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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	R 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	8255 US HIGHWAY 19 EAST NEWLAND, NC 28657

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{D 000}	Initial Comments The Adult Care Licensure Section and the Avery County Department of Social Services conducted a follow-up survey and a complaint investigation on September 5, 2017 to September 7, 2017. The complaint investigation was initiated by the Avery County Department of Social Services on August 29, 2017.	{D 000}		
{D 161}	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task. (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 3 of 5 sampled staff (Staff A, B and C) were competency validated by return demonstration for the Licensed Health Professional Support (LHPS) tasks of providing physical assistance to residents ambulating with assistive devices and transferring of semi-ambulatory or non-ambulatory residents by an appropriate licensed health professional prior to performing the tasks.	{D 161}	1. Staff members without LHPS Nurse validation for skills completed by LHPS Nurse. 2. LHPS Nurse will be monitored by ED & MCM to ensure that all areas of staff qualifications provided by LHPS are in compliance. 3. LHPS Nurse to have exit conference after each visit to discuss duites performed and provide completion certificates. 4. New hired staff will complete all required validations prior to beginning floor training. 5. The Business Office manager and the Memory Care Manager will maintain staff records, schedule required training and assure required training is completed.	10/7/2017

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Jeanette Hayes — TITLE: Administrator — (X6) DATE: 10/16/17

STATE FORM 6899 EB0E12 If continuation sheet 1 of 24

Per telephone discussion with the Memory Care manager, refer to additional information in each tag. (10/25/17 at 10:30am)

Reviewed/accepted
SHH 10/25/17

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(D 161)	Continued From page 1 The findings are: Interviews with seven residents at various times on 9/5/17 and 9/6/17 revealed one resident stated she did not walk and two of the Personal Care Aides (PCAs) transferred her into/out of her wheelchair several times each day. Interview with a family member on 9/6/17 at 10:10am revealed: -The resident had lived at the facility for several years. -The resident needed assistance transferring into her wheelchair. Observations in the facility at various times of the day on 9/5/17, 9/6/17 and 9/7/17 revealed several PCAs were performing LHPS tasks for residents including providing physical assistance to residents ambulating using canes, wheelchairs and walkers and transferring of semi-ambulatory and non-ambulatory residents from wheelchairs to/from bed. 1. Review of Staff A's personnel record revealed: -A hire date of 8/10/17 as a Personal Care Aide (PCA). -There was no documentation a LHPS competency validation had been completed prior to her performing the tasks. Observations on 9/6/17 of Staff A providing LHPS tasks revealed she had transferred one resident from her bed to a nearby chair. Interview with Staff A on 9/6/17 at 4:15pm revealed: -She had starting working at the facility the beginning of August 2017.	(D 161)		

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(D 161)	Continued From page 2 -She assisted residents to and from their wheelchairs. -The other PCAs and the Medication Aides (MAs) had showed her how to take care of the residents. -The LHPS nurse had not gone over the competency validation checklist with her. -The LHPS nurse would be at the facility on 9/7/17 and she would be checked off at that time. Refer to interview with the Special Care Coordinator (SCC) on 9/6/17 at 10:40am. Refer to interview with the Administrator on 9/6/17 at 10:50am. Refer to interview with the LHPS nurse on 9/7/17 at 3:30pm. 2. Review of Staff B's personnel record revealed: -A hire date of 8/11/17 as a Personal Care Aide (PCA). -There was no documentation a LHPS competency validation had been completed prior to her performing the tasks. Observations on 9/5/17 of Staff B providing LHPS tasks revealed: -She had transferred several residents from their wheelchairs to chairs in their rooms. -She had assisted one unsteady resident with a rolling walker to the dining room. Interview with Staff B on 9/6/17 at 4:30pm revealed: -She had been employed at the facility since 8/11/17. -She had transferred residents to and from their wheelchairs. -She assisted unsteady residents with canes and	(D 161)		

