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| CRESCENT GREEN OF CARRBORO | 624 JONES FERRY ROAD CARRBORO, NC 27510 |

SEP 27 2017

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on August 2, 2017 through August 4, 2017 and August 7, 2017. | D 000 | | |
| D 067 | 10A NCAC 13F .0305(h)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(h) The requirements for outside entrances and exits are:<br>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to assure 10 of 10 exit door alarms were maintained in operational conditions and activated with a sounding device when opened, which resulted in a resident (Resident #4), who was disoriented, exiting the building without staff knowledge.<br><br>The findings are:<br><br>Observation of all ten doors at the facility on | D 067 | The administrator or designee shall ensure that all exit doors are locked at 10pm and unlocked at 6 AM this will be done by the medtech. All exit doors alarms were repaired and have an audible alarm. The alarms will be on at all times if a resident is considered to be a wanderer whenever noted on the FL-2 or evidence exhibited by the Residents. 9/4/17 9/15/17 ✓ | |



Reviewed & Accepted - Revising pg 27
10/13/17 SM for MT

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| D 067 | Continued From page 1<br><br>08/02/17 from 11:15 AM to 12:15 PM revealed:<br>-There were 10 out of 10 exit doors kept unlocked and when opened did not alarm.<br>-There were 10 out of 10 exit doors that had a little box at the top of them that had wires running up into the ceiling.<br><br>Observation of all ten doors at the facility on 08/03/17 at 5:50 AM revealed there were 10 out of 10 exit doors that were unlocked and there was no alarming sound when they were opened.<br><br>Review of Resident #4's current FL-2 dated 07/13/17 revealed:<br>-Diagnoses included dementia with behavioral disturbances, hypertension, hypothyroidism, constipation, insomnia, and allergic rhinitis.<br>-The resident was constantly disoriented.<br>-Resident #4 was admitted to the facility from a Memory Care Unit.<br><br>Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 07/28/17.<br><br>Observation of Resident #4 on 08/02/17 at 2:15 PM revealed:<br>-The resident walked out of the front door and started walking towards the road.<br>-Within a couple of minutes a Personal Care Aide (PCA) ran out of the front door going towards Resident #4.<br>-The PCA got to Resident #4 right as she was about to walk onto the street.<br>-There was oncoming traffic going in both directions of the road.<br><br>Interview with the PCA on 08/02/17 at 2:30 PM revealed:<br>-Resident #4 was disoriented and wandered | D 067 | | |

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| D 067 | Continued From page 2<br><br>constantly.<br>-Resident #4 had only been here for a few days.<br>-She thought that the resident was admitted to the facility on 07/28/17.<br>-She was not aware of Resident #4 getting out of the facility on any other occasion.<br><br>Confidential interview with a resident revealed:<br>-The resident had seen a resident walk out of the side door in the middle of the night.<br>-The resident was not sure who that resident was but shortly after, staff were walking around the building looking for the resident.<br>-This happened sometime this past Sunday night on 07/30/17.<br>-The resident remembered seeing the police walking around the building.<br>-The resident was not sure of the exact time.<br>-There had never been a door alarm on any of the exit doors since he had been living at the facility.<br><br>Attempted interview with Resident #4 on 08/03/17 at 3:30 PM revealed resident #4 was not interviewable at this time.<br><br>Review of a police report that was filed on 07/31/17 at 2:22 AM revealed:<br>-The police were called to the facility in response to a missing person.<br>-The name of the person missing listed on the police report was Resident #4.<br>-Resident #4 was last seen around 1:30 AM.<br>-The report listed Resident #4 as found but did not specify who found her.<br><br>Interview with a Medication Aide (MA) on 08/03/17 at 6:30 AM revealed:<br>-She usually worked third shift.<br>-The doors were locked at night around 10:00 PM | D 067 | | |

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| D 067 | Continued From page 3<br>and would be unlocked before first shift around 6:30 -7:00 AM.<br>-She had not unlocked the doors this morning and was not sure who unlocked the doors.<br>-She had been working at the facility for about 6 months and she had never heard any door alarms on the doors.<br>-The residents could go in and out as they wanted to as long as they signed out.<br>-She was not aware of any of the residents that were wanderers.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/03/17 at 9:10 AM revealed:<br>-He was not at the facility when Resident #4 went missing.<br>-He had heard about the incident of her getting out of the facility by some of the other staff who worked night shift.<br>-He felt that Resident #1 should not have been admitted to the facility due to constant wandering.<br>-The facility she had come from did not verbalize all the information specific to Resident #4's care.<br>-The Administrator did the assessment on Resident #4.<br>-He was not aware that Resident #4 was transferred from a Memory Care Unit.<br>-The door alarms had been turned off due to some of them not working correctly.<br>-The alarms had been off for some time now but he was not sure of an exact date.<br>-The only ones that were required to be on was the doors in the back hallways.<br>-The door alarm system was damaged at the circuit board and the company that worked on it went out of business.<br>-The new company that the facility hired did not work on this alarm system; they only deal with the security cameras.<br>-He had spoken with the owners about getting a | D 067 | | |

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| D 067 | Continued From page 4 | D 067 | | |

new company so that the door alarm system could be repaired.
-The doors should remain locked at night during third shift and remain locked until first shift arrived.
-He was not aware that the doors had been left unlocked at nighttime.
-He would discuss this with the staff to make sure they understood about locking the doors at night time.

Interview with the Administrator on 08/02/17 at 4:30 PM revealed:
-The police had been called to the facility on 07/31/17 due to Resident #4 was missing.
-Resident #4 had walked outside and the PCA had not seen her walk outside.
-They staff member checked on Resident #4 around 1:00 AM to 1:30 AM and Resident #4 was in her room sleeping.
-When the staff returned to check on Resident #4 around 2:00 AM, the resident was gone, and they called the police and the Administrator.
-The staff found the resident outside before the police arrived.
-Resident #4 was found on the ground outside at the back of the building.
-The staff were unaware if she had fallen or sat down on the ground.
-Resident #4 did not have any injuries noted.
-The door alarms were not on because the residents went in and out all night to smoke or walk down to the restaurant down the street.
-She knew some of the door alarms were not working but was not sure which ones worked and which ones did not.
-All doors were to be locked around 9:00 PM to 10:00 PM every night and left locked until first shift arrived.
-The doors were unlocked because the residents

