STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085009	A. BUILDING: _____ B. WING _____	11/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIDDY MANOR ASSISTED LIVING	1294 PRIDDY ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted a complaint investigation on November 7-8, 2017.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure cleaning supplies which may be hazardous if ingested, inhaled, or handled were locked and/or monitored by staff and not accessible to residents resulting in 1 resident (Resident #3) potentially ingesting a deodorizing agent. The findings are: Review of Resident #3's FL2 dated 09/15/17 revealed: -Diagnoses included dementia, congestive heart failure, and other signs and symptoms including cognitive functions. -Resident was a wanderer. -Resident had intermittent disorientation.	D 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy Bowles, ED — TITLE: ED — (X6) DATE: 12/11/17

Reviewed + accepted. AJS 12/21/17

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D 056	Continued From page 1 -Resident was appropriate for the Special Care Unit (SCU). Review of Resident Register revealed Resident #3 was admitted to the facility and SCU on 09/13/17. Review of Incident Report for 10/03/17 revealed: -Resident #3 "may have ingested" a deodorizer. -Poison control was called and they said there was no harsh chemicals that could harm the resident. -Resident #3's physician was notified. -Resident #3's family was notified. -Resident #3 was not sent for evaluation at the emergency department. Review of Resident #3's hospital report dated 10/7/17 revealed: -Admitting diagnoses of status post fall, severe dementia and combined heart failure. -CT scan of the head showed no intracranial abnormalities. -Chest x-ray showed possible pleural effusion and pneumonia. -The fall did not contribute to her current medical decline. -The resident was transferred to Hospice inpatient on 10/8/17. Review of Hospice records revealed: -Resident #3 was admitted to Hospice services on 05/19/17. -Primary diagnosis listed as acute and chronic congestive heart failure. -Skilled nursing visits 1-3 times a week. -Resident #3 was admitted to Inpatient Hospice services on 10/08/17 from the hospital. -Upper airway secretions noted. -No vomiting noted.	D 056		

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D 056	Continued From page 2 -Resident #3 pronounced dead on 10/10/17. Review of Resident #3's record revealed: -Resident notes from 10/03/17 through 10/07/17 had no documentation of episodes of vomiting. -Hospice notes from 09/13/17 through 10/07/17 had no documentation of episodes of vomiting. Interview on 11/07/17 at 10:00 am with a first shift housekeeper in the Special Care Unit (SCU) revealed she always kept the housekeeping cart locked except when in use then she pushed the side where the door opened against the wall if the door was unlocked. Observation on 11/07/17 from 10:58 am revealed: -The housekeeping cart on the Assisted Living Unit (ALU) was closed but unlocked and unattended. -The housekeeper was in a resident's room; in the bathroom. -The housekeeping cart was in the resident's doorway, unlocked and unattended. -The housekeeper had the cleaning supplies in the bathroom with her while cleaning. -The housekeeper put the cleaning supplies back in the cart and locked the cart after cleaning the room. Interview on 11/07/17 at 11:00 am with the housekeeper on ALU revealed: -She had worked at the facility about 8 months. -She kept the cart locked at all times. -She must have forgotten to lock the cart on 11/07/17 when she took the cleaning supplies out to clean in the resident's room. Interview on 11/07/17 at 2:34 pm with Resident #3's family member revealed: -The Horizon Wellness Director (HWD) called	D 056		

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D 056	Continued From page 3 him on 10/03/17 around 10:00 pm-11:00 pm and informed him that Resident #3 went up to the medication cart and poured chemicals. -The HWD informed him that she watched the facility video footage and she did not think the resident ingested any of the chemical. -The HWD informed him the liquid was a chemical but did not mention the name of the chemical. -The HWD informed him Poison Control had been called and they informed facility staff the chemical had nothing in it that would harm the resident. -The HWD assured him that she would make sure everything was locked so it would not happen again. -He did not watch the video and did not request to watch the video. -After the incident on 10/03/17 the resident experienced vomiting every day; until her passing. -The resident's vomit was mucus like and clear; denied any presence of blood. -He witnessed the resident vomit twice, but did not report it to the staff. -He did not feel the vomiting was important at the time. -He had never witnessed unlabeled or unsupervised chemicals in the SCU. -Resident #3 had a fall on 10/07/17 and was transported to the local hospital and diagnosed with pneumonia. -Resident #3 was transferred to inpatient Hospice services on 10/08/17 and passed away on 10/10/17. Interview on 11/07/17 at 3:10 pm with the contracted Information Technology (IT) Company revealed: -The facility video footage data only went back to	D 056		