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{D 161}	Continued From page 3 rolling walkers to the dining room. -The other PCAs and the Medication Aides (MAs) had showed her how to take care of the residents. -The LHPS nurse had not gone over the competency validation checklist with her. -The LHPS nurse would be at the facility on 9/7/17 and she would be checked off at that time. Refer to interview with the Special Care Coordinator (SCC) on 9/6/17 at 10:40am. Refer to interview with the Administrator on 9/6/17 at 10:50am. Refer to interview with the LHPS nurse on 9/7/17 at 3:30pm. 3. Review of Staff C's personnel record revealed: -A hire date of 8/7/17 as a Personal Care Aide (PCA). -There was no documentation a LHPS competency validation had been completed prior to her performing the tasks. Observations on 9/6/17 of Staff C providing LHPS tasks revealed: -She assisted one resident with a rolling walker to the dining room due to the resident being unsteady on her feet. -She transferred two residents into wheelchairs and had taken them to the dining room. Interview with Staff C on 9/6/17 at 4:10pm revealed: -She had been employed at the facility since 8/7/17. -The other PCAs and the Medication Aides (MAs) had showed her how to take care of the residents.	{D 161}		

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(D 161)	Continued From page 4 -She transferred residents to and from their wheelchairs. -The LHPS nurse had not gone over the competency validation checklist with her. -The LHPS nurse would be at the facility on 9/7/17 and she would be checked off at that time. Refer to Interview with the Special Care Coordinator (SCC) on 9/6/17 at 10:40am. Refer to interview with the Administrator on 9/6/17 at 10:50am. Refer to interview with the LHPS nurse on 9/7/17 at 3:30pm. Interview with the Special Care Coordinator (SCC) on 9/6/17 at 10:40am revealed: -She had been hired as the SCC "about a year ago". -She was responsible for scheduling the LHPS task validations for the new staff. -In March 2017, the facility had hired a new LHPS nurse to ensure all staff had been LHPS competency validated. -When the LHPS nurse left the position during the summer, the Administrator and the SCC had been told "everything was up to date" but that was not the case. -It was her responsibility to notify the LHPS nurse when there was new staff to be task competency validated and when the current staff needed additional training and competency validation. -It was the LHPS nurse's responsibility to complete the competency training validation checklist with the staff member. -When the training was completed, the LHPS nurse would submit the checklist to her and she would file it in her office. -The current LHPS nurse had been in the facility	(D 161)		

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{D 161}	Continued From page 5 on 9/4/17 and had competency validated two rehired employees and two new employees. -The LHPS nurse would be in the facility on 9/7/17 to competency validate three new PCAs. -She currently had no system in place to assure the LHPS task validations were done and up to date. Interview with the Administrator on 9/6/17 at 10:50am revealed: -She had been the Administrator for approximately six months. -In March 2017, the facility had hired an LHPS nurse to ensure all staff had been LHPS competency validated and the facility was back in compliance. -When the LHPS nurse left the position this summer, the Administrator had been told all care staff had been LHPS competency validated. -A review of staff records at that time revealed not all staff had been LHPS competency validated -The current LHPS nurse had been to the facility on 9/4/17 and had competency validated two rehired employees and two new employees. -The LHPS nurse would be in the facility on 9/7/17 to competency validate three new PCAs. Interview with the LHPS nurse on 9/7/17 at 3:30pm revealed: -He had been rehired by the facility to provide Medication Aide training and competency evaluations, Personal Care training and competency evaluations, staff LHPS competency validation by return demonstration, resident record reviews and LHPS resident assessments for the facility. -On 9/4/17, he had LHPS competency validated two rehired employees and two new employees. -He was currently at the facility to LHPS competency validate three new PCAs (Staff A,	{D 161}		

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{D 161}	Continued From page 6 Staff B and Staff C).	{D 161}		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13D .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report allegations of physical and mental abuse and neglect by Staff D (Personal Care Aide) of residents residing in a special care facility to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of the events and for failure to complete the 5 day report to the HCPR. The findings are: 1. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -Resident #6 was the resident a staff member had identified in a verbal statement given to the Administrator on 8/26/17. -The staff member had witnessed Staff D, Personal Care Aide (PCA), who had been feeding Resident #6, place food in the resident's mouth and then hold her hand over the resident's face. - The Administrator and SCC were aware of the incident and verified it had occurred during their	D 438	1. Staff D terminated on 9/7/2017 after facility investigation was completed. 2. As of 9/7/2017 all allegations of abuse/ neglect have been reported to HCPR via 24 hr 5 day report. ~~3. Aggresive Resident In-service to be completed on 10/6/2017~~ 3. Random staff ~~meetings~~ interviews to be held with ED or designee to discuss resident needs and appropriateness of care. This will be ongoing. 4. Managing aggressive behaviors inservice to be completed 10/6/17. 5. Ombudsman and DSS to complete training on recognizing, preventing and reporting abuse for all staff on 10/7/17. 6. Any allegation of resident abuse, neglect or exploitation will be reported to the appropriate agency (agencies) and investigated as required.	10/7/2017