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| D 067 | Continued From page 5<br>were going in and out of the doors and when they were opened from the inside, it would unlock the door.<br>-She would make sure that all doors were kept locked at night and that a functioning alarm was placed on all the doors today.<br>-She had done the initial assessment on Resident #4.<br>-The resident was sleeping when she went to assess her at the other facility.<br>-She was in a Memory Care Unit but the resident's doctor said she was okay to be in an assisted living.<br>-She would talk with the family about possible placement back into a Memory Care Unit because they could not meet the needs of Resident #4.<br>_____<br>The facility's failure to assure exit door alarms were maintained in operating conditions and activated with a sounding device when opened with sufficient volume to alert staff resulted in Resident #4, who had a diagnosis of dementia and was constantly disoriented, exiting from the facility on two occasions without staff knowledge and the resident almost making it to the road. This was detrimental to the resident's safety and welfare and constitutes a Type B Violation.<br>_____<br>Review of the facility's Plan of Protection dated 08/03/17 revealed:<br>-A battery powered door alarm is being placed on every door leading to the outside of the building.<br>-It will alarm when the door is opened and continue to ring until the door is closed.<br>-It is a loud audible noise.<br>-The door alarms will be checked by the Medication Aide on each shift.<br>-The doors will be locked from 10:00 p.m. until | D 067 | | |

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| D 067 | Continued From page 6<br>6:00 a.m.<br>-The battery powered alarms will be on doors until the permanent door alarm is reactivated.<br>-The permanent door alarm system will be reactivated and it will be on at all times.<br>-The system will be monitored by the Resident Care Coordinator or Resident Coordinator/ Medical Records.<br>-This will be completed in the next 30 days.<br>- The monitoring will be done weekly.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2017. | D 067 | | |
| D 119 | 0A NCAC 13F .0311(j) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br>(j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews the facility failed to assure that an operational call light system was in place for residents who were non ambulatory or needing assistance with assistive devices for 2 of 2 sampled resident's (Resident #1 and Resident #2).<br><br>The findings are:<br><br>1. Review of Resident #2's current FL-2 dated | D 119 | The administrator or designee shall assure that all Residents that are unable to evacuate without staff assistance are given a signaling device upon admission to the facility or when there is a change of status. Each Resident will sign acknowledging receipt of such device. The CNA or PCA will Check the rooms daily to be sure the device<br>see copy of form Residents sign<br>8/8/17 | |

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| D 119 | Continued From page 7<br>06/07/17 revealed:<br>-Diagnoses included Sequelae of cerebral infarct, generalized muscle weakness, diabetes, and essential hypertension.<br>-The resident was semi-ambulatory with the use of an electric wheel-chair.<br><br>Review of Resident #2's Resident Registry revealed the resident was admitted to the facility on 07/01/16.<br><br>Review of Resident #2's care plan dated 07/05/17 revealed Resident #2 required staff assistance to transfer or ambulate.<br><br>Observation of Resident #2's room on 08/07/17 at 11:20 AM revealed:<br>-There was no call light system in the resident's room.<br>-There was no bedside bell or hand bell in the resident's room.<br>-When the resident spoke he had a low pitched raspy voice that could barely be heard.<br><br>Interview with Resident #2 on 08/07/17 at 11:30 AM revealed:<br>-He did not have a call light or hand bell in his room.<br>-He had not been given one since he had been at the facility.<br>-He required assistance from staff to get in and out of the bed.<br>-After he had been put in the bed at night he could not get anything that he needed unless staff come down to his room.<br>-The staff hardly ever come down to his room to check on him.<br>-He had to sleep one night with his leg hanging off the bed all night since he could not call for help and was unable to move his leg on the bed | D 119 | is within reach of the Residents. This will be done on all shifts. The third shift staff will sit on the halls 200 Hall, 300 Hall Med tech will sit on the 100 Hall outside the medicine room so that all the hallways are monitored. | |

CRESCENT GREEN OF CARRBORO
624 JONES FERRY ROAD
CARRBORO, NC 27510
OFFICE: (919)933-9570
FAX: (919)933-9572)

NAME:_____

DATE:_____

I ACKNOWLEGE THAT I WAS GIVEN A BELL TO RING FOR ASSISTANCE WHEN NEEDED.

RESIDENT'S SIGNATURE:_____
DATE:_____

STAFF SIGNATURE:_____

DATE:_____

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| D 119 | Continued From page 8<br><br>independently.<br>-He also had to sleep one night in bowel where he had defecated on himself due to not being able to get up and go to the bathroom and he had no way of calling staff.<br>-He had called 911 a few months ago from his personal cell phone due to not being able to get to the restroom.<br>-He needed a call bell in his room so that he would be able to call the facility staff when he needed assistance.<br>-He had told staff that he needed a call bell but they had never brought one to him.<br><br>Review of an incident report dated 04/09/17 revealed Resident #2 had called 911 to send transport to pick him up since he could not get up and use the restroom.<br><br>Confidential interview with a resident revealed:<br>-There was no call system or bells in the rooms for residents to use when they needed help.<br>-This resident would walk down to get staff when the resident needed help.<br>-A resident would also walk down to get assistance for other residents if they were hollering out that they needed assistance.<br>-The staff only come around 1-2 times per shift and that was usually to change the trash cans or pass medications.<br>-The resident had never gotten staff to assist Resident #2 because he had never heard him calling out.<br>-The resident had seen staff assisting Resident #2 in and out of the bed.<br><br>Interview with a Medication Aide on 08/07/17 at 11:16 AM revealed:<br>-There should be a staff member on each hall at all times to check on residents. | D 119 | | |

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| D 119 | Continued From page 9<br>-The residents should be checked on every 2 hours.<br>-All the residents that required a call bell should have a hand bell at the bedside.<br>-The ones that required call bells were those who were not able to transfer or ambulate and required assistance with transferring and ambulation.<br>-Resident #2 should have a call bell in his room.<br>-Resident #2 could transfer on and off the toilet independently but required assistance with transferring in and out of the bed.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/07/17 at 11:45 AM revealed:<br>-Resident #2 had been given a call bell since being admitted to the facility.<br>-Resident #2 had actually been given 2 or 3 call bells since being at the facility.<br>-He was not sure where the call bells that he had been given were located.<br>-The facility did not have an electric call light system.<br>-He did not recall the events of the incident report dated 04/09/17.<br>-The Administrator was responsible for making sure that all residents that required them had one.<br>-Any resident needing assistance with ambulation or transfers required a call bell.<br>-He was not sure if there was any documentation that Resident #2 had been given one or not.<br>-Resident #2 could transfer from the chair to the toilet, but required 1-2 people to assist him in and out of the bed.<br>-He would let the Administrator know that Resident #2 needed a call bell.<br>-Staff should be rounding on the residents every 1-2 hours.<br><br>Interview with the Administrator on 08/07/17 at | D 119 | | |

