STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	HAL008041	A. BUILDING _____ B. WING _____	R-C 08/03/2017

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WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

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)	COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted a follow-up survey and a compliant investigation on July 31 2017-August 3, 2017	D 000		
D 176	10A NCAC 13F 0601 (a) Management Of Facilities 10A NCAC 13F 0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter The co-administrator when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter The term administrator also refers to co-administrator where it is used in this Subchapter This Rule is not met as evidenced by. TYPE A1 VIOLATION Based on 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 health care and resident rights. The findings are Noncompliance identified during the survey	D 176		

POC approved per addendum
10/3/17
DDRagers

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D 176	Continued From page 1 included Interview with the Administrator on 8/2/17 at 4 10pm revealed -She usually came to check the facility about once a month for the last 4-5 months because she had other facilities to run -She had been at the facility every day since 7/10/17 when she hired a new manager. 1 Based on observations, record reviews, and interviews the facility failed to meet the health care needs for 5 of 7 sampled residents (#1, #2, #3, #4, #7) by failing to coordinate a mental health referrals for a resident (#7) with a documented history of physical aggressiveness; a resident (#1) with a bipolar disorder diagnosis who displayed mood swings; and 3 other residents (#2 #3, #4) who displayed erratic behaviors [Refer to Tag D 273, 10A NCAC 13F 0902(b) Health Care (Type A1 Violation)] 2 Based on interviews and record review, the facility failed to assure 3 of 7 sampled resident (#3, #4 and #9) were protected from assault by Resident #7 [Refer to Tag D 358, 10A NCAC 13F .0909 Resident Rights (Type B Violation)] The Administrator failed to assure the management, operations, and polices of the facility were implemented including implementation of residents' rights The facility failed to provide the services necessary to maintain the mental health wellbeing for 5 of 7 sampled residents (#1, #2, #3, #4 #7), by not referring the residents for mental health services The Administrator failed to assure appropriate care and services were provided by the failure to maintain substantial compliance with rules and statutes related to health care and residents'	D 176		

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D 176	Continued From page 2 rights which is the responsibility of the Administrator The failure of the Administrator to implement rule and regulations in substantial risk of serious neglect and physical harm for all residents, which constitutes a Type A1 Violation _____ A plan of protection was requested by this office CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 2, 2017.	D 176	The facility has and did provide a plan of protection. The facility has been providing follow-up appts and an escort as one could be assigned for resident as need. Interdisciplinary team will initiate and Administration to follow up weekly. 9/29/17	
D 273	10A NCAC 13F 0902(b) Health Care 10A NCAC 13F 0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 5 of 7 sampled residents (#1, #2, #3, #4, #7) by failing to coordinate a mental health referrals for a resident (#7) with a documented history of physical aggressiveness, a resident (#1) with a bipolar disorder diagnosis who displayed mood swings, and 3 other residents (#2, #3, #4) who displayed erratic behaviors The findings are	D 273	The facility has assured proper training has provided to show how the difficult issues the best way to handle and help Residents cope with each other - 9/29/17	

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A0 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 3	D 273	The facility has reached 9/16/17 out for outside resources in the attempt to have other assistance with helping with Resident with difficult issues such as behavioral issues. The facility will assure that each resident will receive the care that they need Mental Health providers and or medical providers. The will include but not limited to Crisis Mobile Assistance in time of Behavioral Crisis.	

1 Review of Resident #7's current FL-2 dated 1/25/17 revealed:
-Diagnoses included anxiety, depression, chronic obstructive pulmonary disease, diabetes, hypertension, anemia, and gastroesophageal reflux disease
-Resident #7 was intermittently disoriented.
-The resident was semi-ambulatory and had a wheelchair
-Medications included Seroquel 100mg once daily at bedtime and Zoloft 100mg - 1 and ½ tablets once daily (Seroquel is a medication used to treat depression and Zoloft is a medication used to treat depression and anxiety)

Review of Resident #7's Resident Register revealed an admission date of 1/25/17.

Review of Resident #7's care plan dated 1/25/17 revealed
There was no assessment of Resident #7's mental health or social history.
-Resident #7 had limited range of motion.
-Resident #7 required limited assistance with bathing, grooming, dressing, transferring, ambulating, and toileting.
-Resident #7 required supervision with eating.

Review of an emergency room encounter for Resident #7 dated 1/18/17 revealed:
-Resident #7 had been physically aggressive toward staff and other residents at another assisted living facility.
-Resident #7 had swung and/or hit staff/residents while living at the other assisted living facility.
-Resident #7 was considered a safety risk to the residents and staff
-He was involved in a physical altercation at the facility that resulted in criminal charges being filed against Resident #7(Date and time of physical

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altercation were not specified)
-He was discharged from the facility after the criminal charges were filed and his family refused to pick Resident #7 up from the hospital.
-Resident #7 resided in a behavioral center from 1/18/17 until he was placed in this facility on 1/25/17.

Review of Resident #7's level of care screening tool dated 1/25/17 revealed Resident #7 was dangerous to self, others, and property.

Review of nurse's notes for Resident #7 revealed
-Resident #7 was arguing with another resident on 6/13/17 during the 7am-3pm shift.
-Resident #7 was arguing with another resident over cigarettes and tried to break (push his way) into the same resident's room on 6/28/17 during the 3pm-11pm shift.
-Resident #7 was in a fight with another resident on 7/1/17 during the 7am-3pm shift.
-Resident #7 groped a female resident on 7/1/17 during the 3pm-11pm shift.
-Resident #7 was arguing with a female resident and staff had to diffuse the argument on 7/2/17 during the 3pm-11pm shift.
-Resident #7 struck another resident in the back with a rock on 7/7/17 during the 3pm-11pm shift and the police were called.
-He wanted to fight another resident on 7/7/17 during the 11pm-7am shift.
-Resident #7 kicked and hit another resident on 7/19/17 during the 3pm-11pm shift and the police were called.
-Resident #7 kicked and hit the same resident again on 7/20/17 during the 7am-3pm shift.
-There was no documentation of any behavioral interventions or that staff attempted to make any mental health referrals for Resident #7's aggressive behaviors.