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D 438	Continued From page 7 investigation on 8/27/17 when it had been reported by other staff as well. -The Administrator and the SCC stated Staff D did not hold her hand over Resident #6's face or mouth but had held her hand under the resident's chin to "keep the resident from spitting food out and to keep from being spit on." -The Administrator stated she had conducted an investigation but there were no staff interviews for review. -The Administrator and the SCC stated they did not recall the date of the incident. -The Administrator and the SCC had not reported the allegation to the Health Care Personnel Registry because they did not substantiate the allegation. -The Administrator had requested a written statement from Staff D. -Staff D stated she had placed the tips of her fingers under Resident #6's chin and told the resident not to spit out food. A confidential interview with a staff member revealed: -A few months ago (May/June), the staff member had witnessed Staff D feeding Resident #6. -Staff D had her cupped hand under the resident's chin holding the resident's mouth closed. -The staff member stated that was not common practice. Interview on 8/29/17 at 3:47pm with the Business Office Manager (BOM) revealed: -He had worked the second shift (3:00pm to 11:00pm) the night of the incident as a Medication Aide. -He stated the incident occurred approximately in June 2017. -When he learned of the incident with Resident	D 438		

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D 438	Continued From page 8 #6 and Staff D, he had contacted the Administrator. -He did not recall writing a statement or being asked to do so by the Administrator. -He had been instructed by the Administrator to talk with staff regarding the incident. -He had spoken to a staff member who reported "the incident lasted 10-20 seconds and did not look forceful". -He then spoke with Staff D, who stated she had not intentionally tried to hurt Resident #6, she was just trying to stop the resident from spitting, she did not want to be spit on. -He stated Staff D "could be loud, boisterous, opinionated and had a foul mouth". A confidential telephone interview with a staff member revealed: -She had witnessed Staff D feeding Resident #6. -She stated the incident had occurred a few months ago. -Staff D had placed a bite of food in Resident #6's mouth. -Staff D then placed the back of her hand under the resident's chin and held the resident's mouth shut. -Staff D knew the staff member had witnessed the incident and told the staff member she (Staff D) "did not want to be spit on" by the resident. -The resident had showed some distress while her mouth was being held shut by grunting and immediately spit the food out when Staff D removed her hand. -The staff member immediately reported the incident to the Administrator who asked her to provide a signed and dated written statement which she did. Based on record review and observations on 9/5/17 and 9/6/17, the resident was determined	D 438		

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D 438	Continued From page 9 not to be interviewable. Refer to interview on 9/7/17 at 2:15pm with the Administrator. 2. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -The Administrator and the SCC stated Staff D could be very loud and they could see where some residents might think she had been yelling. -They were unaware staff members had heard Staff D swearing and cussing at the residents. -They had been told by staff members Staff D had been leaving residents wet and soiled for entire shifts. -They had investigated by making rounds and marking incontinence briefs. -They had not reported the allegations of resident neglect to the Health Care Personnel Registry because their investigation did not substantiate the allegations. -The Administrator had requested a written statement from Staff D on 9/7/17. -Staff D admitted, in the written statement, to leaving Resident #7 wet and soiled. -It had been brought to her (the Administrator) attention by the current Business Office Manager (BOM) who, at the time of the incident, had been a 2nd shift MA. Interview on 8/29/17 at 3:23pm with a staff member revealed: -Resident #7 was the resident identified in the staff members written statement dated 8/28/17 and given to law enforcement concerning verbal abuse and neglect of Resident#7 by Staff D. -She had witnessed verbal abuse of Resident #7 by Staff D including name calling and yelling at the resident.	D 438		