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| D 119 | Continued From page 10<br><br>12:30 PM revealed:<br>-Resident #2 had received call bells in the past.<br>-She was not sure where the call bells were. Sometimes the resident's would put them in the drawers of their chest of drawers.<br>-She was not aware that Resident #2 did not have a call bell in his room.<br>-Resident #2 had been given more than one call bell since being at the facility.<br>-She did not have any documentation that he had been given a call bell.<br>-Resident #2 could transfer himself on and off the toilet but required assistance by 2 staff to get in and out of the bed.<br>-The staff should be rounding on the resident's every 1-2 hours to assess if they needed anything.<br>-There should be a staff member on each hall at all times during the night in case a resident needed assistance.<br>-She would make sure that Resident #2 received a call bell today and it was where he could use the call bell if needed.<br>-She was responsible for making sure the residents received a call bell.<br>-The floor staff were responsible for making sure the call bell was where the resident could reach it.<br><br>2. Review of Resident #1's current FL-2 dated 03/21/17 revealed:<br>-Diagnoses included acute renal failure, colon cancer, hypertension, urinary tract infection, nephrolithiasis, hyperlipidemia, status post illeal conduit, sepsis secondary to urinary tract infection, normocystic anemia, metabolic acidosis, constipation, diabetes, small bowel resection.<br>-The resident was semi-ambulatory with the use of a walker. | D 119 | | |

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| D 119 | Continued From page 11<br><br>Review of Resident #1's Resident Registry revealed the resident was admitted to the facility on 12/12/16.<br><br>Review of Resident #1's care plan dated for 01/16/17 revealed Resident #1 required staff assistance to transfer and ambulate.<br><br>Interview with Resident #1 on 08/07/17 at 10:51 AM revealed:<br>-He did not have a call bell in his room.<br>-He had never been given a call bell to use.<br>-When he needed help, he had to get out of bed and walk down to the medication room.<br>-Even when residents would call out, the staff would not respond.<br>-There used to be a resident that lived across the hall from him that would holler out that he needed help.<br>-That resident was no longer at the facility.<br>-He had to finally go down and tell the staff that the resident had been hollering out for about 10-15 minutes and needed help.<br>-The staff told him to go down and tell the resident to stop hollering out, they could hear him, and would be down shortly to check on him.<br>-The staff never come around at night to check on him.<br>-He had put a motion sensor bell on his door so he knew when someone came around and he had never heard it go off at night.<br>-He needed assistance to move around in his room and leave his room, but staff never helped him so he had to do it all on his own.<br><br>Interview with a Medication Aide on 08/07/17 at 11:16 AM revealed:<br>-Resident #1 was not provided a call bell because he had brought in his own bell to use.<br>-It was some type of motion sensor bell that staff | D 119 | | |

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| CRESCENT GREEN OF CARRBORO | 624 JONES FERRY ROAD CARRBORO, NC 27510 |

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| D 119 | Continued From page 12<br>would respond to if it went off.<br>-Resident #1 could ambulate independently but required some assistance to get in and out of bed.<br>-The third shift staff were to be checking on him every 2 hours and as needed.<br>-They should be responding immediately to someone calling out for assistance.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/07/17 at 11:45 AM revealed:<br>-He could not recall if Resident #1 had received a call bell when he was admitted.<br>-Resident #1 required some assistance from staff to get in and out of bed.<br>-Resident #1 hollered out when he needed help.<br>-Resident #1 should be rounded on every 2 hours.<br>-Staff should be responding immediately when a resident was hollering out.<br>-He had not received complaints from residents that staff were not responding to residents calling out and doing rounds every 2 hours.<br>-The Administrator was responsible for making sure that all residents that needed a call bell had one.<br><br>Interview with the Administrator on 08/07/17 at 12:30 PM revealed:<br>-She had offered Resident #1 a call bell on several occasions and he refused to take it.<br>-Resident #1 said he did not need the call bell and did not want it in his room.<br>-Resident #1 required some assistance to get in and out of bed but wanted to do things independently and would usually refuse help.<br>-She was responsible for making sure that all residents were provided a call bell.<br>-She would make sure that Resident #1 was provided a call bell today in case he needed | D 119 | | |

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| D 119 | Continued From page 13<br><br>assistance.<br>-She had not received complaints from any of the residents that staff were not responding to call outs and doing their rounds.<br><br>The facility's failure to assure that all residents who required a call bell had one in their room and the call bell was in reach for the resident to use for 2 of 2 sampled residents (#1 and #2), including a resident who was chair bound and requires assistance from at least one to two staff for assistance to transfer out of the bed (#2), and a resident using a walker for ambulation and required assistance to transfer and ambulate (#1). This was detrimental to the residents' safety and constitutes a Type B Violation.<br><br>Review of the Plan of Correction received from the facility on 08/07/17 revealed:<br>-The Administrator or designee will ensure that each resident has a bell to ring for assistance.<br>-Each Nurse Assistant or Personal Care Aide will check to be sure the bell is within reach of the resident.<br>-This will be done daily.<br>-The Resident Care Coordinator will assure that the staff is checking the rooms daily for call bells.<br>-The staff will remind the residents what the purpose of the bell is and remind them not to put them in their drawers.<br>-The third shift will sit on the 200, 300 halls and the Medication Aide will sit outside the medication room.<br>-That way all the halls will be monitored.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2017. | D 119 | | |

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| D 201 | Continued From page 14 | D 201 | The administrator or deoignee shall ensure that the facility is staffed to the minimum standard in the rule book on each shift. The staff has been told if there is a call out the RCC is to be Notified so coverage can be made. If needed the administrative staff with CNA or PCA certification will be called back to work to ensure adequate staffing. | 8/4/17 |
| D 201 | 10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing<br><br>10A NCAC 13F .0604 Personal Care And Other Staffing<br>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.<br>(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:<br>(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) | D 201 | | |

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| D 201 | Continued From page 15<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to assure there was adequate staff on third shift for 4 of 4 shifts on 07/28/2017-07/31/ 2017. The findings are:<br><br>Review of the census for 08/02/2017 revealed there were 85 residents in the facility. A facility with a census of 81-90 residents is required to have 24 hours of aide staffing and 8 hours of supervisor staffing on third shift.<br><br>Interview with the Administrator on 08/02/2017 at 11:00 a.m. revealed there were 85 residents in the facility on that day.<br><br>Interview with a third shift Medication Aide (MA)/ Personal Care Aide (PCA) on 08/03/2017 at 7:00 a.m. revealed there was one Personal Care Assistant and one Medication Aide working on third shift Sunday night, 07/30/2017.<br><br>Review of staff time cards revealed:<br>-On 7/28/17 there was 8 hours of aide duty and 8 hours of supervisor duty on third shift. The facility was short 8 hours of aide staffing with only two staff in the building.<br>-On 7/29/17 there was 8 hours of aide duty and 8 hours of supervisor duty on third shift. The facility was short 8 hours of aide staffing with only two staff in the building.<br>-On 7/30/17 there was 8 hours of aide duty and 8 hours of supervisor duty on third shift. The facility was short 8 hours of aide staffing with only two staff in the building.<br>-On 7/31/17 there was 8 hours of aide duty and 8 hours of supervisor duty on third shift. The facility | D 201 | | |

