Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL069002	A. BUILDING: _____ B. WING _____	R 11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF PAMLICO	22 MAGNOLIA WAY GRANTSBORO, NC 28529

(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 Pamlico County Department of Social Services conducted a follow-up survey and complaint investigation on November 28, 2017 through November 30, 2017. The complaint investigations were initiated by the Pamlico County Department of Social Services on October 5, 2017, October 23, 2017, and November 21, 2017.	{D 000}		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the kitchen oven and two large storage shelves were cleaned and free of contamination. The findings are: Observation of the oven on 11/29/17 at 11:16am revealed: -The stove flame control knobs and oven temperature knobs were covered in a thick tarry grime. -The temperature indicator numbers on the oven control knob could not be read through the thick tarry substance. -The two handles on the two oven doors were covered in grime and a sticky substance. -The exterior of the oven doors and side panels were stained and had a sticky substance.	{D 282}	Responses to the cited deficiency does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set-forth in the Statement of Deficiencies or the Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with state law. Deep Cleaned Oven The Executive Director has established a cleaning schedule to be conducted daily and/or as needed.	12/14/17 12/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mesten Lewis — TITLE: Executive Director — (X6) DATE: 1/15/18

Reviewed & Accepted with Revisions — 1/26/18

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{D 282}	Continued From page 1 -The interior of the oven was coated with thick tarry grime. Observation of the two large metal storage shelves mounted over the sink area on 11/29/17 at 11:20am revealed: -The two metal shelves were dirty and sticky to the touch -Both shelves were covered with dried food particles. -The metal shelves had dark brown sticky grime between each of the two shelves. -Both shelves were covered with a white sticky substance. Interview with a dietary staff on 11/29/17 at 11:25am revealed: -The kitchen staff cleaned the kitchen on a daily basis, but did not sign any cleaning schedule sheet. -She and the kitchen staff followed the cleaning schedule posted on the bulletin board in the kitchen. -All surfaces were wiped down between meals. -She could not recall the last time the kitchen had a deep cleaning. -She had cleaned the oven a week ago. -"The oven looked worse than that on last week before she had cleaned it." -Everyone worked together to get the cleaning done every day. Observation of the kitchen area on 11/30/17 at 11:00am revealed the oven and two large wall shelves had not been cleaned and were covered in sticky grime. Interview with the Dietary Manager on 11/30/17 at 11:56am revealed: -The kitchen staff performed general cleaning	{D 282}	Kitchen Manager will follow up daily. Executive Director will follow up weekly. 12/28/17 Large metal storage shelves deep cleaned. 12/14/17 Per Conversation with Executive Director on 1/22/18 - The Kitchen Manager will follow-up daily to make sure cleaning schedule for the kitchen has been done by kitchen staff. - The ED will follow-up weekly to make sure tasks are completed on the ~~the~~ Kitchen cleaning schedule. — KS	

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{D 282}	Continued From page 2 and followed the general cleaning schedule. -Staff did not sign a cleaning schedule sheet. -All surfaces were wiped down daily between meals and when needed. -The oven was cleaned weekly or as needed. -He was new to his role and could not remember the last time the kitchen had a deep cleaning, but he would follow up. Interview with the Administrator on 11/30/17 at 2:30pm revealed: -She supervised the Dietary Manager. -The Dietary Manager was new to his role and he was learning what needed to be done. -She was unaware that the cleaning schedule was not being followed. -Her expectation was for dietary staff to clean all areas daily and as needed. -She would follow up with the Dietary Manager to ensure that the oven and two large shelves were cleaned. -She would determine the level of cleaning needed for each kitchen appliance. -She would recommend replacing the oven if dietary staff were unable to clean it.	{D 282}		
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 A2 VIOLATION	D 338		

