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	HAL043015	A. BUILDING: _____ B. WING _____	C 10/26/2017

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OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 10/18/17 - 10/20/17 and 10/23/17-10/26/17. The complaint investigation was initiated on 09/20/17 by Harnett County Department of Social Services.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure the dining room floor was kept clean and in good repair and failed to keep the mini blinds in the windows of the dining room clean. The findings are: Review of the facility's sanitation report dated 10/25/17 revealed the facility received a score of 93. Observation of the dining room floor on 10/19/17 at 9:33 a.m. revealed: -There was a black build-up of dirt and grime along the edges of the floor baseboards with a heavier concentration in the front section of the dining room. -There was collected dust and debris in the	D 074		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 12/14/17

The plan of correction was reviewed and accepted with addendum on 12/20/17. Refer to addendum on pages 4, 10, 54, and 72. -Bradley 12/20/17

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D 074	Continued From page 1	D 074		

corners of the floor throughout the dining room.
-The floor around the first 3 tables had scattered black scuff marks.
-There were long black scuff marks around a second table located close to an outer window.
-There were scattered areas of a black build-up on the dining room floor.
-The floor covering had 2 chipped areas that exposed the black under layer surface of the floor.

Interview with a Dietary Aide (DA) on 10/ 19/17 at 3:46 p.m. revealed the DAs did the sweeping and mopping three times daily in the dining room after the residents' meals were served.

Interview with the Dietary Manager (DM) in 10/20/17 at 9:07 a.m. revealed:
-The DM had worked at the facility since 2013 and in his current role as DM since last year.
-Dietary Aides were responsible for cleaning tables, sweeping and mopping the floors every day in the dining room.
-The DM and the cook were responsible to assure all cleaning was done in the kitchen and dining room at the end of their shift.
-The DM was not sure who was responsible to do the "deeper cleaning" of the dining room floor and baseboards but thought it may be housekeeping or maintenance.
-The DM had noticed the black build-up along the floor's baseboards a few weeks ago.
-The DM had a laminated cleaning schedule for dietary staff to follow that was posted in the kitchen.
-The DM or the Cook assigned the cleaning tasks.
-The laminated cleaning schedule had been missing for about 2-3 weeks but the DM had planned to have the cleaning schedule reposted

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D 074	Continued From page 2 as soon as possible. -All dietary staff had been instructed by him about the cleaning tasks for the dining room. -The DM or the Cook were required to physically walk around the dining room at the end of each shift to assure all cleaning needs had been done. -The DM knew that some cleaning tasks were missed from time to time. Interview with Maintenance person on 10/25/17 at 10:31 a.m. revealed: -Maintenance was responsible for stripping and buffing the floor. -The dining room floor was last stripped and buffed in the spring of this year and it was time to be done again. -The Maintenance person usually stripped and buffed the dining room floor 2-3 times per year. Confidential interview with a staff member revealed: -The black build-up around the baseboards and floor "bothered the staff member" but the staff never heard any of the resident's complaining about it. -The staff member had not reported the black build-up to management. Confidential interview with a second staff member revealed dietary staff mopped after the residents meals but did not have time to do detailed mopping in the dining room. Interview with the Administrator, Assistance Executive Director and the Marketing Director on 10/20/17 at 9:34 a.m. revealed: -The dining room floor had some damaged areas that could not be removed, other areas were scuffs and other areas were dents. -The baseboard edges had been damaged and	D 074	D074 Standard Def. Housekeeping & Furnishings *Facility informed surveyor that building improvements would start in November 2017, not be completed. *Facility housekeeping immediately cleaned the baseboards in the dining room on 10/20/17. *Baseboard and blinds cleaning was added to monthly cleaning schedule on 12/7/17, to be implemented on 12/22/17. (attachment A) *Dining staff will be responsible for items on the monthly cleaning schedule. The Dietary Manager will ensure compliance. *Plan will be ongoing. Facility back into compliance by 12/10/17 *On 12/6/17 facility marketing director contacted Lee Marshall to repair dented/ chipped tiles in the dining room. The repair work will be completed by 1/30/18 (attachment B) *New blinds for the dining room were ordered by the facility administrator on 12/7/17. Installation will take 3-6 weeks. (attachment C) *Facility back into compliance of floors & blinds by 1/30/18.	