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D 438	Continued From page 10 -She had also witnessed Staff D neglect Resident #7 when she had not changed the resident leaving him wet and soiled. -She stated she had given Staff D a written warning for not changing the resident's soiled or wet incontinence brief but did not remember the date of the write-up. -The write-up had been torn up by the SCC who said to give Staff D a verbal warning first. -Staff D had received a verbal warning from a previous MA, who was now the BOM. Interview on 8/29/17 at 3:47pm with the BOM revealed: -As a MA, he had given a verbal warning to Staff D for leaving Resident #7 laying in his bed soaking wet. -Staff D had told him the resident had been changed, but the MA had discovered the resident had not. -He informed the Administrator and the SCC he had given Staff D a verbal warning for lying about changing the resident. Based on record review and observations on 9/5/17 and 9/6/17, the resident was determined not to be interviewable. Refer to interview on 9/7/17 at 2:15pm with the Administrator. 3. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -The Administrator and the SCC stated Staff D "could be very loud and they could see where some residents might think she had been yelling". -They were not aware staff members had heard Staff D swearing and cussing at the residents. -They were not aware staff members had seen	D 438		

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D 438	Continued From page 11 Staff D pin Resident #2 to his bed and also twist his arm behind his back. -They had not reported the allegations of resident abuse to the Health Care Personnel Registry because they were not aware of the allegations. A confidential telephone interview with a staff member revealed: - Resident #2 was the resident identified in the their written statement dated 8/28/17 and given to law enforcement. - The staff member had witnessed Staff D, a PCA, threatening, cursing and screaming at Resident #2. -She had witnessed, Staff D, place her hands on Resident #2's shoulders and shove the resident down and pin him to his bed. -She had witnessed Staff D twisting the resident's arm behind his back. -She was unsure of the dates of these occurrances. -She did not report the incidents to the Administrator "because other staff had reported Staff D and nothing had been done". Interview on 9/7/17 at 1:00PM with Resident #2 revealed the resident did not recall the incidents with Staff D. Refer to Interview on 9/7/17 at 2:15pm with the Administrator. 4. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -The Administrator and the SCC stated Staff D "could be very loud and they could see where some residents might think she had been yelling". -They were not aware Resident #8 had told staff members Staff D had hurt her in the shower.	D 438		

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D 438	Continued From page 12 -They had not reported the allegations of resident abuse to the Health Care Personnel Registry because they were not aware [of] the allegation. Interview with a staff member revealed Resident #8 had told a staff member, Staff D had hurt her while giving her a shower. -The staff member did not recall what staff member Resident #8 had told this to. -She had passed it on in report to the next shift but she had not reported it to the Administrator or the SCC. Interviews with two staff members on 9/6/17 revealed: -They both confirmed Resident #8 had stated Staff D had hurt her in the shower approximately one month ago. -The resident was reluctant to get a shower and identified Staff D by name, stating she had hurt the resident's foot and back in the shower. -They had reported the incident to the MA on duty. Based on record review and observations on 9/5/17 and 9/6/17, the resident was determined not to be interviewable. Refer to interview on 9/7/17 at 2:15pm with the Administrator. 5. A confidential telephone interview with a staff member revealed: -A staff member had reported witnessing Resident #9 being called names by Staff D. -The staff member had been encouraged to report incident to the Administrator. -She was not aware if the staff member had reported the incident.	D 438		

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	HAL008007	A. BUILDING: _____ B. WING _____	R 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D 438	Continued From page 13. Based on record review and observations on 9/5/17 and 9/6/17, the resident was determined not to be interviewable. Interview on 8/29/17 at 1:55pm with the Administrator revealed: -A staff member had told her she had witnessed Staff D calling Resident #9 names. -Staff D could be very loud and she could understand how a resident might think Staff D had been yelling. Refer to interview on 9/7/17 at 2:15pm with the Administrator. Interview on 9/7/17 at 2:15pm with the Administrator revealed: -She became aware of the allegations of resident abuse and neglect on 8/29/17. -A county employee came to the facility and informed her a complaint had been filed against Staff D (PCA) alleging verbal and mental abuse and resident neglect. -The county employee had been given multiple signed and dated statements from witnesses of the abuse and neglect. -The Administrator and the SCC had come into the facility one evening and marked incontinent briefs after a staff member told her Staff D had not been changing incontinent residents. -This "investigation" had occurred prior to the county employee's visit and the allegation of neglect was not substantiated. -Initially the allegation of resident neglect by Staff D had not been reported to the HCPR "because the allegation was not substantiated". -She did not file a 24 hr/5 day report regarding the allegation on 10/31/16. -She did file the 24-hour report to the Health Care Personnel Registry after the Department of Social	D 438		