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| D 201 | Continued From page 16<br>was short 8 hours of aide staffing with only two staff in the building.<br><br>Interview with the Resident Care Coordinator (RCC) at 4:00pm on 08/07/2017 revealed:<br>- All Medication Aides were qualified to act as the Supervisor.<br>- The RCC was in charge of scheduling the Personal Care Aides (PCA) for the facility.<br>- The RCC scheduled 3 to 4 PCAs to work on second shift.<br>- The RCC scheduled 3 PCAs to work on third shift.<br>- If the PCA gave advance notice that they were not able to work their assigned third shift, he would look at the work assignment schedule to see if there was anyone available to come in for the third shift.<br>- If the RCC could not find anyone to come to work the 8-hour shift, he would ask the PCA working on second shift to stay on and work a double shift to assure 3 PCAs worked third shift.<br>- Management personnel (the Administrator or the RCC), may work third shift in order to assure enough staff were available to provide services for residents.<br>- The RCC was aware there had been times when only 2 PCAs were available to work on third shift.<br>- There have been times when PCAs did not give advance notice that they were unable to work their assigned shift.<br>-Sometimes no one could be found to fill in for the missing PCA.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/07/2017 at 3:30 p.m. revealed:<br>-Staffing had always been an issue.<br>-It was hard to find staff to work.<br>-On third shift there should be two Medication | D 201 | | |

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| D 201 | Continued From page 17<br>Aides (MA) and two Personal Care Aides (PCA).<br><br>Interview with the Administrator on 08/07/2017 at 3:50 p.m. revealed:<br>-The Administrator was not aware that there was only two staff on duty for third shift on 07/30/2017 until she arrived at the facility.<br>-There were usually 3 PCAs in the building, with one of the PCA working as the Medication Aide (MA) and the Resident Care Coordinator (RCC) who lived in the apartment that was attached to the building.<br>-The RCC did the schedule "according to what the owner tells him to do".<br>-The Administrator would make sure that the staffing was adequate.<br><br>---<br><br>The facility's failure to assure that there was adequate staff to provide supervision to residents resulted in Resident #4, who had a diagnosis of dementia and was constantly disoriented, exiting the facility without staff knowledge between 1:30 a.m. and 2:22 a.m. on 07/31/2017. This was detrimental to the resident's safety and welfare and constitutes a Type B Violation.<br><br>---<br><br>Review of the Plan of Protection received from the facility on 08/04/2017 revealed:<br>-The Administrator shall ensure that there are enough staff to provide care.<br>-The facility will staff to the minimum standard in the rule book on each shift.<br>-The staff will be told if there are call outs the Resident Care Coordinator will be notified so coverage can be made.<br>-If need be the Administrative staff with Nursing Assistant or Personal Care Aide certification will be called in to work. | D 201 | | |

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| D 201 | Continued From page 18<br>-The Administrator will check the schedule weekly once the Resident Care Coordinator has made it to ensure that the staffing meets the standards.<br>-New staff will be hired and trained when warranted.<br>-Staff will be asked to work on their off time if needed.<br>-The Resident Care Coordinator or designee will check at the beginning of each shift to be sure there is enough staff.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2017. | D 201 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews the facility failed to provide supervision according to the resident's current symptoms for 1 of 7 sampled residents (#4), who had a diagnosis of Dementia and eloped from the facility. The findings are:<br><br>Review of Resident #4's FL-2 dated 07/13/2017 revealed:<br>-Diagnoses included, Dementia with Behavioral | D 270 | The administrator or designee will ensure that there is adequate staff to supervise the Residents ~~Staffing~~ Staff shall reflect the minimum standard in the rule book. | 8/4/17 |

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| D 270 | Continued From page 19<br><br>Disturbances, Hypertension, Hypothyroid, Constipation, Insomnia and Allergic Rhinitis.<br>-Resident #4 was constantly disoriented.<br>-Resident #4 was admitted to the facility from a Memory Care Unit.<br><br>Review of Resident #4's Resident Register revealed that she was admitted to the facility on 07/28/2017.<br><br>Observations on 08/02/2017 at 10:30 a.m.and 11:00 a.m. revealed there was no operating sounding device on the front exit door and the exit doors on the 200 hall were able to be opened, but had no operating sounding devices.<br><br>Observation of Resident #4's room on 08/02/2017 at 2:08 p.m. revealed that she had a sounding device attached to her door that went off when her door was opened.<br><br>Interview with a first shift Personal Care Aide (PCA) on 08/02/2017 at 2:08 p.m. revealed:<br>-Resident #4 was admitted last Friday, 07/28/2017.<br>-Resident #4 came out of her room on Sunday, 07/30/2017, and went out an exit door.<br>-Resident #4 tried to go up the hill in front of the facility, but could not, so she slid back down the hill and just laid there.<br>-A Medication Aide (MA) came outside two minutes later and got Resident #4.<br>-The Administrator made the decision to place an alarm on Resident #4's door on Sunday.<br><br>Observation on 08/02/2017 at 2:15 p.m. revealed:<br>-Other residents told the first shift PCA that Resident #4 had gone out one of the side exit doors.<br>-When the PCA went out the front exit door, | D 270 | | |

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| D 270 | Continued From page 20<br><br>Resident #4 had gone up the hill in front of the building and was headed toward the busy two lane street.<br>-The PCA ran toward Resident #4 and reached her as she was steps away from the busy two lane street.<br>-The PCA was able to redirect Resident #4 back down the hill and in the front door of the facility.<br><br>Observation of the facility's front entry/exit door on 08/03/2017 at 6:10 a.m. revealed that it could be opened for entry to the facility with no operating sounding device.<br><br>Interview with a third shift MA on 08/03/2017 at 6:15 am revealed:<br>-There was one PCA on the 100 & 200 hall and one PCA on the 300 hall.<br>-All facility doors were locked at night and reopened at 6:30 -6:45 a.m.<br>-The facility doors had not alarmed in the 6 months since she had been there.<br>-She did not know that facility had alarms.<br>-There were two residents that wandered.<br>-Resident #4 was checked every 15- 30 minutes.<br>-The 15-30 minutes check were not documented.<br><br>Observation of Resident #4 on 08/03/2017 at 6:20 a.m. revealed she was lying on her left side in bed in her room with her eyes closed.<br><br>Observation of the facility doors on 08/03/2017 at 6:25 a.m. revealed:<br>-The exit door at the end of the 100 hall that leads to the smoking area could be opened and reentered from outside the building.<br>-The exit door on the left end of the 200 hall could be opened and reentered from outside the building.<br>-The exit door on the right end of the 200 hall | D 270 | | |