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Review of facility's incident reports for Resident #7 revealed:
-Resident #7 hit and kicked another resident on 7/19/17 at 9:40pm
-Resident #7 was communicating threats and kicked the same resident on 7/20/17 at 9:00am
-There were no other incident reports documenting behaviors exhibited by Resident #7 prior to 7/19/17

Review of police dispatch records revealed
-The police were called on 5/16/17 by two residents at the facility who reported that Resident #7 had physically assaulted them
-The police were called by a resident on 7/7/17 for a complaint that Resident #7 had hit him with a rock
-The police were called on 7/19/17 by an unnamed person for a complaint that Resident #7 had hit a female resident at the facility

Observation of Resident #7 on 7/31/17 at 11:30am revealed:
-Resident #7 was sitting in his wheelchair smoking on the front porch of the facility with 2 other residents
-Resident #7 stared out into the street in front of the facility.
-He did not interact with the other residents who were on the front porch.
-He did speak appropriately when the other residents spoke to him.

Observation of Resident #7 on 8/1/17 at 11:00am revealed:
-Resident #7 was lying on his bed with his eyes closed in his room
-Resident #7 was the only resident that resided in this room.

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-Resident #7's wheelchair was adjacent to the left side of his bed

Interview with Resident #7 on 8/1/17 at 11:00am revealed:
-He denied physically assaulting or communicating verbal threats to any residents or staff at the facility.
-He did recall arguing with another resident over money and he threatened to hurt the resident.
-The police were called for that incident but the other resident got in trouble with the police.
-The resident whom Resident #7 threatened no longer resided at the facility.
-He denied throwing a rock at a resident or groping a female resident.
-He could not remember having any type of confrontation with a female resident on 7/19/17 or 7/20/17.
-He could not remember if any residents or staff had called the police due to him being aggressive on 7/19/17 or 7/20/17.
-He was not sure if he had a mental health provider of if he was seen by a mental health provider since he had been admitted to the facility.

Telephone interview with a family member of Resident #7 on 08/02/17 at 10:08am revealed:
-He usually came to visit Resident #7 about twice a month at the facility.
-Resident #7 could be physically and verbally aggressive at times.
-Resident #7 had been discharged from his last facility because he was physically aggressive with staff and residents.
-Resident #7 had to stay in a behavioral center until placement was found at this facility.
-Resident #7 told him about getting into a physical altercation with another resident at the facility.

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about a month after he was admitted
-He could not remember the details that Resident #7 told him about that physical altercation
-He did not know about any other episodes of aggressiveness exhibited by Resident #7 since he was admitted at the facility.
-No staff had called him and reported any aggressive behaviors by Resident #7
-He did not know if Resident #7 had being seen by a mental health provider since he was admitted to the facility
-Resident #7 did have mental health services at the previous assisted living facility

Interview with a personal care aide (PCA) on 8/2/17 at 3:14pm revealed:
-Resident #7 had an anger problem.
-Resident #7 liked to yell and hit other residents when he got mad.
-"If another resident yells or acts out, Resident #7 would just go up to that resident and hit them".
-Resident #7 had gotten into a fight with another resident over a lighter and again over money.
-She was unable to specify when any of these incidents occurred and the other resident no longer lived at the facility
-Resident #7 had hit and kicked a female resident one night last week because the female resident was pacing back and forth
-Resident #7 laughed at the female resident because the police were called and nothing was done
-Resident #7 had hit and kicked the same female resident again the next day and nothing was done regarding Resident #7's physical assaulting the female resident
-The manager and the Administrator were both aware of what Resident #7 had done to the female resident.
-She could not specify what days these incidents

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occurred last week

Interview with a second personal care aide (PCA) on 8/3/17 at 8:40am revealed:
-Resident #7 fussed a lot with other residents and "he was quick to hit other residents when he got mad"
-Resident #7 was very argumentative with other residents
-Resident #7 tried to intimidate other residents by rolling up on them too close in his wheelchair when he got mad
-Staff had to intervene several times to keep Resident #7 from getting into fights with other residents but she was not able to specify how many times this occurred
-She had witnessed Resident #7 hit another resident during an argument a couple of months ago
-Resident #7 had picked up a wet floor sign and threatened to throw it at another resident when he got angry with that resident about 3 months ago.
-She had to call the manager because he was so aggressive during that incident.
-The manager told her to take Resident #7 outside to smoke and he calmed down after that
-Staff had reported Resident #7's aggressive behaviors to the previous manager several times
-The previous manager had told the staff to keep other residents out of Resident #7's way and to try to talk softly to the resident
-Resident #7's aggressiveness "had not been a real problem since the new manager took over in 7/10/17"
-Resident #7 had cursed and hit another resident about a week ago and the police were called.
-The new manager knew about this incident but no interventions had been given to any staff
She did not know if Resident #7 was receiving mental health services but he acted like he

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needed some help to deal with his aggressiveness.

