GLENDALE DRIVE EDEN, NC 27288

(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
C 000	Initial Comments The Adult Care Licensure Section and the Rockingham County Department of Social Services conducted an annual survey on July 31, 2017 with a telephone exit on August 1, 2017.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the	C 007	see attached	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sophie B. Williams — TITLE: Administrator — (X6) DATE: 9/17/17

STATE FORM 6899 GCZE11 If continuation sheet 1 of 19

jeanne S Robinson RN

Reviewed and acknowledged 10/3/17

I am writing in response to the July 31, 2017 annual survey and the corrective action issued as a result of that visit. Please find attached the result of the facility audit and plans for future adherence.

In response to **10A NCAC 13G.0206 Capacity**

8/2/2017

On August 2, 2017, resident #3 and #4 ambulation status was assessed by facility staff and the Administrator. Resident #3 and #4 were able to independently demonstrate ambulation in accordance with the facilities criteria for ambulating using assistive devices. In order to successfully demonstrate their continued ambulatory status residents had to demonstrate the following:

The resident must independently ambulate with a walker as follows

- Push off a chair or bed to come to a standing position.
- Hold the walker on the hand grips for stability.
- Lift the walker, placing it in front of them while leaning their body slightly forward.
- Walk into the walker, supporting their body weight on their hands with when advancing walker , permitting partial weight bearing or non-weight bearing as prescribed
- Balance themselves on their feet.
- Lift the walker, and place it in front of them again
- look up as they walk.

This assessment is in agreement with the findings of client's initial FL-2 assessment completed by Wesley Long / Cone hospital and PT assessment of resident #3. Resident #3's use of a wheelchair was not due to the inability to ambulate but served as a convenience tool for resident when walking long distances outside the facility and to ease the discomfort of client's right knee pain due to arthritis. Resident was walking prior to admission the facility and has not suffered decreased ambulation while a client in the facility in fact resident has improved ambulatory status. Resident does not exclusively use wheelchair for mobility. Since 8/19/17 resident #3 uses her walker for mobility inside the facility and outside onto the porch. Resident reclines and sits on fixed furniture.

Resident # 4 continues to use walker to ambulate and does so independently. Ambulation of both resident #3 and #4 has been verified by staff, family and video recording.

On 8/17/17, the administrator and a representative from the division of health service regulation construction section discussed and observed all residents in the facility. Serving to show the residents residing in the facility.

Additionally, each resident and resident family were notified on 8/19/2017 that a resident would be discharged from the facility, following the approved discharged process, if that resident becomes immobile and unable to ambulate. This is in accordance with the state mandated policy.

8/2/17 and ongoing

The facility will re-assess and re-evaluate the ambulatory status of all residents. Any resident found to have decreased ambulatory status will be assessed by their physician. If residents found incapable of the ability to ambulate we will notify DHSR and the facility will follow directives, Any resident unable to ambulate or found to be immobile will be discharged from the facility in accordance with applicable rules. All residents will be assessed upon admission to the facility to verify ambulation status as documented on residents' FL2 and admission papers. Any resident incapable of ambulation will not be admitted. Assessment and care plans will be reviewed and updated to accurate performance codes.

In response to **10 NCAC 13 G. 0316 Fire Safety and Disaster Plan**

8/17/117

Staff received in-service training on the facility fire safety and evacuation plan. The training included review of the facility disaster plan, the procedures for evacuation during a fire and other disasters, demonstration of evacuation procedures, fire drill procedures and the training on the proper documentation of drills and rehearsals. The importance of proper and accurate documentation of drills was stressed as these reflect the scope staff competency and residents' capability to evacuate and the accessibility of the facility for resident evacuation. The training focused on the following facility policy:

FIRE DRILLS

Policy Statement Fires in Adult Homes do happen and must guard against this threat constantly. To achieve this level of vigilance, fire drills, on a routine basis, help to ensure that all personnel have a working knowledge of the facility's fire safety prevention and protection plans.

Policy Interpretation and Implementation

1. Fire drills are required quarterly on each shift.

2. The purpose of the drill is to familiarize all personnel with emergency procedures and to practice the skills necessary to ensure the safety of all.

3. The drills are to focus on specific tasks not routinely performed, but critical to the safe management and evacuation of residents, visitors, and staff in the event of a real fire.

4. Drills are serious and not to be taken lightly. Professionalism is expected, and required.

5. Both residents and staff should be included in drill exercises. All facility employees (including office, laundry, dietary, etc.) on the premises at the time of a fire drill are required to participate and expected to follow all instructions issued.

6. The emphasis of a drill is to place an emphasis on orderly and safe evacuation procedures rather than on the duration of an evacuation.

7. Visitors on the premises during a fire drill are required to evacuate the premises. Visitors must follow all instructions issued by staff members.