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D 074	Continued From page 3 pushed in at the bottom that adjoined the floor which made it difficult to clean in the edges. -Dietary staff were responsible for sweeping and mopping three times a day and to assure the dining room floor remained clean. -The dining room was planned for renovation the end of November 2018. Observation of the dining room floor on 10/24/17 at 4:20 p.m. revealed: -The black build-up had been removed along the baseboards. -The Black scuff marks had not been removed. Observation of the blinds in the dining room on 10/24/17 at 4:23 p.m. revealed: -There was a mini blind hanging in the window on the right side of the dining room that was heavily soiled in orange and red stains that covered the bottom fourteen slats of the mini blind. -There was a second mini blind hanging in a window of the dining room with a brown spattered stains across the lower 12 slats. -There was another mini blind hanging in a window of the dining room that had dust and grime that covered most of the slats. -There were seven other mini blinds in the dining room that had a build-up of dust and with brown stained specks scattered across the mini blinds. Confidential interview with a resident revealed the blinds in the dining room needed to be cleaned. Confidential interview with a staff revealed the staff had never seen anyone clean the blinds in the dining room. Interview with the Cook on 10/19/17 at 3:55 p.m. revealed the cook was not sure who cleaned the blinds in the dining room but thought it would be	D 074	D074 Addendum per telephone with Mr. Will Jowers, Administrator on 12/20/17: The Dietary Manager will be Conducting monthly Monitorings the dining room. BRachels	

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D 074	Continued From page 4 housekeeping staff. Interview with the Dietary Manager (DM) in 10/20/17 at 9:07 a.m. revealed the DM was not sure who was responsible to clean the blinds in the dining room but thought it may be housekeeping or maintenance. Interview with a second housekeeper on 10/23/17 at 12:18 p.m. revealed she had never cleaned the mini blinds in the dining room. Interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. revealed kitchen staff were responsible to clean the blinds in the dining room. Interview with Maintenance person on 10/25/17 at 10:31 a.m. revealed: -He had cleaned the blinds in the dining room before. -He last cleaned the blinds just before the spring of 2017 and were due to be cleaned now. Interview with the Administrator, Assistance Executive Director and the Marketing Director on 10/20/17 at 9:34 a.m. revealed: -The dining room was planned for renovation the end of November 2018 and all of the blinds in the dining room would be replaced. -Dietary staff were responsible to clean the blinds as needed.	D 074		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows	D 083		

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D 083	Continued From page 5 in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to replace vertical window mini blinds in 2 occupied resident rooms, 1 occupied resident room with bent slats in the blind and a broken curtain rod, 1 mini blind with bent slats in the front Parlor (a common sitting area) and 2 mini blinds in the dining room. The findings are: Interview with a resident assigned to room #105 on 10/23/17 at 11:59 a.m. revealed: -The mini blind in her room had been broken more than 6 months ago. -The mini blind was damaged and the curtain rod had been torn down by a previous roommate one night after her roommate with dementia "flipped out". -She had spoken with the current Assistant Executive Director about replacing the blind and the curtain rod but it had not been done yet. -She could not remember when she had told the Assistant Executive Director about the mini blind and the curtain rod but it had been a few months ago. Observation in resident room #105 on 10/23/17 at 12:14 p.m. revealed: -The mini blind had several bent slats resulting in a gap which permitted unobstructed vision from outside to the inside. -There was not a curtain over the window and a curtain rod was standing upright in the corner of the room.	D 083		

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D 083	Continued From page 6 -The resident's room was located beside the courtyard and a common sitting area was in view from the resident's window. Interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. revealed the Housekeeping Supervisor had not noticed the mini blind or curtain rod in resident room #105. Interview with the Maintenance person on 10/25/17 at 10:31 a.m. revealed: -He was told about the need for a new mini blind and the curtain rod needed to be replaced in resident room #105 about 2 weeks ago. -He was currently trying to locate a part to attach the curtain rod to in order to rehang the curtain. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed: -The Assistant Director was aware that the mini blind and curtain rod needed to be replaced in resident room #105 and had a quote to re-due the curtain rod. -The mini blind would be replaced today (10/25/17). Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Observation of resident room #206 on 10/18/17 at 11:28 a.m. revealed there were greater than ten broken and or bent slats in the mini blind hanging in the window resulting in a gap which permitted unobstructed vision from outside to inside.	D 083		