Interview with the manager on 8/2/17 at 3 30pm revealed.
-She started working at the facility on 7/10/17
-She was trying to review all of the residents' charts but she had not reviewed all of them yet
-She was not aware that Resident #7 had a history of aggressive behaviors.
-The incident on 7/19/17 was the first time that she knew anything about Resident #7 being physically aggressive.
-Staff called her on 7/19/17 when Resident #7 had a physically assaulted a female resident and the police were called
-She told the staff on 7/19/17 to keep Resident #7 away from the other residents and to keep check on Resident #7
-The police came out on 7/19/17 but the police did not take Resident #7 out of the facility
-Staff did not report any other problems regarding Resident #7 on 7/19/17
-Resident #7 did hit and communicated threats to the same female resident on the morning of
-Resident #7 was really mad but staff was able to get him to calm down
-She did not know what might have triggered Resident #7 to hit the female resident on 7/19/17 or 7/20/17
-Resident #7's mental health provider was his primary care provider (PCP)
-She was not sure if the PCP had been notified of Resident #7's behaviors on 7/19/17 or 7/20/17

Interview with the Administrator on 8/2/17 at 4 10pm revealed.
-She usually came to check the facility about once a month for the last 4-5 months because

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she had other facilities to run
-She had been at the facility every day since 7/10/17 when she hired a new manager.
-All potential admissions are screened by their corporate marketing manager and she usually reviewed the FL-2 and other paperwork with the marketing manager to see if the facility can meet the needs of the resident.
-She could not recall reviewing any history on Resident #7 prior to his admission to the facility
-She was not aware that Resident #7 had a previous history of being aggressive prior to his admission.
She was not aware of the documentation from 1/18/17 of Resident #7's aggressive behaviors on the emergency room encounter form.
-She had prepared Resident #7's care plan dated 1/25/17 but she did not know why his mental health history was not assessed.
-She was not aware Resident #7 had been aggressive at the facility so many times since he was admitted because the previous manager did not report it to her
-She knew that Resident #7 had gotten into an argument with another resident over some money and Resident #7 had thrown a rock and hit the resident in the back
-Criminal charges had been filed against Resident #7 for hitting the resident with the rock and he had to go to court for it.
-She wasn't aware of any other incidents except when Resident #7 got into a fight with a female resident and hit her one morning last week.
-Staff had to separate Resident #7 and the female resident because they kept arguing back and forth.
-Resident #7 was really upset and hard to calm down so the Administrator texted Resident #7's PCP on 7/20/17 for an order for Haldol
-The new order for Haldol was not received until

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7/26/17
-She did not know of any other episodes of Resident #7 hitting another residents since 7/26/17
-Once a resident is admitted to the facility, it was a responsibility of the manager to coordinate any services a resident needs
-The previous manager had not reported to her that Resident #7 had been aggressive with the other residents before.
-She did not know why the previous manager had not referred Resident #7 for mental health services.
-If she had known, she would have tried to get Resident #7 some mental health services but she wasn't sure what mental health providers were available in the area
-She would contact the PCP for a mental health referral for Resident #7
-The PCP was not expected to provide mental health services for Resident #7
-She planned to train staff on how to identify residents who may need mental health services
-She would update Resident #7's care plan to reflect his mental health needs
-She was going to be speak with her marketing team about screening potential new admissions to identify if any mental health services were needed prior to their admission

Review of physician's orders dated 7/26/17 revealed there was a written order for Haldol 5mg twice daily and Ativan 1mg every 4 hours as needed for anxiety (Haldol is an antipsychotic drug used to treat acute psychosis and Ativan is a medication used to treat anxiety)

Interview with the Administrator on 8/3/17 at 5:00pm revealed:
-She had to intervene when Resident #7 got into

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a fight with a female resident on the morning of 7/20/17
-She did not know that Resident #7 had hit and kicked the same female resident on the night before
-The manager, nor any of the staff, reported to her that Resident #7 had been in a fight with the same female resident on 7/19/17
-She had contacted Resident #7's PCP to get a mental health referral on 8/3/17
-A training had be scheduled for all staff on 8/4/17 at 2:00pm on crisis intervention.

Telephone interview with Resident #7's primary care provider (PCP) on 8/3/17 at 2:15pm revealed
-She was the PCP for Resident #7 and she did not provide any type of mental health services for any of the residents at the facility
-The facility was responsible to arrange for any mental health services that the residents needed.
-She was not aware that Resident #7 had exhibited any type of aggressive behaviors prior to 7/20/17
-She last saw Resident #7 on 7/26/17 and wrote the orders for the Ativan and Haldol to help with his aggressiveness.
-The facility did not request a mental health referral for Resident #7 until 8/3/17.

2. Review of Resident #1's current FL-2 dated 5/2/17 revealed:
-Diagnoses included bipolar disorder, anxiety disorder, moderate intellectual disability, intestinal fistula, gastroesophageal reflux disease, and spinal pine
-Resident #1 was ambulatory
-Medications included Seroquel 100mg twice daily, Buspar 15mg twice daily, and Klonopin [illegible] tablets as needed for anxiety

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(Seroquel is a medication used to treat depression. Buspar and Klonopin are medications used to treat anxiety)

Review of Resident #1's Resident Register revealed an admission date of 5/1/17

Review of Resident #1's care plan dated 7/18/17 revealed:
-There was no assessment of Resident #1's mental health or social history
-Resident #1 required supervision with eating
-Resident #1 was independent with bathing, grooming, dressing, transferring, ambulating, and toileting

Review of nurse's notes for Resident #1 revealed
-Resident #1 got into a fight with her roommate at the facility on 7/30/17 on the 3pm-11pm shift
-There was no documentation of any behavioral interventions or that staff attempted to make any mental health referrals for Resident #1

Observation of Resident #1 on 8/1/17 at 12:20pm revealed:
-Resident #1 was pacing back and forth in the hallway with both hands clenched in fists
-Resident #1 appeared to be mumbling to herself
-Resident #1 would not speak to staff when they approached her and walked away from them
-She stared at staff and residents when they walked down the hallway

Attempted interview with Resident #1 on 8/1/17 at 12:25pm was unsuccessful because Resident #1 refused to talk

Interview with a personal care aide (PCA) on 8/1/17 at 12:30pm revealed:
-Resident #1 had a lot of mood swings