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	HA1006007	A. BUILDING: _____ B. WING _____	R 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	8268 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D 438	Continued From page 14 Services worker came to the facility 8/29/17on the complaint investigation and instructed her to do so. -She was not aware any and all allegations of resident abuse, neglect and exploitation must be reported to the Health Care Personnel Registry within 24 hours of the allegation. -She was not aware a five day report was also to be filed after the facility investigated and substantiated/unsubstantiated any allegation(s). -Staff-D had been terminated 9/7/17 based on substantiation of the verbal abuse allegations.-The 5-day report sent to the HCPR on 9/7/17 substantiated the allegation of-resident neglect	D 438		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relavant federal and state laws and rules and regulations related to being treated with respect and free from physical and verbal abuse. The findings are: 1. Based on interviews and record reviews, the	{D912}	1. Staff member with substantiated verbal abuse terminated on 9/7/2017 2. Ombudsman completed in-service on Resident Rights 9/7/2017 3. ED/or designee will incorporated daily facility walk through to monitor the rights and needs of each resident are being met, along with montioring direct care provided by staff. This will be ongoing. 4. ombudsman and DSS to Complete Hearing Recognizing, reporting and preventing abuse for all staff on 12/7/17. 5 any allegation of resident abuse, Neglect or Exploitation will be reported to the appropriate agency (agencys) and investigated as required 6. ED or designee will conduct random staff interviews on an ongoing basis to discuss resident needs, care provided and/or staff Concerns.	10/7/2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

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{D912}	Continued From page 15 facility failed to assure 5 of 5 sampled residents (Resident #2, Resident #6, Resident #7, Resident #8 and Resident #9), residing in a Special Care facility, were treated with respect and free from physical and verbal abuse and neglect by an employee (Staff D). [Refer to Tag 914, GS 131D-21(4) Declaration of Resident's Rights (Type A2 Violation)]	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to assure 5 of 5 sampled residents (Resident #2, Resident #6, Resident #7, Resident #8 and Resident #9), residing in a Special Care facility, were treated with respect and free from physical and verbal abuse by an employee (Staff D). The findings are: 1. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -Resident #6 was the resident a staff member had identified in a verbal statement given to the Administrator on 8/26/17. -The staff member had witnessed Staff D, Personal Care Aide (PCA), who had been feeding Resident #6, place food in the resident's mouth and then hold her hand over the resident's face.	D914	1. Staff member D terminated on 9/7/2017 on substantiated findings of verbal abuse. 2. Ombudsman along with ~~AHS~~ DSS to complete Abuse Prevention training on 12/7/2017. including recognizing and prevention of abuse, reporting 3. A behavioral log has been implemented and maintained by the facility administrator. 4. Appropriate interventions put into place to assure rights of residents are ~~maintained~~. safety of the residents. 5. Education completed and ensure all residents rights on 9/7/17. 6. ED or designee will conduct random staff interviews on an ongoing basis to ensure resident needs, care provided and/or staff concerns.	10/7/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6265 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D914	Continued From page 16 - The Administrator and SCC were aware of the incident and verified it had occurred during their investigation on 8/27/17 when it had been reported by other staff as well. -The Administrator and the SCC stated Staff D did not hold her hand over Resident #6's face or mouth but had held her hand under the resident's chin to "keep the resident from spitting food out and to keep from being spit on." -The Administrator stated she had conducted an investigation but there were no staff interviews for review. -The Administrator and the SCC stated they did not recall the date of the incident. -The Administrator and the SCC had not reported the allegation to the Health Care Personnel Registry because they did not substantiate the allegation. -The Administrator had requested a written statement from Staff D. -Staff D stated she had placed the tips of her fingers under Resident #6's chin and told the resident not to spit out food. A confidential interview with a staff member revealed: -A few months ago (May/June), the staff member had witnessed Staff D feeding Resident #6. -Staff D had her cupped hand under the resident's chin holding the resident's mouth closed. -The staff member stated that was not common practice. Interview on 8/28/17 at 3:47pm with the Business Office Manager (BOM) revealed: -He had worked the second shift (3:00pm to 11:00pm) the night of the incident as a Medication Aide. -He stated the incident occurred approximately in	D914		