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D 338	Continued From page 3 Based on observations, record reviews, and interviews, the facility failed to assure every resident's rights were maintained as related to residents not being treated with dignity and respect and failing to respond to resident's reasonable request. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure 3 residents (#5, #11, #12) were treated with dignity, consideration, and respect as evidenced by 2 residents (#5, #12) exposed to wet carpeting and foul odors for at least 3 days from an overflowed toilet in their room; and Resident #11 being spoken to in a loud, harsh tone of voice and demeaning manner by a staff person (Staff A) [Refer to Tag D 911 G.S. § 131D-21 (1) Declaration of Resident Rights (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to respond to a resident's requests (#9) to be moved to another room due to verbal arguments with his roommate [Refer to Tag D 917 G.S. § 131D-21 (7) Declaration of Resident Rights (Type A2 Violation)].	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.	D911		

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D911	Continued From page 4 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 3 residents (#5, #11, #12) were treated with dignity, consideration, and respect as evidenced by 2 residents (#5, #12) exposed to wet carpeting and foul odors for at least 3 days from an overflowed toilet in their room; and Resident #11 being spoken to in a loud, harsh tone of voice and demeaning manner by a staff person (Staff A). The findings are: 1. Review of Resident #5's current FL-2 dated 8/22/17 revealed: -Diagnoses included Alzheimer's disease, dementia, major depression, hypothyroidism, and enlarged prostate. -Resident #5 was ambulatory. -Resident #5 was constantly disoriented and his level of care required placement in a Special Care Unit (SCU). Review of the Resident Register for Resident #5 revealed he was admitted to the facility on 7/25/17. Review of care notes for Resident #5 revealed Resident #5 had resided in Room #106 in the SCU prior to his discharge from the facility on 11/21/17. Confidential interview with a staff member revealed: -Resident #5 resided in resident room #106 in the SCU while he was at the facility. -The carpeted floor was soaked with water in	D911	Resident Rights in-service conducted by local ombudsman.	12/12/17
			In-service regarding redirecting residents and residents behavior conducted by local Health Resources.	12/12/17
			In-services regarding reporting maintenance issues after normal hours conducted by Executive Director.	12/12/17
			Maintenance repair issues will be followed by ED on a weekly basis until the repair has been completed.	12/30/17
			Per Conversation with the ED on 1/30/2018 - all staff @ the facility received the training on residents rights, reporting resident behaviors, and reporting maintenance issues — TS. Per Conversation with the ED on 1/30/2018 - the carpet in the affected room had been deep cleaned as of 12/30/2017.	

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D911	Continued From page 5 resident room #106 because the toilet had overflowed sometime after lunch on 11/18/17. -Several blankets had been placed on the carpet to soak up the water because the facility did not have anything else to help absorb the water from the toilet overflowing. -Resident #5 remained in his room on the night of 11/18/17 even though the carpet was still wet from the toilet overflowing. -Resident #5 was walking around on the wet carpet barefooted and his family had to help him change because the hem of his pajama pants had gotten wet. -The family told the staff person present in the room about Resident #5's pajama pants hem being wet. -The family asked if Resident #5 could stay in a different room until the carpet was cleaned and dried, but there were no rooms available on the SCU side of the facility. Confidential interview with a family member revealed: -The family member reported to a staff person that on 11/18/17, "Resident #5's room had a strong, musty, damp smell that was appalling" when the family visited that afternoon. -Staff told the family member that the toilet had overflowed in Resident #5's room earlier on 11/18/17. -"There were no towels or blankets on the carpet but the carpet was still wet and mushy". -There was a dark brown smelly substance all over the carpet and up to the bottom of Resident #5's bed. -The toilet in Resident #5's bathroom had not worked properly since August 2017. -The family member had made the staff in the Special Care Unit aware that Resident #5's toilet was not flushing properly.	D911		