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-Resident #1 would just pace around in the facility for no reason sometimes
-Resident #1 may be sitting happy and talking to herself and then the resident would be crying for no reason
-Most of the time Resident #1's crying spells were because she had done something wrong (broken facility rules) at the facility and got into trouble
-Staff just monitored Resident #1 to make sure the resident was okay but she could not specify how often Resident #1 was checked
-She did not know if Resident #1 was receiving mental health services but she believed Resident #1 needed some type help

Observation of Resident #1 on 8/1/17 at 4:35pm revealed:
-Resident #1 was sitting in the main sitting room of the facility.
-Resident #1 was crying and Resident #1 asked to speak with the Administrator when the Administrator walked by her.
-Resident #1 and the Administrator went outside to talk on the side porch area
-Resident #1 was still crying as she talked with the Administrator outside

Telephone interview with a county social worker for Resident #1 on 8/1/17 at 11:00am revealed:
-She was appointed as the responsible person for Resident #1
-Resident #1 was admitted to the facility on 5/1/17
-Resident #1 was always getting into trouble and was very argumentative.
-Resident #1 did not believe any rules should apply to her whether she was in the facility or in the community
-Resident #1 was incarcerated from 5/27/17 through 6/7/17 for prostitution, possession of marijuana, and breaking and entering

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D 273	Continued From page 15 -The resident acted out while she was incarcerated by not following jail rules and getting into fights with other inmates -Resident #1 would not take responsibility for her actions and then would have crying episodes when she was confronted about her behaviors -Resident #1 was supposed to be receiving mental health services provided through the facility. -She was not sure if Resident #1's mental health services were being provided in-house at the facility or from an outside provider -She was not sure what mental health provider the facility had for Resident #1 or when Resident #1 was last seen by a mental health provider Interview with a PCA on 8/3/17 at 8:40am revealed: -Resident #1 had a bad attitude and did not get along with too many people at the facility. -Resident #1 walked around like she was mad at everybody every day. -Resident #1 did not like to follow the rules at the facility and would cry if she was confronted for breaking the rules -Resident #1 had been caught in an abandoned building having sex with a man about 2 months ago -She had accused her roommate several times of stealing deodorant and other personal hygiene items -Resident #1 can be "fire mad" with her roommate in one minute and then act like she is her best friend in the next minute. -"You just have to watch her mood swings." Interview with the manager on 8/1/17 at 12:50pm revealed: -Resident #1 was receiving mental health services through her primary care provider (PCP)	D 273		

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-She was the new manager at the facility and staff had not reported any problems with Resident #1's mood swings to her
-She did not know why the previous manager had not reviewed Resident #1's mental health or social history on Resident #1's care plan but it should have been done
-She had started working at the facility on 7/10/17 and she was still reviewing the residents' charts

Interview with the manager on 8/2/17 at 3 30pm revealed:
-Resident #1 was not receiving mental health services through her PCP.
-She was setting up mental health services for Resident #1 but had not gotten an appointment yet.
-She did notice Resident #1 was crying a lot yesterday afternoon but she was not sure why

Interview with the Administrator on 8/2/17 at 4 10pm revealed:
-She did not know why Resident #1 had not received any mental health services while at the facility.
-The previous manager should have set up mental health services for Resident #1 when she was admitted
-The current manager was working on getting mental health services set up for Resident #1.
-The PCP was not the mental health provider for Resident #1
-Resident #1 "did have a lot of mood swings but mostly when she could not get her a way with staff"
-Resident #1 had gotten upset on the afternoon of 8/1/17 because her social worker called to tell Resident #1 that she was being transferred to another facility

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Second attempted interview with Resident #1 on 8/3/17 at 12:05pm was unsuccessful because the resident declined to be interviewed

Telephone interview with a county social worker for Resident #1 on 8/3/17 at 2:45pm revealed
-She did not know Resident #1 had not received any mental health services since she was admitted to the facility.
-It was the facility's responsibility to coordinate mental health services for Resident #1 and they should have contacted her if the facility was unable to do so

Telephone interview with Resident #1's primary care provider (PCP) on 8/3/17 at 2:15pm revealed.
-She was the PCP for Resident #1 and she did not provide any type of mental health services for any of the residents at the facility.
-The facility was responsible for arranging for any mental health services that the residents needed
-Resident #1 should have been referred for mental health services due to her bipolar diagnoses.
-She could not remember if the facility had reported any problems with mood swings for Resident #1
-The facility did request a mental health referral for Resident #1 on 8/3/17

3. Review of Resident #2's current FL-2 dated 2/2/17 revealed diagnoses included schizophrenia, tobacco use disorder, hyperlipidemia, hypertension, type II diabetes mellitus

Review of the nurse's notes for Resident #2 revealed
-On 7/26/17 (3-11 shift), Resident #2 was walking

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back and forth and talking about killing people in their sleep. He is not acting like himself.
-On 7/27/17 (7-3 shift), Resident was threatening other residents and staff. He was walking around talking to himself.

Review of an incident report dated 7/27/17 at 1:00 p.m. revealed:
-"Resident #2 stated he was going to stab another resident with a fork.
-He stated he was going to kill staff.
-Resident then walked around talking to himself.
-Talking to "someone" who stole his identify. Stated he live [somewhere else] and they changed address on his ID.

Review of the nurse's notes revealed no documentation Resident #2's Primary Care Physician (PCP) had been contacted for a mental health referral.

Review of Resident #2's Resident Register revealed he was admitted on 1/27/14.
Interview with a personal care aide (PCA) on 8/2/17 at 5:55 p.m. revealed:
-Resident #2 started acting differently about 2-3 days before he was involuntarily committed on 7/27/17.
-He was usually quiet, but he had started yelling out for no reason.
-She noticed that Resident #2 stayed up all night when she worked.
-Resident #2 had started talking to himself too.
-He threatened to kill another resident, but she could not remember when.
-She did report to the current manager that Resident #2 had threatened the resident.
-The manager was supposed to make an appointment for Resident #2 to be evaluated for mental health.