8. All procedures are expected to be carried out "live" and not "simulated", i.e. if the drill scenario places the "fire" in Room 126 on the 100 Hall, then additional fire extinguishers should actually be brought from other locations of the facility to "combat" the fire.

9. At least one drill annually on each shift will be conducted with the assistance of the local fire department's Fire Prevention representatives and/or such agencies having jurisdiction over such matters.

10. A post-drill critique, staff discussion/debrief shall be conducted. The results of which will be documented on a standardized Fire Drill Report which shall include the following:

o Date and Time of the drill

o On which shift the drill was conducted

o Staff Members present

o Time for evacuation

Additionally, a drill was held on at 11:41am on **8/17/17** in which the total time of evacuation was 1 minute 59 seconds. All residents exited without staff assistance. The drill was observed by the Administrator and video recorded.

Drills were held daily during the week of 8/20/17-8/27/17. Drills were held at various times during this period. Residents exited independently. Evacuation times ranged from 1minute 13 secs to 2 min 45 seconds.

8/17/17 and ongoing

The facility will insure that all staff has adheres to disaster plan and drill procedures. Residents will continue to participate in drills no less than once a month. The administrator will conduct random audits of fire rehearsal log to insure adherence to facility policy. Additionally, the administrator or designee will conduct unannounced drills to insure staff competency and residents evacuation time and ability.

In response to **10 NCAC 13 G. 0904(a) Nutrition and Food Service**

7/31/17

Staff was informed to offer snacks to clients in the morning at 10 am , afternoon at 2pm, and evening at 7pm. Staff should place snacks at the residents specified place at the dining room table. If a resident refuses the snack is to be discarded. Staff are not to ask if resident wants a snack instead, the snack should be placed. Staff was also told to follow the snack menu which is posted in the kitchen. The facility will continue to insure that the food supply is adequate to provide nutritious snacks.

7/31/17 and ongoing

The administrator or designee will randomly audit the facility at designated snack times to insure staff compliance. Additionally, the administrator will poll residents to insure dissemination of snacks on a routine basis. The facility will also seek suggestions for snacks from residents. The administrator will also audit camera footage to insure snacks are received and audit food supply to guarantee specified snacks are given to residents.

In response to **10A NCAC 13G. 1004(a) Medication administration**

7/31/17

The facility insured that the Medication aide faxed Resident #3's order dated 7/27/17 to the pharmacy. The facility verified receipt of the order with the pharmacy and pick-up of discontinued medications were made, as well as, proper documentation of MAR to reflect discontinuation of Norvasc, Celexib and Lasix 20mg. The facility policy was reviewed with the medication aide to insure compliance.(Please see attachment)

7/31/17 and ongoing

The facility will insure that all staff completes annual continuing education requirement for medication aides. The facility will also audit medication records in between pharmaceutical reviews to insure compliance. Staff will familiarize and adhere to the facility's policy for medication orders. Staff will adhere to the following policy:

<u>New and Changed Orders</u>

1. For medications ordered before a MAR has been created (ie: on admission) date and addressograph the "Supplementary MAR" and transcribe the medication order and the administration times. Initial each of these entries on the right hand side of the page.

2. When a new medication order is received, transcribe the physician's order and administration times onto the existing MAR and initial beside the transcription. Check and initial "MAR" on the physician's order sheet.

3. Communicate all medication orders to Pharmacy by faxing the original physician's order to Pharmacy. Indicate this on the physician's order sheet under the appropriate column. If the order is STAT, fax the order and phone Pharmacy. Note: Medication orders faxed to Pharmacy before MAR printing will be included on the preprinted MAR for the following 24 hours.

4. **When a medication is discontinued or a dose/frequency is changed**

- Using a highlighter "Black Out" the complete order and the remaining times on the MAR and initial at the end of the line.
- On the physician's order sheet check "MAR" beside the physician's order and initial.
- If the medication is discontinued and there are still doses to be given, indicate on the MAR the medication is discontinued and black out only the times that will not be administered. When the last dose has been given, then black out the name of the medication
- If the dose/frequency is changed, rewrite the new order and the administration times on a new line. Highlight the previous order and the times of the doses remaining. Note: Every new order must be a new entry on the MAR. DO NOT change existing orders.

In response to **G.S 131D-21(2) Declaration of Residents Rights**

The facility will insure that all residents meet the criteria for admission and continued occupancy in the facility under the current licensure requirements. Any resident found to have decreased ambulatory status will be assessed by their physician. If residents found incapable of the ability to ambulate the facility will notify DHSR. The facility will follow directives of DHSR construction. Construction was notified of all residents in the facility on 8/17/17.Any resident unable to ambulate or found to be immobile will be discharged from the facility in accordance with applicable rules. All residents will be assessed upon admission to the facility to verify ambulation status as documented on residents' FL2 and admission papers. Any resident incapable of ambulation will not be admitted.