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| D 270 | Continued From page 21<br>could be opened to the outside but could not be opened to reenter facility from the outside.<br>-There were no operational alarms on exit doors leading to the outside of facility.<br><br>Interview with a second third shift MA/PCA on 08/03/2017 at 7:00 a.m. revealed:<br>-There was one PCA and one MA working on third shift Sunday night, 07/30/2017.<br>-Sunday on third shift, early Monday morning, 07/31/2017 was when Resident #4 disappeared.<br>-She checked on Resident #4 at 12:00 a.m. and 1:15 a.m. and she was sitting in her chair sleeping.<br>-The MA checked on Resident #4 forty-five minutes later and she was gone.<br>-A resident told the MA that he saw Resident #4 go by his room on the 300 hall.<br>-When we realized Resident #4 was out of her room, we started to search for her immediately throughout the building and grounds, and we called the local Police Department and the Administrator.<br>-Resident was found by the police in the corner in the courtyard .<br>-Resident #4 was missing for 30 minutes.<br><br>Review of an Incident Accident Report dated 7/31/2017 at 2:00 a.m. revealed:<br>-The staff was told when they came in that Resident #4 wandered.<br>-The staff made rounds and "kept an eye" on Resident #4.<br>-The last time they saw Resident #4 was at 1:00 a.m. or 1:15 a.m.<br>-The staff checked on Resident #4 forty-five minutes later and she was gone.<br>- The staff looked all over the building for Resident #4 and could not find her.<br>-The Administrator and the Police Department | D 270 | | |

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was called.
-Resident #4 was found in the courtyard by the police and complained that her ankle hurt.
-Resident #4 was taken by Emergency Medical Service to the hospital.
-Resident #4's family was notified at 3:00 a.m. and her doctor was notified at 3:30 a.m. on 7/31/2017.

Review of the Police Department Incident/Investigation Report dated 7/31/2017 revealed:
-They were called to the facility on 7/31/2017 at 1:30 a.m. for a "missing person/ adult".
-The resident was located by the police at 2:22 a.m.

Observation of Resident #4's bedroom door on 8/07/2017 at 11:00 a.m. revealed:
-Resident #4's door was opened and the alarm sounded for 30 seconds before the door was closed and it went off.
-At 11:07 a.m. a MA came to check on Resident #4.

Interview with the first shift MA on 8/07/2017 at 11:07 a.m. revealed:
-She did not hear the bedroom door alarm going off.
-She was doing a routine check on Resident #4 to make sure she was in her room and that her alarm was not going off.

Interview with Resident #4's family member on 8/07/2017 at 1:10 p.m. revealed:
-Resident #4 got out of the facility one night.
-It was two days after she was admitted to the facility.
-Resident #4's family member was told by staff that Resident #4 was found within 45 minutes of

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| CRESCENT GREEN OF CARRBORO | 624 JONES FERRY ROAD CARRBORO, NC 27510 |

| (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 |
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| D 270 | Continued From page 23<br>when she got out of facility.<br>-Resident #4 was in a memory care unit at another facility before she was admitted to the current facility.<br>-Resident #4 needed to have "an eye kept on her".<br>-The wandering was contained during the day.<br>-Resident #4 was now sleeping during the night since the incident.<br>-The family member "thinks the facility has the problem solved to keep Resident #4 safe with alarm on her door and alarms on the exit doors".<br><br>Interview with the Resident Care Coordinator (RCC) on 8/07/2017 at 3:30 p.m. revealed:<br>-The RCC found out after the fact that Resident #4 eloped.<br>-Resident #4 currently had a body alarm, bedroom door alarm and was on every 15-30 minutes checks.<br>-The facility was inquiring into getting Resident #4 moved to a locked unit for Memory Care.<br>-The RCC was not sure if the Administrator was told that Resident #4 came from a locked unit.<br>-Resident #4 was not appropriate to be a resident in the facility.<br>-The Administrator was responsible for assessing residents for admission.<br>-The RCC felt not knowing Resident #4 and her medical history, they were not prepared to care for her.<br>-The RCC was not sure if the door alarms on the door would prevent Resident #4 from eloping.<br><br>Interview with the Administrator on 8/07/2017 at 3:50 p.m. revealed:<br>-The Administrator received a call at 2:12 a.m. on 07/31/2017 from the MA on duty for third shift notifying her that Resident #4 was missing from her room. | D 270 | | |

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| D 270 | Continued From page 24<br>-The staff last checked on Resident #4 at 1:15 a.m. and she was in her room.<br>-When staff went to check on Resident #4 at 2:00 a.m. she was not in her room.<br>-Staff searched the building and the grounds and did not find her.<br>-The staff called the Administrator and the police at 2:00 a.m.<br>-When the Administrator arrived at the facility at 2:30 a.m., Resident #4 had already been found.<br>-Resident #4 was sent out to the Emergency Room by Emergency Medical Service to be checked out because she complained of her foot hurting.<br>- Staff called Resident #4's family and left a message.<br>-Resident #4's family member called the facility back between 8:00 a.m. and 9:00 a.m. on 7/31/2017.<br>-A personal body alarm was placed on Resident #4 and an alarm was placed on her bedroom door.<br>-Staff started taking Resident #4 outside after lunch and that seem to "pacify" her.<br>-On Wednesday, 8/02/2017 Resident #4 left out of the dining room and went out the front door, "at least that's the door I think it was".<br>-Staff went out to get Resident #4 and she was given "something as needed for agitation", which was effective.<br>-Staff tried to keep Resident #4 engaged with activity, especially during busy times.<br>-The Administrator was not aware that there was only two staff on duty for third shift on 7/30/2017 until she arrived at the facility.<br>-There were usually three PCAs in the building, with one of the PCAs working as the MA and the RCC who lived in the apartment that was attached to the building.<br>-The RCC was not aware of the incident with | D 270 | | |