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-She did not know if the mental health appointment was ever made for Resident #2
-The next day after she reported about Resident #2 making threats, Resident #2 was taken to the [illegible]

Interview with the manager on 8/2/17 at 3:30 p.m. revealed:
-Resident #2 had been acting differently the last couple of days he was in the facility.
-He had been pacing a lot during those days
-She was unsure of the date, and she would have to review Resident #2's chart.
-Staff had to monitor Resident #2 throughout the night on 7/26/17, but she was unable to specify what behaviors required monitoring
-She expected staff to monitor Resident #2 every 15 minutes for two hours, then check the resident every hour, and then every 2 hours if the resident experienced any type of mental crisis
-The staff did not document the checks on 7/26/17
-She had not contacted Resident #2's primary care physician for a mental health referral.
-Involuntary commitment papers were taken out on Resident #2 on 7/27/17

Interview with the Administrator on 8/2/17 at 4:10 p.m. revealed
-Resident #2 was usually a quiet man however his mood change during the last couple of days when he was in the facility
-He had started yelling out for no reason and making threats at other residents
-She was unable to specify when but she remembered during a meal time that Resident #2 had threatened to stab another resident
-When Resident #2 was outside sometimes, he jumped aggressively at other residents and yelled "Get back"

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-Resident #2 never hit anyone at the facility
-She talked with the manager and told the manager to have Resident #2 involuntarily committed but she did not specify when she talked with the manager
-She was not sure if Resident #2 was receiving mental health services or if he had been referred for mental health services when staff first noticed his mood changes.

Telephone interview with Resident #2's primary care provider (PCP) on 8/3/17 at 2:15 p.m. revealed:
-She was the PCP for Resident #2, and she was not his mental health provider
-The facility was responsible for arranging for any mental health services that the resident needed
-She last saw Resident #2 on 7/26/17, and he was agitated about some money
-Resident #2 was not a threat to staff, other residents or himself
-The staff had not reported that Resident #2 had any mood changes
-She would have assisted the facility with a mental health referral for Resident #2 if she had been notified

Refer to interview with the Administrator on 8/02/17 at 4:10 p.m.

4. Review of Resident #3's current FL-2 dated 7/10/17 revealed:
-Diagnoses included psychotic disorder due to traumatic brain injury (TBI), minor neurocognitive disorder due to TBI and seizure disorder

Review of Resident #3's resident office visit notes dated 4/20/17 revealed:
-Resident #3 was seen by his mental health provider on 4/20/17

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-Resident #3's next appointment was 08/21/2017, and it was made prior to resident's admission to the facility
-He was admitted to the facility on 4/21/17

Review of the nurse's notes for Resident #3 revealed
On 6/19/17 (3-11 shift no time), Resident #3 kicked the front door 5-6 times, and the manager was notified
-On 7/1/17 (7-3 shift no time), Resident #3 started a fight with another resident
-On 7/2/17 (3-11 shift no time), staff smell "weed" in Resident #3's room, but he denied smoking in his room
-On 7/5/17 (3-11 shift no time), Resident #3 got mad because there was no snack. He got mad because it was time for him to get off the phone. He threw his tablet down and broke it. He kicked and hit the office door, and then ran down the street

Interview with a personal care aide (PCA) on 8/2/17 at 5:55 p.m. revealed:
-Resident #3 had been yelling and "going off" in the facility since a few days after he was admitted.
-Staff had to call his guardian about every other day because of his behaviors
-She was not sure if Resident #3 was getting any type of mental health services because he had only been at the facility for maybe a month

Telephone interview with Resident #3's guardian on 8/03/17 at 12:34 p.m. revealed
-Resident #3 had more freedom, and he was bringing back illegal drugs to the facility
-Resident #3 stated he had not been to a mental health provider after his admission to the facility
-On 7/12/17, the guardian transferred Resident

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D 273	Continued From page 22 #3 to a more structured facility. Interview with the manager on 8/2/17 at 3 30 p m revealed. -She was aware of Resident #3's anger issues -She expected staff to monitor Resident #3 every 15 minutes for two hours, then check the resident every hour, and then every 2 hours if the resident experienced any type of mental crisis -Her expectations of how often staff should monitor the resident who was in a mental crisis may change depending on the resident. -The staff did not document the checks -Resident #3 had not been seen by his mental health provider since his admission to the facility. -Resident #3 was discharged to another facility on 7/12/17 Interview with the Administrator on 8/2/17 at 4 10 p m revealed -Resident #3 was involved in two altercations in the facility that she knew about -Resident #3 was hit in the back with a rock by another resident when they were arguing over money on 7/7/17 -The second incident involved Resident #3 spending another resident's money who had sent him to the store -She could not recall when this happened. -She thought "his change in behaviors may have been related to illegal drug use". -She was not sure if Resident #3 was receiving mental health services Telephone interview with Resident #3's primary care provider (PCP) on 8/3/17 at 2.15 p m revealed. -She was the PCP for Resident #3, and she did not provide mental health services for Resident #3	D 273		

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D 273	Continued From page 23 -The facility was responsible for arranging for any mental health services that the resident needed -She last saw Resident #3 in May 2017, and he had a diagnosis of traumatic brain injury. -She knew Resident #3 had anger issues, however no mental health problems had been reported to her Refer to interview with the Administrator on 8/02/17 at 4:10 p.m 5. Review of Resident #4's current FL-2 dated 1/5/17 revealed -Diagnoses included schizophrenia paranoid type, hypertension, anemia, and diabetes mellitus Review of Resident #4's care plan dated 4/13/17 revealed Resident #4 had a mental health provider Review of the mental health notes for Resident #4 revealed: -On 7/07/17, Resident #4 was loud and delusional. She stated, "She was working, and the she wanted the judge to call me" Staff reported Resident #3 had been refusing her medications for 2 months. Risperdal Contra injection was given on 7/07/17 -On 7/17/17, Resident #4 was seen by the mental health provider and given Risperdal Contra injection Review of a facility incident report dated 7/19/17 revealed -At 3:00 a.m., Resident #4 was going off when staff came on at 11:00 p.m -Resident #4 was cursing and kept walking back and forth. -She threatened staff and two other residents and made unspecified racist comments	D 273		

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-Resident #4 kept going outside and staff had to call law enforcement 2-3 times.
-Resident #4 left the facility between 2:00 a.m.-3:00 a.m. while law enforcement was at the facility.
-The law enforcement officer told staff he could not make Resident #4 stay at the facility, and he left.
-Staff contacted the manager around 5:00 a.m.
-Resident #4 returned to the facility around 9:45 a.m. and she was involuntarily committed.