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D911	Continued From page 6 -The family member had to tell the staff because Resident #5 was not able to tell staff about the toilet not working properly because of his cognitive status. -A (confidential) staff person would tell the Resident Care Coordinator (RCC) to address the toilet issue. -The family member spoke with the RCC on two occasions and was assured each time she'd get someone to fix it. -The socks and hem of Resident #5's pajama pants were soaked when family came to visit on 11/19/17 because Resident #5 had been walking on the wet carpet in his room. -A staff member did offer to change Resident #5's socks but the family member said "no" because the clean socks would get soiled again by the wet carpeting Resident #5 had to walk on to go to his bathroom. -The staff member then proceeded to wash Resident #5's feet, the staff member removed the soiled wet pajama pants and laid them on Resident #5's bed which was very upsetting to the family member. -"It was a germy thing to lay his pajama pants on the bed like that after he had walked on the wet carpet soiled with waste water from the toilet". -"I was very embarrassed to find the carpet was still mushy wet and the room had a foul stench on 11/19/17 because other visitors came with me to see Resident #5 in his room". -"I requested a different room for Resident #5 to stay in until the carpet in his room could be cleaned and dried but was told no rooms were available." -The family member went home and brought back a fan to help dry the carpet in Resident #5's room. -Staff never offered to move Resident #5 to another room.	D911		

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D911	Continued From page 7 -Staff said that they were told they didn't have any rooms for Resident #5. -The family went to the facility on the morning of 11/20/17 to talk to the Administrator. -The family member spoke with the RCC and Administrator and told them how very upsetting and hurtful it was to see Resident #5 living in horrible living conditions from the wet carpet and the odor from the wet carpet for two days. -"The Administrator said 'you don't need to do anything, she had already called corporate and would have an answer about what could be done because she had to get approval from corporate before they were allowed to clean up the Resident #5's room'." -The Administrator did not offer to move Resident #5 to another room within the facility. -The Administrator told the family member staff had not informed her about any problems with the toilet in resident room #106. -The family member removed Resident #5 from the facility on 11/21/17 because the family member did not want Resident #5 to continue to live in the room with wet carpeting and foul odor. -There were no plans to move Resident #5 from the facility, but the family member felt they had no other choice. -The family member was not sure what had been done about the wet carpet after 11/20/17. Interview with the Administrator on 11/30/17 at 1:40pm revealed: -She was aware of a leak in resident room #106 in the SCU that occurred over the weekend of 11/18/17. -Resident #5 stayed in resident room #106 during the weekend of 11/18/17 when carpet was wet because there were no other rooms available in the SCU. -She was not sure if the family had been notified	D911		

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D911	Continued From page 8	D911		

of the leak prior to their visit at the facility.
-The family of Resident #5 came in on the morning of 11/20/17 and told her what happened over the weekend.
-The family wanted the carpet to be removed from Resident #5's room but she told the family she couldn't rip the carpet up because of the water damage without approval from the corporate office.

Refer to confidential interview with a second staff member.

Refer to confidential interview with a third staff member.

Refer to interview with the RCC on 11/30/17 at 1:11pm.

Refer to interview with the Administrator on 11/30/17 at 1:43pm.

2. Review of Resident #12's current FL-2 dated 8/10/17 revealed:
-Diagnoses included dementia with behavior disturbances, atrial fibrillation, anxiety, mononeuropathies, hypertension, arteriosclerotic heart disease, gastro-esophageal reflux, and hyperlipidemia.
-Resident #12 was intermittently disoriented and a wanderer.
-Resident #12 was ambulatory.
-Resident #12's level of care required placement in a Special Care Unit.

Review of the Resident Register for Resident #12 revealed he was admitted to the facility on 2/20/17.

Review of Resident #12's Care Plan dated

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D911	Continued From page 9 3/24/17 revealed: -Resident #12 was a wanderer and intermittently disoriented. -Resident #12 had significant memory loss and had to be directed. Based on observation, interview, and record review, Resident #12 was not interviewable. Confidential interview with a staff member revealed: -Resident #12 resided in resident room #106 in the SCU. -The carpeted floor was soaked with water in resident room #106 because the toilet had overflowed sometime after lunch on 11/18/17. -Resident #12 remained in his room while the carpet was wet from the toilet overflowing on 11/18/17. -Resident #12 had to walk on the wet carpet to use the bathroom. Refer to confidential interview with a second staff member. Refer to confidential interview with a third staff member. Refer to interview with the RCC on 11/30/17 at 1:11pm. Refer to interview with the Administrator on 11/30/17 at 1:43pm. Confidential interview with a second staff member revealed: -The toilet overflowed in resident room #106 in the Special Care Unit (SCU) on 11/18/17 during the early afternoon. -Water had overflowed from toilet the bathroom,	D911		