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D 083	Continued From page 7 Based on an attempted interview with the two residents that resided in room #206 on 10/18/17 at 11:39 a.m. revealed the residents were not interviewable. Interview with a Housekeeper on 10/23/17 at 12:18 p.m. revealed: -The resident's in resident room #206 pulled and tugged on the blinds a lot to look out. -The blinds in resident room #206 had been bent for several months. -She had not reported the bent blinds to anyone. Observation of the blind in room #206 on 10/23/17 at 12:20 pm revealed the blind with the bent slats had been removed leaving nothing to cover the window. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed: -The residents in room #206 would only allow a family member to do heavy cleaning in the room. -The family member comes twice yearly to do heavy cleaning. The family member just came a few days ago and took the mini blind down in the room. The facility had replaced the mini blind for the window in room #206. Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Observation of an occupied resident room #109 on 10/25/17 at 6:38 p.m. revealed:	D 083		

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D 083	Continued From page 8 -The mini blind had greater than eight bent slats resulting in a gap which permitted unobstructed vision from outside to inside. -The resident's room was located beside the courtyard and a cemented walkway was in view from the resident's window. Interview with one of the residents assigned to room #109 on 10/25/17 at 6:38 p.m. revealed she had just been moved into the room today. Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Observation of the mini blinds in the dining room on 10/24/17 at 4:23 a.m. revealed: -There was a mini blind hanging in the window on the right side of the dining room with six bent slats. -There was a second mini blind hanging in a window of the dining room that had one broken slat. Interview with the Administrator, Assistance Executive Director and the Marketing Director on 10/20/17 at 9:34 a.m. revealed the dining room was planned for renovation the end of November 2018 and all of the blinds in the dining room would be replaced. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed the mini blinds would be replaced in the dining room when the renovation was done.	D 083		

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D 083	Continued From page 9 Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Observation of the mini blind hanging in the right window in the front Parlor of the facility on 10/23/17 at 12:18 p.m. revealed the mini blind had 5 bent slats on the right side of the blind. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed the mini blind with the bent slats had been removed from the front Parlor. Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Interview with the Maintenance person on 10/25/17 at 10:31 a.m. revealed: -Staff were expected to fill out a maintenance work request when needed repairs were seen at the facility. -He inspected the facility daily and completed repairs when he seen them. Interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. revealed the Housekeeper Supervisor had noticed some bent and broken	D 083	D083 Standard Def. Housekeeping & Furnishings *Facility maintenance immediately replaced blinds in 105, 109 and 206 during inspection on 10/20/17. *On 12/8/17 facility maintenance reviewed all rooms for any repairs needed. *Blinds in the palor were ordered by facility administrator on 12/8/17. Installation will take 3-6 weeks. (attachment C) *Facility housekeeping & furnishings will be reviewed at quarterly QA meetings. Next meeting will take place in December 2017. *Facility back into compliance by 1/30/18. D083 Addendum per telephone with Mr. Will Jowell, Administrator on 12/20/17: The Maintenance Director will be conducting monthly and as needed monitoring of resident rooms and other areas of the facility. Bradley	

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D 083	Continued From page 10 mini blinds in the facility and when she saw a broken or bent mini blind she would verbally tell maintenance. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed: -Residents "mess with the blinds" and eventually the mini blinds became damaged. -The facility had received an estimate for new mini blinds in the facility a few months ago. -Maintenance was expected to do a physical walk through of the facility for needed repairs.	D 083		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 7 resident's sampled (#1, #4) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:	D 234		