Review of the nurse's notes for Resident #4 revealed:
-On 7/19/17 (3-11 shift) no time, [Resident #4] refused to eat and take medications. Resident #4 was hit and kicked by Resident #7.
-On 7/20/17 (7-3 shift), [Resident #4] was out of the facility this a.m. Police brought resident back to the facility. She was not herself and she was transported to the hospital.

Interview with a personal care aide (PCA) on 8/2/17 at 3:14 p.m. revealed:
-Resident #4's mental status would have been better if the resident would have taken her medications from her medical provider.
-Resident refused to take her other medications because she did not want to pay for them.
-Resident #4 was always acting out.
-She had to go pick up Resident #4 at least 4 times from a local fast food restaurant because Resident #4 was scaring the customers by yelling out and pacing around the restaurant.
-She did not remembered the dates.
-Resident #4 was pacing a lot one night last week in the front sitting room when she was hit and kicked by another resident.
-Resident #4 was yelling and screaming that she was "going to call her son".

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-The manager was called but the manager did not do anything except say keep the residents apart
-The police were called and Resident #4 wanted to press charges against the other resident but staff did not have permission to use the facility van to take Resident #4 to the magistrate's office
-Resident #4 was hit and kicked again by the same resident the next day and Resident #4 went off again.
-Resident #4 was involuntarily committed when she would not calm down after the second incident

Interview with a personal care aide (PCA) on 8/2/17 at 5:55 p.m. revealed
-Resident #4 refused to take any of her medications at the facility.
-She would only take the injection that was administered at her mental health provider
-Resident #4 "acted crazy, and she paced around a lot"
-Resident #4 had threatened to kill PCA and 2 other residents a couple of weeks ago but she could not specify when that happened.
-She had reported Resident #4's behavior to the previous and current manager several times but nothing was ever done
-She believed Resident #4 "would have been better if she would have taken her medications
-She did not know anything about how Resident #4 ended up being involuntarily committed except the police were called to the facility 3 times because of Resident #4's behaviors last week

Interview with the manager on 8/2/17 at 3:30 p.m. revealed:
-Resident #4 did receive mental health services through an outside provider
-Resident #4 refused all of her medications at the

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	HAL008041	A. BUILDING _____ B. WING _____	R-C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 26	D 273		

facility and would only take the injections given by her mental health provider
-She remembered that staff had called on the evening of 7/19/17 because Resident #4 had been hit by another resident and Resident #4 was going off
-She could not specify what time staff called her but she told the staff to keep Resident #4 and the other resident away from the other residents
-If the situation got any worse, she instructed the staff to call her back
-Staff called her again in the early morning of 7/20/17 and told her that Resident #4 was walking and cursing and kept walking in and out the facility
-Staff informed her the police had come out to the facility but the police could not get Resident #4 to return back to the facility
-The police told the staff that the police could not make the resident come back to the facility if the resident did not want to return
-Resident #4 refused to return to the facility and the police left.
-She could not remember if staff had reported Resident #4 had threatened to kill other residents or staff
-She was not aware that Resident #4 had requested to press criminal charges against another resident on 7/19/17
-She would have given staff permission to take the resident to the magistrate's office if she had known
-Resident #4 was hit and kicked again by the same resident from the evening of 7/20/17.
-She could not recall if Resident #4's mental health provider was notified prior to the facility taking out the involuntary commitment papers

Review of the nurse's notes for Resident #4 revealed no documentation the mental health

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	HAL008041	A. BUILDING _____ B. WING _____	R-C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

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D 273	Continued From page 27	D 273		

provider had been notified prior to taking out the involuntary commitment papers

Resident #4's responsible person could not be reached for a telephone interview on 8/03/17 at 10:30 a.m.

Interview with the Administrator on 8/2/17 at 4:10 p.m. revealed:
-She was not sure if Resident #4 received mental health services, but she would check with manager
-She was not aware that Resident #4 had been hit and kicked by a resident on 7/19/17
-She only knew about the incident on 7/20/17 when a male resident hit Resident #4 and staff had to separate them from arguing back and forth.
-Resident #4 was screaming and yelling and staff could not get her to calm down
-She could understand now why Resident #4 was so upset on 7/20/17 since she had been hit by the same male resident on 7/19/17
-She told the manager to take out involuntary commitment papers on Resident #4 when staff could not get her to calm down

Telephone interview with Resident #4's primary care provider (PCP) on 8/3/17 at 2:15 p.m. revealed:
-She was the PCP for Resident #4 but not her mental health provider
-She last saw Resident #4 on 3/29/17
-Resident #4 had a problem with hallucinations and frequently talked to herself
-Resident #4 received her mental health services from a mental health provider
-She knew Resident #4 refused all of her medications except the injections she received at her mental health provider