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D911	Continued From page 10 into the resident's room and out into the SCU main hallway. -"Water was everywhere". -"The water was pooling on the carpet when you walked in the room". -Staff tried to use towels but there was too much water. -The RCC was there and she told the staff to use blankets to help absorb up the water. -The RCC notified the Administrator about the flooding in resident room #106 in the SCU on the afternoon of 11/18/17 (time not specified). -No residents were in the room when the staff discovered the toilet had overflowed on 11/18/17. -The carpet in resident room #106 was still mushy and wet on 11/19/17. -Resident #5 and Resident #12 were both living in resident room #106 but there was no other room on the SCU for the residents. -Resident room #106 in the SCU had a strong musty odor 3 or 4 days because of the wet carpeting. Confidential interview with a third staff member revealed: -Water flooded out of resident room #106's bathroom on 11/18/17 sometime after lunch. -The toilet had overflowed in resident room #106's bathroom and water had flooded from the bathroom all the way out into the hallway in the SCU. -"The water had pooled about 2 inches deep inside resident room #106 because the water came up on the staff shoes". -No residents were in the room when the toilet overflowed on 11/18/17. -Staff was able to dry up the floor in the hallway but they did not know what to do about the carpet in resident room #106. -The staff told the RCC about the overflowing	D911		

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toilet and flooding but the RCC did not help.
-The staff had to use blankets to help absorb the water in the carpet.
-The staff left the blankets on the carpet to help absorb the water and remove them as they got wet.
-There was no color to the water from the carpet initially when the toilet first overflowed.
-The water from the carpet did turn brown later but staff thought it may have been from dirt in the carpet.
-The carpet in resident room #106 was still wet on 11/19/17 and the room had foul musty odor from the wet carpet.
-Staff still had to use blankets to help absorb the water out of the carpet.
-Both Resident #5 and Resident #12 were still living in resident room #106 on 11/20/17.
-Neither resident was moved out of the room while the carpet was still wet.
-There were no empty rooms in the SCU to move the residents to.
-The staff sprinkled carpet deodorizer on the carpet before it was shampooed because of the odor.
-The Administrator had the carpet in resident room #106 in the SCU shampooed on 11/20/17.

Interview with the Resident Care Coordinator (RCC) on 11/30/17 at 1:11pm revealed:
-She saw the leak in resident room #106 in the SCU during the weekend of 11/18/17, but she was unsure of the time.
-She kept putting towels on the leaking water due to the toilet running over.
-The leaking water came out onto the carpet in resident room #106.
-The flooding from the toilet was in the bathroom in resident room #106 and extended approximately a 2 foot radius into the living space

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D911	Continued From page 12 of the resident room. -Staff turned off the water supply to the toilet and contacted housekeeping. -The RCC told the housekeeper to put a sign on the door saying not to use the bathroom. -The RCC contacted the Administrator on 11/18/17 and informed her of the overflowing toilet in resident room #106 in the SCU. -The water was cleaned up by using towels. -Staff texted the RCC on 11/19/17 that the carpet was still wet in resident room #106. -The residents stayed in the room on 11/18/17 and 11/19/17 because there were no other rooms available in the SCU. -The Administrator began to follow up on the incident that had occured over the weekend on Monday, 11/20/17. -On 11/20/17, the facility staff got a shampooer and cleaned the carpet in resident room #106 in the SCU. -"There was an odor in resident room #106 on 11/20/17 but not due to wet carpet (she could not specify origin of odor was not from the wet carpet)". Interview with the Administrator on 11/30/17 at 1:43pm revealed: -She was aware of a leak in resident room #106 in the SCU that occurred over the weekend of 11/18/17. -The RCC and staff cleaned the water up on 11/18/17. -Staff did not report any problems with the carpet being excessively wet on 11/19/17. -Both residents stayed in the resident room #106 during the weekend of 11/18/17 when carpet was wet because there were no other rooms available in the SCU. -Staff told her the leak was located in the bathroom of resident room #106 and only a small	D911		