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| D 270 | Continued From page 25<br>Resident #4 until the Administrator called him after she arrived to the facility.<br>-The RCC did the schedule "according to what the owner tells him to do".<br>-The Administrator spoke with the owner of the facility on the morning of the incident with Resident #4 to make her aware of what occurred.<br>-The Administrator would make sure that the staffing was adequate.<br><br>Review of facility staff time cards for 07/30/2017 revealed only two staff were in the building to work for third shift.<br><br>See Tag D 0201.<br><br>---<br><br>The facility failed to assure that adequate supervision was provided for Resident #4, who had a diagnosis of dementia and was known to wander, which resulted in Resident #4 exiting from the facility twice and almost making it to the busy road. This was detrimental to the resident's safety and welfare and threrfore constitutes a Type B Violation.<br><br>---<br><br>Review of the Plan of Protection received from facility on 8/02/2017 revealed:<br>-The resident will wear a personal body alarm<br>-The Nursing Assistant will check her to see that she is safe every 15-30 minutes while she is awake and every hour when she is asleep.<br>-There is a door alarm on her door.<br>-The Resident Care Coordinator will ensure the staff are checking during first shift.<br>-The Medication Aides will ensure the staff is checking on second and third shifts.<br>-She will be taken to activities when activities are been offered. | D 270 | | |

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| D 270 | Continued From page 26<br><br>-A check sheet will be placed on her door.<br>-Any resident that starts to wander, their doctor will be notified.<br>-The staff will monitor them every 15-30 minutes.<br>-If there is no medical reason for the change, the facility will ask the doctor to consider a memory care unit.<br>-The family or responsible party will be notified.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2017. | D 270 | | SM 8/8/17 |
| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure the kitchen appliances, kitchen equipment, and floors of the kitchen and food storage areas were clean and protected from contamination.<br><br>The findings are:<br><br>Observation of the kitchen mop/sink room at 10:30am on 8/3/17 revealed:<br>-The tile floor was dirty.<br>-There were 4 dead roaches on the floor.<br>-There were 2 live roaches crawling on the floor.<br><br>Observation of the kitchen and pantry on 8/3/17 | D 282 | The administrator or dietary staff shall ensure that the kitchen is cleaned daily. The building is eptermin ated monthly by a professional pest control Company. If pest are noticed between visit the eptermin ated will be called to come back | |

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| D 282 | Continued From page 27<br>at 10:45am revealed:<br>-The wire shelving units to the right of the stove and behind the stove were dusty and dirty, covered with a yellow film that was greasy to the touch.<br>-Clear plastic containers stored on the shelves had dirty streaks and fingerprints.<br>-A dirty pan was dented and had a black-brown coating of burnt grease.<br>-There were two chairs with broken legs and armrests stored to the left of the refrigerator; a white powdery stain was on the floor below the chairs.<br>-The exterior of the microwave oven was streaked with food smears and fingerprints.<br>-The interior of the microwave oven was littered with food particles; the food particles were cooked onto all surfaces of the microwave interior.<br>-The wire shelving was dirty, and appeared to be rusty.<br>-Large plastic bins on the bottom shelf of one rack held rice, sugar, and flours. The bins were not closed to protect the contents from contamination. The plastic bins appeared to be dusty on top.<br>-The shelving unit held dry cereal packaged in disposable plastic bowls and a large assortment of disposable paper and Styrofoam cups, lids, and boxes of condiments and seasonings.<br>-There were dried liquid spills on the floor of the pantry.<br>-There were rusted spots from the metal shelving.<br>-Food particles, including dry cereal, nuts, crackers, flour were on the floor.<br>-Gray streaks of dirt were left on the floor after mopping.<br><br>Observation of the kitchen on 8/4/17 at 2:30pm revealed: | D 282 | | |

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| D 282 | Continued From page 28<br><br>-Pan racks behind the stove were dusty.<br>-Pots and pans on the racks had burnt grease staining the exteriors of steam table pans and assorted pots and pans.<br>-The deep fat fryer baskets were not washed.<br>-The fat in the deep fat fryer was not covered to prevent contamination<br>-There were brown, greasy streaks down the sides of the stove.<br>-The racks of the ovens were dirty.<br>-The griddle on top of the stove was dirty<br>-A metal fan in the kitchen was greasy and covered with fine gray dust.<br>-A small metal scale used to portion food was dirty.<br>-The sheets of paper on the bulletin board were encased in plastic sheet protectors that were dirty.<br><br>Interview with the Dietary Manager on 8/3/17 at 3:00pm revealed:<br>- She was just hired about a week ago.<br>- She has spent most of her time cooking and familiarizing herself with the kitchen equipment, food supplies, therapeutic diets, and the menus.<br>- She was aware the kitchen and its equipment needed cleaning.<br>- She would get organized and would receive guidance from the Administrator and owners of the facility.<br><br>Interview with the Dietary Aide on 8/5/17 at 3:00pm revealed:<br>- There was no schedule for deep cleaning the kitchen and the equipment.<br>- He was responsible for cleaning the floors.<br>- The Dietary Manager and he work together to get meals prepared for residents as efficiently as possible. | D 282 | | |

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| D 300 | Continued From page 29 | D 300 | | |
| D 300 | 10A NCAC 13F .0904(d)(3)(B) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(d) Food Requirements in Adult Care Homes:<br>(3) Daily menus for regular diets shall include the following:<br>(B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to provide two servings of fruit each day to residents of the facility.<br>The findings are:<br><br>Observations of the breakfast meals on 8/3/17 and 8/4/17 revealed:<br>-All residents were served an orange-flavored drink mix with added vitamin C.<br>-No fruit was served to the residents at either meal.<br><br>Observation of the pantry revealed:<br>-There were containers of dry orange-flavored drink.<br>-There were five cans of applesauce, each can holding approximately 20 servings. | D 300 | The administrator or dietary staff shall ensure that all residents are served 2 servings of fruit daily. Fruit will be ordered by the owner who orders the grocery. | 8/9/17 |

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| D 300 | Continued From page 30<br><br>Review of food receipts for June 2017 revealed 6 cans of applesauce had been purchased, each can holding approximately 20 servings.<br><br>Review of food receipts for July 2017 revealed:<br>-Twelve cans of applesauce, each can holding approximately 20 servings, had been purchased.<br>-Ninety six 4-ounce cups of mixed fruit/peaches had also been purchased.<br><br>The facility had 556 servings of fruit available as purchased in June and July 2017, plus fruit available in the pantry.<br><br>The facility needed 5185 servings of fruit to offer 2 servings of fruit or 100% juice to each of the 85 residents.<br><br>Confidential interviews with twelve residents revealed the residents complained that they received no fruit juice or fresh fruit at the facility. | D 300 | | |
| D 376 | 10A NCAC 13F .1005 (b) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self-Administration Of Medications<br><br>(b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. | D 376 | The Medtech shall check all Residents medication on Tuesdays that have a self-Administration order. If the Resident is not taking the medicine as ordered the doctor will be notified. If the | 8/8/17 |