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	HAL008041	A. BUILDING _____ B. WING _____	R-C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 28 -She had encouraged Resident #4 to take her medications but the resident still refused them Refer to interview with the Administrator on 8/02/17 at 4:10 p.m. --- Interview with the Administrator on 8/2/17 at 4:10 p.m. revealed: -Most of the residents in the facility had some type of mental illness -Sometimes it was hard for staff to deal with all of the different personalities -She expected that if a resident was in crisis for the staff to try to calm them down and keep them away from the other residents in the facility -She would prefer if the staff called the manager before they called the police if a resident was in crisis and then call her -She had a form that she used at her other facility that helped to identify those residents who may be in mental crisis. -She would have an in-service to train the staff at the facility how to use this form to identify residents who are in crisis -She would have to talk with her marketing manager too about how to identify residents who are at risk for mental health crisis prior to their admission --- The facility failed to provide the services necessary to maintain the mental health wellbeing for 5 of 7 sampled residents (#1, #2, #3, #4, #7) by not referring the residents for mental health services. The facility failed to refer Resident #4, who refused her daily psychotropic medications for 60 days, resulting in the resident being involuntarily committed, Resident #7, who had a history physical aggression, resulting in the	D 273		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

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resident physically assaulting 3 other residents. Resident #1, who had a bipolar disorder that went unmanaged resulting in mood swings and periods of crying. Resident #2 who had a threatening behaviors towards others, resulting in the resident being involuntarily committed; Resident #3 who had an anger issue toward others, resulting in resident being involuntarily committed. Three of the 5 residents receiving no mental health services were subsequently involuntarily committed. The facility's failure resulted in serious neglect and constitutes a Type A1 Violation

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Review of the facility's plan of protection dated 8/2/17 revealed:
-The facility with make contact with a mental health provider for the residents who needed services.
-The facility will until then work closely with their medical provider for services.
-A mental health assessment will be done to help identify residents needing assistance with mental health issues.
-Will contact the primary care provider for referrals for immediate mental health consults on 8/2/17.
-The facility with contract outside resources to come in to provide training to the staff by 8/3/17.
-The manager will go over the facility policy and procedure as review on steps in handling difficult situations by 8/4/17.
-The facility will focus on working more closely with the marketing manager in review of all information before placement by 8/2/17.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 2, 2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21 Declaration of Residents' Rights, are maintained and may be exercised without hindrance This Rule is not met as evidenced by TYPE B VIOLATION Based on interviews and record review, the facility failed to assure 3 of 7 sampled resident (#3, #4 and #9) were protected from assault by Resident #7 The findings are: 1. Review of Resident #9's current FL-2 dated 3/24/16 revealed -Diagnoses included diabetes mellitus - type II, hypertension, peripheral vascular disease, amputation below the knee and after surgical amputation encounter -He was semi-ambulatory Review of Resident #9's Resident Register revealed an admission date of 7/26/16 and that Resident #9 was his own responsible person. Review of Resident #9's care plan dated 7/26/17 revealed -Resident #9 used a wheelchair for mobility -Resident had limited vision and he was only able to see large objects -Resident #9 required limited assistance toileting, ambulation, dressing, and transferring	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

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D 338	Continued From page 31 -Resident #9 required extensive assistance with bathing and grooming. -Resident #9 required supervision with eating. Review of police dispatch records revealed Resident #9 called the police on 5/16/17 and reported that he had been physically assaulted by Resident #7. Review of nurse's notes for Resident #9 dated 5/16/17 revealed -Resident #9 was hit in his back, while he was eating by Resident #7. -Resident #9 called 911 and the police handled the incident. Interview with Resident #9 on 8/1/17 at 10:45am revealed -Resident #9 denied having being hit by Resident #7 or any other resident at the facility. -He did not remember calling the police for being hit by Resident #7 in May 2017. Interview with Resident #7 on 8/1/17 at 11:00am revealed. -He denied having any physical or verbally altercations with any residents or staff at the facility. -He could not remember hitting Resident #9. Interview with a personal care aide (PCA) on 8/2/17 at 3:14pm revealed -Resident #9 was hit by Resident #7 over an argument about a cigarette lighter and again over money. -She was unable to specify when any of these incidents occurred. -She was not sure if Resident #9 suffered any injuries from when he was hit by Resident #7. -Staff just tried to keep the two residents	D 338		

vision of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 32	D 338		

separated after the incidents
-The manager was aware of both incidents but she was not sure what the manager did to rectify the situation.

Interview with a second PCA on 8/3/17 at 8:40am revealed
-Resident #7 really did not like Resident #9
-She had witnessed Resident #9 and Resident #7 argue several times
-Resident #9 was hit by Resident #7 sometime during May 2017 but she could not remember the exact date
-Resident #9 called the police on Resident #7 during the May 2017 incident
-She was not sure if any charges were filed against Resident #7 for hitting Resident #9

Interview with the manager on 8/2/17 at 3:30pm revealed
-She started working at the facility on 7/10/17
-She could not comment on the May 2017 event since she was not working at the facility at that time
-The Administrator may have knowledge of the May 2017 incident between Resident #7 and Resident #9

Interview with the Administrator on 8/2/17 at 4:10pm revealed
-She was not aware of any reports that Resident #9 had been hit by Resident #7 in May 2017
-The previous manager had not reported the May 2017 incident to her or that the police had been called
-It was her expectation that the manager should have notified her especially since the police were involved
-It was a priority at the facility to make sure all residents at the facility were safe

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D 338	Continued From page 33 -She would talk with Resident #9 to further investigate the incident. 2. Review of Resident #4's current FL-2 dated 1/5/17 revealed diagnoses included schizophrenia paranoid type, hypertension, anemia, and diabetes mellitus. Interview with a personal care aide (PCA) on 8/2/17 at 3:14 p.m. revealed: -Resident #4 was pacing a lot one night last week -He [illegible] kicked by [Resident #7] -Resident #4 was yelling and screaming that she was "going to call her son" -The manager was called but the manager did not do anything except say keep the residents apart -The police were called and Resident #4 wanted to press charges against [Resident #7], but staff did not have permission to use the facility van to take Resident #4 to the magistrate's office -Resident #4 was hit and kicked again by [Resident #7] the next day Interview with the manager on 8/2/17 at 3:30 p.m. revealed: -She remembered that staff had called on the evening of 7/19/17 because Resident #4 had been hit by another resident and Resident #4 was going off. -She could not specify what time staff called her but she told the staff to keep Resident #4 and the other resident away from the other residents -If the situation got any worse, she instructed the staff to call her back -She was not aware that resident requested to press criminal charges against [Resident #7] on 7/19/17 -She would have given staff permission to take	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