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D911	Continued From page 13 area of the carpet outside the bathroom door had gotten wet. -She was not aware of complaints from any family members about resident room #106 about odors. -The carpet in resident room #106 was still damp and she shampooed the carpet several times on 11/20/17. -There was a faint odor when she walked in the SCU on 11/20/17 and resident room #106 smelled "old". -"The odor only lasted a day or so" after she cleaned the carpet. -She had a meeting on 11/21/17 with staff regarding how to handle emergency situations like flooded residents' rooms. -If flooding happened again in a resident's room, she would call corporate and move the residents to another facility. 3. Confidential interview with a family member revealed: -The family member was there with two other visitors in the SCU on the afternoon of 11/18/17. -The family member and visitors heard loud voices that could be heard from down the hall. -The visitors stood up and walked out into the hallway to see what the commotion was. -They observed Staff A yelling at Resident #11 but could not hear clearly what was said by Staff A or knew what Staff A's position was called. -Staff A yelled at Resident #11 loud enough to be heard from the activity room down the hallway in the SCU and Staff A continued yelling at Resident #11 for a few minutes. -The family member could not specify how long the encounter was but Resident #11 got upset and started yelling back at Staff A when Staff A yelled at her. -"Resident #11 was a nice lady" and the family member could not understood why Staff A was	D911		

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D911	Continued From page 14 screaming at Resident #11." -"Other staff were present but there was no intervention to stop Staff A from yelling at Resident #11." -Resident #11 eventually walked away but the family member could see that Resident #11 was upset. -The family member and visitors were surprised to think that something like that could happen in a SCU but did not report the incident to anyone at the facility. Confidential interview with a staff member revealed: -The staff member observed Staff A hollering at Resident #11 during the weekend 11/18/17. -Staff A yelled loudly at Resident #11, "she's everywhere; she can't be in there". -"Staff A's tone of voice was harsh and unnecessary". -Resident #11 became very upset and "went off" on Staff A. -Resident #11 started yelling back at Staff A after Staff A yelled at Resident #11. -She did not intervene or report the incident because she did not want to lose her job. Interview with the Resident Care Coordinator (RCC) on 11/30/17 at 1:11 PM revealed: -She was not aware of staff using a harsh tone of voice with any resident. -No one had reported any issues to her regarding staff speaking to residents inappropriately in the SCU. -She was unaware of any reports of Staff A speaking loudly to Resident #11. Interview with the Administrator on 11/30/17 at 1:40pm revealed: -She was not aware of staff speaking loudly to	D911		

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D911	Continued From page 15 Resident #11 during the weekend of 11/18/17 or during any other time. -She expected all residents to be treated with dignity and respect with their rights honored. -She would initiate an investigation into what happened involving a report of Resident #11 being spoken to in a harsh and loud tone of voice by Staff A. Staff A was not available for interview prior to survey exit. _____ The failure of the facility to maintain the dignity and respect of residents in the Special Care Unit by allowing two residents (#5 and #12) to being subjected to substandard living conditions by exposure to contaminated carpeting saturated from seepage from an overflowed toilet and one resident being yelled at disrespectfully by staff resulted in substantial risk for serious neglect and constitutes a Type A2 Violation. _____ Review of the facility's Plan of Protection dated on 12/1/17 revealed: -Complete an internal maintenance system order to have carpet in resident room #106 removed within 48 hours. -Order will be tracked weekly. -Complete 24 hour report on alleged abuse by 12/1/17. -Complete internal investigation by 12/8/17. -Complete 5 day report and send to Health Care Personnel Registry by 12/8/17. -Inservice with staff about reporting abuse and resident rights by 12/15/17. -Inservice with staff regarding reporting maintenance issues by 12/15/17. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER	D911		