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D 056	Continued From page 4 11/03/17. -The video footage was not archived. -In the past the video was motion activated only, but in the last few months the cameras were changed to continuous. -The IT staff could not track if facility staff had viewed the facility video footage. -If an incident occurred and facility staff needed the facility video footage to be archived they could request IT to pull video footage and archive it. -The facility did not request IT pull footage to be archived for 10/03/17. Interview on 11/07/17 at 3:35 pm with Resident #3's second family member revealed: -On 10/10/17 she received a message via social media from a staff member at the facility asking if the family was planning to do an autopsy. -The staff member allegedly informed the family that the resident did drink the chemical and staff did not know what the chemical was. -She never spoke with the staff member. The only communication was through social media. -The staff member allegedly informed another family member that staff were told to not talk about the incident. -She did not view the facility video footage. Interview on 11/07/17 at 4:17 pm with a second shift personal care aide (PCA) in the SCU revealed: -When asked about the incident on 10/3/17, she responded, "I don't recall'. -"I don't feel comfortable talking about it". Interview on 11/07/17 at 4:20 pm with second shift medication aide (MA) in the SCU revealed: -She was working as a MA on 10/03/17. -She had brought a deodorizer out of the resident community locked bathroom, where the	D 056		

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D 056	Continued From page 5 deodorizer was usually kept, to spray the trash cans due to an odor. -She was unable to recall if the cap was loose when she brought the deodorizer out to spray the trashcans. -She stepped away from the medication cart leaving the deodorizer unattended on the medication cart as she went to get medication totes from the Assisted Living unit. -She estimated to be gone only a few minutes. -The PCA's were giving baths at the time of the incident. -When she returned to the medication cart in the SCU, Resident #3 was standing at the cart with a cup of clear liquid that was not on the medication cart when the MA left to get the medication totes. -She did not witness what was poured into the cup that Resident #3 was suspected to have ingested. -She did not see Resident #3 drink from the cup with the clear liquid. -There was also a pitcher of water on the medication cart. -The deodorizer was sitting near the cup with the cap on, but the cap was loose. -She did not smell the liquid in the cup. -The remaining liquid in the cup was poured out. -She called the Horizon Wellness Director (HWD) and the physician on call. -The HWD instructed the MA to call poison control. -She called poison control and was informed the deodorizer was not a harmful chemical and poison control would make a follow up call in one hour to check on the status of the resident. -Poison Control did follow up in one hour and the resident was not having any symptoms of a reaction. Interview on 11/07/17 at 4:30 pm with the	D 056		

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D 056	Continued From page 6 Executive Director revealed: -She was notified by the HWD on 10/03/17 that Resident #3 may have ingested the deodorizer. -The housekeeping carts were to always be kept locked. -All housekeepers had keys to their carts. -The facility video footage only went back 30 days. -The facility did not currently have a chemical storage policy. Observation of the deodorizer container on 10/08/17 at 8:30 am revealed a bottle with screw on cap and clear liquid with floral odor. Interview on 11/08/17 at 11:55 am with the HWD revealed: -The MA working second shift on 10/03/17 notified her of the possibility that Resident #3 may have ingested the deodorizer. -The MA informed the HWD she was unsure if the resident ingested water or possibly a deodorizer that was near the cup with clear liquid in it. -The MA did not inform the HWD where she was while Resident #3 may have ingested the deodorizer. -The HWD called the Executive Director (ED) and the ED instructed the HWD to tell the MA to call poison control, physician, and family. -The HWD called the MA and instructed her to call poison control and the physician but decided to call Resident #3's family herself -Poison control informed the MA that if the resident ingested the deodorizer it did not contain harsh chemicals and they would call back in one hour to check for symptoms of a reaction. -Resident #3 did not show any signs or symptoms of reaction/sickness. -The HWD denied the resident experienced any	D 056		