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D 338	Continued From page 34	D 338		

[Resident #4] to the magistrate's office, if she had known
-Resident #4 was hit and kicked again by the same resident from the evening of 7/20/17
-She could not recall if Resident #4's mental health provider was notified prior to the facility taking out the involuntary commitment papers

Interview with the Administrator on 8/2/17 at 4 10 p m revealed
-She was not aware that Resident #4 had been hit and kicked by a resident on 7/19/17.
-She only knew about the incident on 7/20/17 when a male resident hit Resident #4 and staff had to separate them from arguing back and forth

3 Review of Resident #3's current FL-2 dated 7/10/17 revealed
-Diagnoses included psychotic disorder due to traumatic brain injury (TBI) minor neurocognitive disorder due to TBI and seizure disorder

Review of Resident #3's nurse's notes dated 7/7/17 (3-11 shift) revealed Resident #3 was struck in the back by [Resident #7] and the previous manager and police were called.

Interview with the current manager on 8/2/17 at 3 30 p m revealed
-She was not working at the facility on 7/7/17 when Resident #4 was hit in the back by Resident #7
-She started working at the facility on 7/10/17

Telephone interview with Resident #3's guardian on 8/03/17 at 12 34 p m revealed the guardian was unaware of Resident #3 being struck in the back by another resident

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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STON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

) ID FIX NG	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
338	Continued From page 35 Interview with the Administrator on 8/2/17 at 4:10 p.m. revealed: - Resident #3 was hit in the back with a rock by [Resident #7] when they were arguing over money on 7/7/17. -It was a priority at the facility to make sure all residents at the facility were safe. The facility failed to protect Residents #3, #4 and #9 from physical assault by Resident #7, who had a history of physical aggression and assaultive behaviors, resulting in emotional distress and physical harm of these 3 residents. The facility's noncompliance was detrimental to the health, safety and welfare of residents in the facility and constitutes a Type B Violation. Review of the facility's plan of protection dated 8/03/17 revealed: -Effective 8/03/17, if residents need to make a report of physical harm, they will be provided a means of transportation to do such a report. -Administrator and staff make sure every Resident Rights are follow. -Administrator and staff will treat residents with respect and dignity. -A plan staff in-service will be done by the Administrator on 8/4/17 to train staff on how to deal with difficult situations. -Staff will be retrained on Resident Rights by the Administrator on 8/4/17. -On 8/4/17, the administration will call the Ombudsman and asked her to schedule a Resident Rights in-service for Manager and staff. . DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2017.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that all residents were free of neglect related to Resident Rights. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 5 of 7 sampled residents (#1, #2, #3, #4, #7) by failing to coordinate a mental health referrals for a resident (#7) with a documented history of physical aggressiveness; a resident (#1) with a bipolar disorder diagnosis who displayed mood swings; and 3 other residents (#2, #3, #4) who displayed erratic behaviors. [Refer to Tag D 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on interviews and record review, the facility failed to assure 3 of 7 sampled resident (#3, #4 and #9) were protected from assault by Resident #7. [Refer to Tag D 358, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]	D914		

Kingston Gardens

10A NCAC 13F .1902(b) Health Care

The facility will assure that when residents are admitted into the facility, needing any type of health care needs such as any mental or special needs that the assigned physician or the family physician will be notified immediately - Effective August 4, 2017

The Administrator and the Administrator-in-Charge of Sister facility that is assisting the Manager / Administrator-in-charge of the facility will both work together to train her effective August 4, 2017 The facility will notify the physician ~~immediately~~ within 24 hours when a referral is needed for any new resident. Effective date August 4, 2017.

The Administrator in charge will follow up to assure that Appointments that comes in twice a week to Assist the Administrator-in-charge of the facility - The Administrator will then review follow-up weekly effective August 4, 2017

10/3/17 at 1:30 p.m
Telephone interview with the Administrator revealed physician would be contacted within 24 hrs
D. Dawson-Rogers

Resident Rights

10A NCAC 13F .1909 Resident Rights

The ~~facility~~ Admin-in-charge will assure that resident use property ~~facility~~ Admin-in-charge provided for and not violated in any way - The ~~facility~~ Admin-in-charge will assure that residents will get the same visit things need to receive at anytime necessary - The ~~facility~~ Admin-in-charge will assure that all staff that includes current staff and future staff be trained on resident rights - Effective August 4, 2017. The Admin.-in-charge will monitor

Owner / Director Business Administrator Oct 2, 2017

daily that each resident is has the care they need to receive by talking too residents and reviewing staff notes. The Administrator will do the overall follow-up to make sure residents rights are being respected by Weekly interacting with the residents and review staff no

effective August 4, 2017.

Winston Gardens

10A NCAC 13F .0601 Management of Facilities

The Admin. in charge ~~facility~~ will assure that the rules and regulations will be followed in accordance to the state guidelines effective August 4, 2017. The Managers who will serve as the Administrator-in-Charge will in the absence & Administrator assure that the rules are being followed in accordance to the state guidelines. In addition to the Manager, An Assistant Administrator-in-Charge from sister facility will come in twice a week to assist in helping to oversee the facility operations also. The Administrator will make weekly visits. Both the Administrator and the second Administrator-in-Charge from sister facility will be provided with training and management staff. Effective date August 04, 2017. The Administrator will assure that the system that is put in place will carried out in accordance to state rules and regulations for Managing ~~the~~ facilities. Effective August 4, 2017.