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D911	Continued From page 16 30, 2017.	D911		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to respond to a resident's requests (#9) to be moved to another room due to verbal arguments with his roommate. The findings are: Review of the facility's resident room assignment provided on 11/28/17 revealed Resident #9 and his roommate were assigned to resident room #208. Review of Resident #9's current FL-2 dated for 8/22/17 revealed: -Diagnoses included renal failure, diabetes, hypertension, coronary artery disease, neuropathy, dysphagia, and urinary retention. -His orientation was listed as intermittent. -There was no documentation that Resident #9 was verbally abusive. Review of Resident Register for Resident #9 revealed he was admitted to the facility on 11/21/16. Interview with Resident #9 on 11/28/17 at 12:08pm revealed:	D917	Resident Rights in-service conducted by local ombudsman. In-service regarding redirecting residents and resident's behavior conducted by local Health Resources. In-Service on accident and incident reporting regarding residents behavior conducted by local Health Resources and Executive Director. * Re conversation with the ED on 1/22/2018 - all staff at the facility received the Training on Resident Rights, Reporting/Redirecting Resident behavior.	12/12/17 12/12/17 12/12/17

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D917	Continued From page 17 -The resident threw his arms up and stated "somebody needed to do something about his roommate." -He was "sick and tired of his roommate yelling and hollering out all times of the night, every night." -He hadn't had any sleep for the past four nights. -He doesn't have any peace of mind or rest in his room because of his roommate. -Resident #9 was tired of his roommate touching his belongings in the room. -He thought his roommate had dementia or something because he couldn't remember anything. -Everybody heard his roommate hollering out for his wife constantly because he was very loud. -He had not gotten along with his roommate since he had been admitted to the facility and became his roommate about 4 months ago. -Resident #9 had told the staff that he could not get along with his roommate; but could not specify what staff were told. -They argued at least every other day and night. -It seemed like they argued all of the time. -When he asked for another room, staff told him to wait for the new wing of the facility to be finished and then he would have his own room. -Staff encouraged him to"hang in there with his roommate." -The resident had to go to the activity room or outside to the smoking area to get away from his roommate to have "peace of mind." -He was going to continue to do his best to wait until the new side of the facility was finished so he could have a private room. Review of Resident #9's charting notes revealed: -Between 8/18/17 and 10/31/17, four different staff members documented five different entries of arguments between Resident #9 and his	D917	Facility will make plans to move the residents to another room if available or assist with finding other placement as soon as possible if resident would like to move. Resident satisfaction, will be monitored weekly by management and reports of any dissatisfaction will be reported to and addressed by management.	12/12/17 12/30/17

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D917	Continued From page 18	D917		

roommate that included yelling that could be heard down the hallway of the facility. All resident verbal arguments between Resident #9 and his roommate occurred in their room.
-Five entries were made by four staff persons noting verbal arguments between Resident #9 and his roommate.
-Two entries noted that the Administrator had been notified of the verbal arguments on several occasions.

Confidential interview with three staff members revealed:
-Both residents had a "love, hate" relationship; but mostly did not get along with each other.
-Sometimes the roommate would go over on Resident #9's side of the room and touch his belongings and the arguments would start.
-Resident #9 would argue and yell att his roommate whenever he would holler out for his wife who was in the Special Care Unit at the facility almost every night.
-Resident #9 would leave the room after they had argued and would go to the activity room to use his computer or outside to smoke.
-They thought Resident #9's roommate had early dementia because he would forget what he had done to make Resident #9 upset.
-His roommate would often forget where his room was located and had to be redirected by staff.
-Resident #9 would start arguments with his roommate by saying "your wife doesn't hear you or want to see you."
-They argued often and loudly possibly two to three times a week.
-Their arguments could be heard down the hallway.
-They had been arguing since his roommate came to the facility about four months ago.
-They did not document the rguments between