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| D 376 | Continued From page 31<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure that the prescribing physician was notified of a resident who had been refusing to take his medication and refusing to allow staff to assess his medications for 1 of 1 sampled residents (Resident #1).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 03/21/17 revealed diagnoses included acute renal failure, colon cancer, hypertension, urinary tract infection, nephrolithiasis, hyperlipidemia, status post illeal conduit, sepsis secondary to urinary tract infection, normocystic anemia, metabolic acidosis, constipation, diabetes, small bowel resection.<br><br>Review of a Physician's order dated 12/06/16 revealed Resident #1 had an order to self-administer all medications.<br><br>Review of Resident #1's Physician's Orders dated 03/21/17 revealed:<br>-An order for Aspirin (used to treat pain, fever, headaches) 81 milligrams 1 tablet daily.<br>-An order for Vitamin B12 (as replacement supplement) 2,500 micrograms 1 tablet sublingual daily.<br>-An order for Lasix (a diuretic used for excess fluid) 40 milligrams 1 tablet daily.<br>-An order for Gabapentin (used for nerve pain) 300 milligrams 1 capsule every night at bedtime.<br>-An order for Ferrous Sulfate (replacement supplement) 325 milligrams 1 tablet daily with breakfast. | D 376 | medications are running low they will be reordered. this will be documenton the M.A.R.<br>If the Resident is noncompliant the RCC will ask his doctor to consider stopping the self-administrator order, the staff will also ask the doctor to explain the importance of taking the medication, On Tuesdays the medications will be counted and documented In the Residents Chart.<br>If the Resident and his doctor refuses to | |

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| D 376 | Continued From page 32<br><br>-An order for Magic Mouthwash (used to treat mouth sores) 10 milliliters four times per day.<br>-An order for Pantoprazole (used to treat acid reflux) 40 milligrams 1 tablet daily.<br>-An order for Melatonin (used as a sleep aide) 3 milligrams 1 tablet every night at bedtime as needed for sleep.<br>-An order for Zofran (used in treating nausea and vomiting) 8 milligrams 1 tablet every 8 hours as needed for nausea and vomiting.<br>-An order for Imodium (used to treat diarrhea) 2 milligrams 2 capsules as needed for diarrhea.<br>-An order for Tamsulosin (used to treat urinary retention) 0.4 milligrams 1 capsule daily.<br>-An order for Oxycodone/APAP (used to treat moderate to severe pain) 5-325 milligrams 1 tablet every 4 hours as needed for pain.<br>-An order for Lisinopril (used to treat high blood pressure) 10 milligrams 1 tablet daily.<br><br>Review of discontinued physician's orders for Resident #1 revealed:<br>-There was a discontinue order dated 07/27/17 for Pepcid (used to treat gas and indigestion) 20 milligrams 1 tablet daily and for Senna (used to treat constipation) 8.6 milligrams 2 tablet as needed for constipation.<br>-There was a discontinue order dated 06/14/17 Oxycodone (used to treat mild to severe pain) 5 milligrams 1 tablet every 4 hours as needed for pain.<br><br>Observation of medications in Resident #1's room on 08/04/17 at 8:10 AM revealed:<br>-The resident had several medication bottles lying all over the room in boxes and on tables.<br>-There was a pack of medication labeled Aspirin 81 milligrams 1 tablet daily, last filled on 02/09/17 and there were 13 pills left in the packet.<br>-There was a pack of medication labeled Pepcid | D 376 | Comply. The Resident's family or responsible Party will be notified that the facility can no longer meet his needs and a discharge notice will be issued. | |

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| D 376 | Continued From page 33<br>20 milligrams 1 tablet twice per day last filled on 03/21/17, and there were 3 pills left in the packet.<br>-There was a bottle of medication labeled Senna 8.6 milligrams take 2 tablets as needed for constipation last filled on 03/21/17, and there were 59 pills left in the bottle.<br>-There was a bottle of medication labeled Oxycodone 5 milligrams 1 tablet every 4 hours as needed for pain last filled on 03/21/17, and there were 57 pills left in the bottle.<br>-There was a pack of medication labeled Remeron (used to help with sleep) 30 milligrams 1 tablet every night at bedtime last filled on 10/28/16, and there were 7 pills left in the packet.<br>-There was a pack of medication labeled Simvastatin (used to lower cholesterol) 20 milligrams 1 tablet every night at bedtime last filled on 11/04/16, and there were 4 pills left in the packet.<br>-There was a pack of medication labeled Omeprazole (used to treat acid reflux) 20 milligrams 1 capsule daily last filled on 11/14/16, and there were 2 pills left in the packet.<br>-There was a pack of medication labeled Potassium Chloride (used as a supplement replacement) 20 milliequivilents 1 tablet daily with food last filled on 11/25/16, and there were 17 pills left in the packet.<br>-There was a bottle of medication labeled Bactrim DS (used to treat infections) 800-160 milligrams 1 tablet twice per day last filled on 11/21/16, and there were 2 pills left in the bottle.<br>-There was a pack of medication labeled Gabapentin 100 milligrams 1 capsule every night at bedtime last filled on 02/27/17, and there were 29 capsules left in the packet.<br>-There was a bottle of medication labeled Compazine (used to treat nausea and vomiting) 10 milligrams 1 tablet every 6 hours as needed for nausea and vomiting last filled on 12/29/16, | D 376 | | |

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| D 376 | Continued From page 34<br>and there were 50 pills left in the bottle.<br><br>Interview with Resident #1 on 8/04/17 at 8:22 AM revealed:<br>-He had been taking his medications since he had been at the facility.<br>-None of the staff had come in and attempted to teach him about his medications.<br>-His doctor told him it was ok to take his medications himself.<br>-He picked up his medications from the clinic where he was seen by the doctor.<br>-He could not remember when he last picked up medications from the clinic; it was probably the last time he went to see his doctor.<br><br>Review of Resident #1's Medication Administration Record (MAR) for May, June, and July 2017 revealed:<br>-Every Tuesday of the month the staff had been documenting an assessment was done to see if Resident #1 had his medications in his room.<br>-On May 2, May 9, May 16, May 23, and May 30, 2017 the staff had documented that they checked Resident #1's medications and they were in his room.<br>-On June 6 and June 20, 2017 the staff documented that they had checked Resident #1's medications and they were in his room.<br>-On June 13 and June 27, 2017 the staff documented that Resident #1 refused to allow them to check his medications.<br>-On July 4, July 11, July 18, and July 25, 2017 the staff documented that Resident #1 had all medications and they were in his room.<br><br>Interview with a Medication Aide on 08/04/17 at 12:45 PM revealed:<br>-She had checked Resident #1's medications before. | D 376 | | |