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D914	Continued From page 17 June 2017. -When he learned of the incident with Resident #6 and Staff D, he had contacted the Administrator. -He did not recall writing a statement or being asked to do so by the Administrator. -He had been instructed by the Administrator to talk with staff regarding the incident. -He had spoken to a staff member who reported "the incident lasted 10-20 seconds and did not look forceful". -He then spoke with Staff D, who stated she had not intentionally tried to hurt Resident #6, she was just trying to stop the resident from spitting, she did not want to be spit on. -He stated Staff D "could be loud, boisterous, opinionated and had a foul mouth". A confidential telephone interview with a staff member revealed: -She had witnessed Staff D feeding Resident #6. -She stated the incident had occurred a few months ago. -Staff D had placed a bite of food in Resident #6's mouth. -Staff D then placed the back of her hand under the resident's chin and held the resident's mouth shut. -Staff D knew the staff member had witnessed the incident and told the staff member she (Staff D) "did not want to be spit on" by the resident. -The resident had showed some distress while her mouth was being held shut by grunting and immediately spit the food out when Staff D removed her hand. -The staff member immediately reported the incident to the Administrator who asked her to provide a signed and dated written statement which she did.	D914		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	5255 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D914	Continued From page 18 Based on record review and observations on 9/6/17 and 9/8/17, the resident was determined not to be interviewable. Refer to Interview on 9/7/17 at 2:15pm with the Administrator. 2. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -The Administrator and the SCC stated Staff D could be very loud and they could see where some residents might think she had been yelling. -They were unaware staff members had heard her swearing and cussing at the residents. -They had been told by staff members Staff D had been leaving residents wet and soiled for entire shifts. -They had investigated by making rounds and marking incontinence briefs. -They had not reported the allegations of resident neglect to the Health Care Personnel Registry because their investigation did not substantiate the allegations. -The Administrator had requested a written statement from Staff D. -Staff D admitted to leaving Resident #7 wet and soiled and it had been brought to her attention by the current BOM who, at the time of the incident, was a 2nd shift MA Interview on 8/29/17 at 3:23pm with a staff member revealed: -Resident #7 was the resident identified in the staff members written statement dated 8/28/17 and given to law enforcement concerning verbal abuse and neglect of Resident#7 by Staff D. -She had witnessed verbal abuse of Resident #7 by Staff D including name calling and yelling at the resident.	D914		

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D914	Continued From page 19 -She had also witnessed Staff D neglect Resident #7 when she had not changed the resident leaving him wet and soiled. -She stated she had given Staff D a written warning for not changing the resident's soiled or wet incontinence brief but did not remember the date of the write-up. -The write-up had been torn up by the SCC who said to give Staff D a verbal warning first. -Staff D had received a verbal warning from a previous MA, who was now the BOM. Interview on 8/29/17 at 3:47pm with the BOM revealed: -As a MA, he had given a verbal warning to Staff D for leaving Resident #7 laying in his bed soaking wet. -Staff D had told him the resident had been changed, but the MA had discovered the resident had not. -He informed the Administrator and the SCC he had given Staff D a verbal warning for lying about changing the resident. Based on record review and observations on 9/5/17 and 9/6/17, the resident was determined not to be interviewable. Refer to interview on 9/7/17 at 2:15pm with the Administrator. 3. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -The Administrator and the SCC stated Staff D "could be very loud and they could see where some residents might think she had been yelling". -They were not aware staff members had heard Staff D swearing and cussing at the residents. -They were not aware staff members had seen	D914		