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D 056	Continued From page 7 nausea or vomiting in the days that followed the possible ingestion on 10/03/17. -The HWD denied any family members reported Resident #3 experienced nausea or vomiting in the days that followed the possible ingestion on 10/03/17. -The HWD viewed the facility video footage of second shift on 10/03/17 from her home. -The angle of the footage did not allow her to see the Resident #3 pouring liquid or drinking from the cup, but she could see that the resident had a cup in her hand with clear liquid. -No other staff was seen around Resident #3 on the facility video footage. -On 10/03/17 there was a MA and 2 PCA's working on second shift at the time of the incident. -She was the only staff member to view the facility video footage and she informed the ED of what she saw on the video. -When Resident #3 was admitted to the facility she was very frail and sick. Observation of live facility video footage in the SCU on 11/08/17 at 12:30 pm revealed: -The medication cart in the SCU was pushed into the corner of the dining room/common area. -The video footage was limited due to the angle/positioning of the camera. -Only a small portion of the front left corner of the medication cart was visible on the video footage. Interview on 11/08/17 at 3:26 pm with the Physician Assistant from Resident #3's primary care physician's office revealed he was not notified because he was not on call on 10/03/17. Interview on 11/08/17 at 3:32 pm with Poison Control revealed: -A small amount of deodorizer ingested would	D 056		

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D 056	Continued From page 8 cause mucosal irritation, vomiting, or loose stool -The amount a person ingested would determine the reaction. -In most cases a person would only ingest a few sips and only experience mucosal irritation. -Poison Control would not have suggested facility send a resident to the hospital that may have ingested the deodorizer. -Poison Control would make a follow up call depending on the case. -Poison Control had the possibility to look at the call log of when calls came in but the manager that had the capability to do so was not available. Review of the Material Safety Data Sheet for the deodorizer revealed: -The deodorizer contained hazardous ingredients of quaternary ammonium chlorides, dimethyl benzyl ammonium chlorides-60%, and dimethyl ethylbenzyl ammonium chlorides-68%. -Health hazard data included irritation to eyes and skin; if inhaled, caused irritation and swelling of mucus membranes; if ingested, caused stomach irritation, nausea and vomiting. -If swallowed, call poison control center or physician immediately. Have the person sip a glass of water if able to swallow. Do not induce vomiting unless told to do so by poison control or a physician. Interview on 11/08/17 at 3:55 pm with the Regional Nurse and Director of Quality Assurance and Compliance revealed: -The Regional Nurse was made aware of the incident that occurred on 10/03/17 with Resident #3 on 10/27/17. -The Director of Quality Assurance and Compliance was made aware of the incident that occurred on 10/03/17 with Resident #3 on 10/30/17 at the facility's "at risk meeting".	D 056		

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D 056	Continued From page 9 -Both the Regional Nurse and the Director of Quality Assurance and Compliance were made aware of the incident on 10/03/17 only after the resident was brought into the discussion due to a fall on 10/07/17 resulting in hospitalization. -Corporate was usually made aware only if an incident required hospital intervention. Attempted interview on 11/07/17 at 3:23 pm with a third family member was unsuccessful. Attempted interview on 11/08/17 at 12:49 pm with a first shift PCA was unsuccessful. Attempted interview on 11/08/17 at 3:30 pm with the Primary Care Physician was unsuccessful. Attempted interview on 11/08/17 at 3:55 pm with another first shift PCA was unsuccessful. The Executive Director was not available for additional interviews on 10/08/17. The facility failed to ensure cleaning supplies were monitored by staff while in use resulting in 1 resident (Resident #3) residing in the SCU potentially ingesting a deodorizing agent. Hazardous ingredients in the deodorizing agent causes stomach irritation, nausea and vomiting after ingestion which vomiting was observed by a family member after the incident on 10/3/17. The facility's failure to secure hazardous cleaning agents while in use was detrimental to the health and safety of the residents and constitutes a Type B Violation. A Plan of Protection was provided by the facility dated 11/08/17: -Chemicals were placed in a secured lock box. -Team members were educated on the	D 056		

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D 056	Continued From page 10 importance of proper chemical storage. -Wellness Director/designee will check daily that chemicals are locked and secure from residents reach. -All team members will continue to be educated on the importance of proper chemical storage. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 23, 2017	D 056	**Chemicals were placed in a secured locked cabinet. Team Members were educated on the importance of proper chemical storage. Wellness Director, MT or designee will check each shift to ensure chemicals are locked and secure from residents reach. All team members will continue to be educated on the importance of chemical storage.** **Residents Rights inservice to be Completed no later than Dec. 23, 2017 with all resident care team members and housekeeping team members.**	11/8/17
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related physical environment. The findings are: Based on observations, record reviews and interviews, the facility failed to ensure cleaning supplies which may be hazardous if ingested, inhaled, or handled were locked and/or monitored by staff and not accessible to residents resulting in 1 resident (Resident #3) potentially ingesting a deodorizing agent [Refer to Tag 0056, 10A NCAC	D912		

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D912	Continued From page 11 13F.0305(f)(4) Physical Environment (Type B Violation)].	D912		