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|---|---|---|---|
| | HAL068024 | A. BUILDING: _____ B. WING _____ | 08/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CRESCENT GREEN OF CARRBORO | 624 JONES FERRY ROAD CARRBORO, NC 27510 |

| (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 |
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| D 376 | Continued From page 35<br>-When she checked his medications she only looked into his room to see if medications were in there.<br>-If medications were not in his room she would let the Resident Care Coordinator know and they would order them.<br>-Sometimes he would allow the staff to check them and other times he would refuse.<br>-She did not check the individual bottles to see if he was taking them or if he needed a refill.<br>-She had been told all she had to do was see if he had medications in his room.<br><br>Interview with a second Medication Aide on 08/07/17 at 11:16 AM revealed:<br>-The Medication Aides should be going through Resident #1's medications and seeing if he was taking them or needed a refill.<br>-He did not work on the hallway that Resident #1 lived on and he had never checked his medications.<br>-Resident #1 had his medications sent to the facility on an automatic refill but Resident #1 refused the medications every month.<br>-The medications were then sent back to the pharmacy for a credit.<br>-Resident #1 refused the medications because he did not want to pay for them.<br>-When he refused the Resident Care Coordinator was notified and he would call the physician.<br><br>Review of Resident #1's progress notes revealed:<br>-There was a progress noted dated 02/09/17 that the Resident Care Coordinator called the physician and notified her of Resident #1's non-compliance with allowing medication staff to assess medications and verify that he was taking them.<br>-There was a progress note dated 03/27/17 that the Resident Care Coordinator called the | D 376 | | |

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| D 376 | Continued From page 36<br>physician and notified her of the concerns with Resident #1's self-administration order and the physician was looking into better placement for Resident #1.<br>-There were no other progress notes regarding Resident #1 self-administering medications.<br><br>Telephone interview with the primary care physician on 08/04/17 at 11:20 AM revealed:<br>-She was not aware that Resident #1 had not been taking his medications as prescribed.<br>-She had not been made aware that he was refusing to allow the staff to check his medications.<br>-Resident #1 was competent enough to self-administer his medications.<br>-She did not find it to be a big deal that he was not taking his medications since he had the right to refuse and he was doing well.<br>-She was understanding that the facility provided him with his medications from their pharmacy.<br>-The clinic did not fill medications and so he was not getting them from her clinic.<br>-She expected the facility to notify her if he was refusing getting medications or assistance with his medications.<br>-She would refer home health to come and evaluate him for his medications and do education with Resident #1.<br><br>Interview with the Resident Care Coordinator on 08/04/17 at 3:30 PM revealed:<br>-Resident #1 told the facility that he would obtain his own medication and refused to take any from the facility.<br>-There were some logs showing that medications were ordered for Resident #1 every month and sent back due to his refusals.<br>-He had notified the doctor on several occasions about his medication refusal and refusing | D 376 | | |

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| D 376 | Continued From page 37<br>assessments of his medications.<br>-He had documented all of the times he had notified the physician so the last date on the progress notes was the last time he notified them.<br>-After so many attempts to notify the doctor with no changes he decided to let the Administrator know and they should have been handling it from there.<br>The Home Health Nurse was to be teaching him about his medication and assessing his ability to take his medications.<br>-Resident #1 had home health several times since he had been at the facility but they kept discharging since he kept refusing.<br><br>Attempted interview with the Home Health Nurse on 08/04/17 at 4:30 PM revealed the nurse was not available for interview.<br><br>Review of the facility pharmacy logs revealed every month since Resident #1 had been admitted to the facility in December 2016, the facility had received a shipment of his current medications, but they had been returned to the pharmacy due to the resident refusing them.<br><br>Interview with the Administrator on 08/04/17 at 2:45 PM revealed:<br>-Resident #1 had refused to allow any of the staff to assist him with his medications or checking his medications.<br>-The facility got his medications every month but he did not want to pay for them so he would refuse them.<br>-The staff had tried on several occasions to notify the physician about him refusing the medications and his non-compliance with taking his medications.<br>-She had been to a physician visit with Resident #1 to speak with the physician and they would not | D 376 | | |

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| D 376 | Continued From page 38<br>see her or talk with her.<br>-The facility had a lot of trouble getting into contact or getting the physician to change any orders for Resident #1.<br>-Resident #1 told the staff he was getting his medications from the clinic.<br>-The staff were to check the resident's room every week to see if his medications were available, but Resident #1 would refuse.<br>-The staff should be going through Resident #1's medications to make sure they are all there and he was taking them.<br>-She would make sure to contact the doctor today to see if they could find placement in another facility for Resident #1 since he was refusing care at this facility. | D 376 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to assure resident received care and services which are adequate related to physical environment, other requirements, personal care and other staffing, and personal care and supervision.<br><br>The findings are:<br><br>1. Based on observations and interviews, the | D912 | The Administrator or designee shall ensure that all Resident Rights are being upheld to ensure quality care | 8/8/17 |

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| D912 | Continued From page 39<br><br>facility failed to assure all exit door alarms were maintained in operational conditions and activated with a sounding device when opened, which resulted in 1 of 7 sampled residents (#4), who was disoriented, exited the building without staff knowledge and made it to the highway in front of the facility before staff got to her. [Refer to Tag 0067, 10A NCAC 13F .0305 (h)(4) (Type B Violation)]<br><br>2. Based on observations, interviews, and record reviews the facility failed to assure that an operational call light system was in place for residents who were non ambulatory or needing assistance with assistive devices for 2 of 2 sampled resident's (Resident #1 and Resident #2). [Refer to Tag 0118, 10A NCAC 13F .0311 (i) (Type B Violation)].<br><br>3.Based on observations, interviews and record reviews, the facility failed to assure there was adequate staff on third shift for 4 of 4 shifts on 07/28/2017-07/31/ 2017. [Refer to Tag 0202, 10A NCAC 13F .0604(e)(1)(C) Personal Care and Other Staffing.(Type B Violation)]<br><br>4. Based on observations, interviews and record reviews the facility failed to provide supervision for 1 of 7 sampled residents with a diagnosis of Dementia (#4) who eloped from the facility. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation.)] | D912 | | |