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	HAL000007	A. BUILDING: _____ B. WING _____	R 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D914	Continued From page 20 Staff D pin Resident #2 to his bed and also twist his arm behind his back. -They had not reported the allegations of resident abuse to the Health Care Personnel Registry because they were not aware of the allegations. A confidential telephone interview with a staff member revealed: - Resident #2 was the resident identified in the their written statement dated 8/28/17 and given to law enforcement. - The staff member had witnessed Staff D, a PCA, threatening, cursing and screaming at Resident #2. -She had witnessed, Staff D, place her hands on Resident #2's shoulders and shove the resident down and pin him to his bed. -She had witnessed Staff D twisting the resident's arm behind his back. -She was unsure of the dates of these occurrences. -She did not report the incidents to the Administrator "because other staff had reported Staff D and nothing had been done". Interview on 9/7/17 at 1:00PM with Resident #2 revealed the resident did not recall the incidents with Staff D. Refer to interview on 9/7/17 at 2:15pm with the Administrator. 4. Interview on 8/29/17 at 1:55pm with the Administrator and the Special Care Coordinator (SCC) revealed: -The Administrator and the SCC stated Staff D "could be very loud and they could see where some residents might think she had been yelling". -They were not aware Resident #8 had told staff members Staff D had hurt her in the shower.	D914		

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CRANBERRY HOUSE	6256 US HIGHWAY 19 EAST NEWLAND, NC 28657

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D914	Continued From page 21 -They had not reported the allegations of resident abuse to the Health Care Personnel Registry because they were not aware of the allegation. Interview with a staff member revealed Resident #8 had told a staff member, Staff D had hurt her while giving her a shower. -The staff member did not recall what staff member Resident #8 had told this to. -She had passed it on in report to the next shift but she had not reported it to the Administrator or the SCC. Interviews with two staff members on 9/6/17 revealed: -They both confirmed Resident #8 had stated Staff D had hurt her in the shower approximately one month ago. -The resident was reluctant to get a shower and identified Staff D by name, stating she had hurt the resident's foot and back in the shower. -They had reported the incident to the MA on duty. Based on record review and observations on 9/5/17 and 9/6/17, the resident was determined not to be interviewable. Refer to interview on 9/7/17 at 2:15pm with the Administrator. 5. A confidential telephone interview with a staff member revealed: -A staff member had reported witnessing Resident #9 being called names by Staff D. -The staff member had been encouraged to report incident to the Administrator. -She was not aware if the staff member had reported the incident.	D914		

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D914	Continued From page 22 Based on record review and observations on 9/5/17 and 9/6/17, the resident was determined not to be interviewable. Interview on 8/29/17 at 1:55pm with the Administrator revealed: -A staff member had told her she had witnessed Staff D calling Resident #9 names. -Staff D could be very loud and she could understand how a resident might think Staff D had been yelling. Refer to interview on 9/7/17 at 2:15pm with the Administrator. Interview on 9/7/17 at 2:15pm with the Administrator revealed: -The allegations of abuse and neglect, regarding Staff D, had been reported to the Health Care Personnel Registry after the Department of Social Services came to the facility on a complaint investigation and instructed her to do so. -She was not aware all allegations of abuse and neglect were to be reported to the registry and then investigated by the facility. -Staff D had been terminated 9/7/17 based on substantiation of the verbal abuse allegations. The facility's failure to assure residents were free of verbal and physical abuse resulted in Staff D, cursing and screaming at Resident #2, pinning him to his bed with her hands and twisting his arm behind his back, feeding Resident #6 and holding her mouth shut so that she could not spit out her food, calling Resident # 7 names, yelling at her and leaving her in soiled incontinent briefs, hurting Resident #8's foot and back while showering her and calling Resident #9 names. This failure to protect the resident's from physical and verbal abuse by an employee placed the	D914		

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D914	Continued From page 23 residents at substantial risk that death or serious injury could occur and constitutes a Type A2 violation. A Plan of Protection provided by the facility revealed: -Staff D was suspended on 8/29/17. -The allegation of verbal abuse was substantiated and Staff D was terminated on 9/7/17. -Training of the staff on Resident Rights was provided by the Ombudsman on 9/7/17. -Management to monitor personal care and address staff concerns in the daily meeting with the option of one on one conference with the Administrator. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 7, 2017.	D914		