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D917	Continued From page 19 the roommates. -They have told the medication aides (MAs) and Resident Care Coordinator (RCC) and the Administrator was aware because she went to their room on at least two occasions. -They were told to remind Resident #9 by the MAs that the new wing of the facility would be complete soon and he would have his own room again. Confidential interview with a fourth staff person revealed: -Residents #9 and his roommate did not get along at all. -They have not been getting along for at least four months now since his roommate came. -Resident #9 had grown used to having the entire room to himself. -She had not told management because "talking to them was like talking to the wall." -She documented everything she could regarding Residents #9 and his roommate were not getting along in their room together. -Resident #9 provoked his roommate by making comments about his wife. -Resident #9 usually left his room after an argument and went to the activity room. -Most of their arguments occurred also because Resident #9 liked the room cold and his roommate liked for the room to be warm. -Resident #9 wanted the door open to their room and his roommate wanted the door closed. -She asked Resident #9 to try and compromise with his roommate so they could get along better but that did not seem to work. -Nothing different was ever tried to deescalate the arguments between the two roommates. -There were at least two empty resident rooms on the adult care side of the facility, but neither resident was moved or offered another room.	D917		

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D917	Continued From page 20 -Resident #9 had asked staff a few times could he have his own room but was told by management to wait for the new side of the facility to be finished. Interview with a Medication Aide (MA) on 11/30/17 at 12:50pm revealed: -Resident #9 picked on hs roommate and started the arguments. -The picking and arguments were an everyday thing for the two residents. -They really needed to be separated. -The facility had extra rooms available. -Resident #9 was told to hold on by management until the new wing was finished. -It would not have been a problem to separate the two residents with the extra rooms available. -Resident #9 wanted to be moved out of the room and had told the Administrator several times. -Resident #9 wanted a room to himself. Interview with the Resident Care Coordinator (RCC) on 11/30/17 at 1:11pm revealed: -Resident #9 and his roommate don't get along at times. -Staff have had to separate them at times. -Sometimes they got along. -They were separated once that she was aware of. -Both had been arguing since Resident #9's roommate moved in about 4 months ago. -She and the Administrator had talked about the issue of the two roommates not getting along in the past. -No one had been moved to another room and she did not know why. -The facility did have unoccupied rooms available maybe one or two; but the Administrator could answer that question. -His rommate didn't bother anyone.	D917		

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D917	Continued From page 21 -The arguments lasted about 5 minutes and got loud at times between the two residents. Interview with the Administrator on 11/30/17 at 1:40pm revealed: -She knew Residents #9 had a roommate. -The roommate of Resident #9 laid in bed a lot and he spent a lot of time on his computer or outside smoking. -One or two times both residents were talking loudly, but were calmer when she talked to them. -No staff had informed her that there was a problem with between the residents. -She was unaware the residents were having arguments or issues with getting along in their room together. -She did not do anything because she was not aware of a problem between the two roommates. -The facility had one extra semi-private room available and one private room available. -She had not told Resident #9 to wait until the new wing of the facility was completed to move into his own room. _____ The facility failed to provide a reasonable response to Resident #9's requests to be moved to another room due to verbal arguments with his roommate, which resulted in Resident #9 experiencing emotional distress, loss of sleep, and an infringement of his right to stay in his room in a nonthreatening, safe environment as evidenced by Resident #9 having to leave his room and go to other areas of the facility when verbal altercations occurred. The facility's failure to respond to Resident #9's repeated requests resulted in serious neglect of Resident #9 which constitutes a Type A2 Violation. _____ Review of a Plan of Protection dated 12/1/17	D917		

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D917	Continued From page 22 revealed: -Give each resident the option to move to an alternate room by 12/6/17. -Notify family, physician, psychologist of resident behaviors within 48 hours. -In-service staff on accident and incident reports regarding resident's behaviors by 12/15/17 -In-service staff on reporting resident's behaviors by 12/15/17. -If an issue arises between two residents, the facility will make plans to move the resident to another room if available or assist with finding other placement as soon as possible. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 30, 2017.	D917		