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D 234	Continued From page 11 1. Review of Resident #1's current FL-2 dated 06/13/17 revealed diagnoses included syncope collapse, congestive heart failure, acute kidney failure, and late effects of cerebrovascular disease. Review of Resident #1's Resident Register revealed an admission date of 06/25/14. Review of Resident #1's tuberculosis (TB) tests revealed: -There was one TB skin test placed on 08/12/14 and read as negative on 08/14/14. -There was an untitled document for an admission/yearly TB screening dated 05/17/17 for a Purified Protein Derivative (PPD) test site of the left forearm for the resident however, there was no documentation to indicate who placed or read the TB skin test or when it was read. -There was no documentation of any other TB skin tests in the record. Interview with the Health Service Director (HSD) on 10/25/17 at 8:42 a.m. revealed: -She was not aware the TB skin test for Resident #1 was incomplete. -She would find out if they had more information on file for the TB skin in Resident #1's thinned record. Based on observations, interviews and record reviews, Resident #1 was not interviewable. Interview with Resident #1's family member on 10/24/17 at 6:45 p.m. revealed the family member was "not sure" if the resident had received a one step or two step TB screening and could not provide any additional information regarding the resident's history of TB screening's at the time the resident was admitted.	D 234	D234 Standard Def. TB Tests *Facility health services director audited all resident charts starting 10/26/17 to discover if any residents needed TB skin tests. *Facility health services director immediately asked RN with RenCare Consulting to administer any missing TB tests. *RenCare will continue to monitor new resident TB needs twice monthly. *Facility health services director will ensure first TB test has been completed prior to admission and second TB test is completed within the first year of residence at the facility. *On 12/6/17 staff were trained to notify facility health services director if TB tests are missing from the resident chart. *Facility back into compliance on 12/10/17.	

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D 234	Continued From page 12 A second interview with the HSD on 10/25/17 at 7:25 a.m. revealed: -There was no additional documentation for a second TB test for Resident #1. -The HSD would contact the primary care provider for an order for a 2 step TB screening. 2. Review of Resident # 4's current FL-2 dated 6/1/2017 included diagnoses of diabetes II, hyponatremia, hyperkalemia, insomnia, heart murmur, and hypertension. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 5/4/2012. Review of Resident #4's tuberculosis (TB) tests revealed: -There was documentation of a TB test placed on 11/16/2011 and read as negative on 11/18/2011. -There was no other TB testing found in Resident #4's record. Interview with Resident #4 on 10/20/17 at 9:07 a.m. revealed the resident was unable to recall any information regarding his past TB screenings. Interview with the Health Service Director on 10/20/2017 at 3:30 p.m. revealed, she would have to review the resident's old records to see if she could find Resident #4's second TB skin test. Interview with HSD on 10/24/2017 at 3:30 p.m. revealed: -She was not able to find Resident #4's second TB skin test in his old records. -She faxed the primary care provider (PCP) and received an order faxed on 10/23/2017 at 4:16 p.m. that the facility can do TB skin testing for	D 234		

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D 234	Continued From page 13 Resident #4.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure the health care needs of 5 of 7 residents sampled (#2 #3, #4, #5 and #6) were met by failing to notify the health care provider of Resident #2, who was experiencing continued itching and rashes, Resident #4, who continued to complain of ear pain after antibiotic ear drops ran out earlier than ordered, Resident #6, with finger stick blood sugar results outside of the established parameters; failing to follow up with a Neurologist for monitoring of a progressive disease and to schedule an Optometry appointment for Resident #5; and failing to follow-up with a urology appointment for Resident #3. The findings are: 1. Review of Resident #2's current FL-2 dated 2/13/17 revealed diagnoses of degenerative joint disease (DJD), hypertension (HTN) and hallucinations. Review of Resident #2's Resident Register	D 273		

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D 273	Continued From page 14 revealed the resident was admitted to the facility on 03/01/17. Review of Resident #2's care plan dated 3/02/17 revealed the resident's skin was normal. a. Interview with Resident #2 on 10/18/17 at 10:50am revealed: -She begin "itching all over my body about 2 months ago and tried to wash it away but it did not help". -The staff told the resident she used too much detergent when washing her clothes, but the itching continued after she decreased the amount of detergent. - The staff instructed the resident to stop scrubbing her groin and vaginal area too much when bathing. The resident started rinsing twice during bathes. -The resident's physician ordered "some powder" over a month ago and the staff "put the powder on the itching" but it did not help. The resident stopped the staff from using it. -The resident's family member transported the resident to her primary physician a few days ago (the resident did not remember the date) and he administered a "shot" and started a new medication for the itching. The itching was better. Interview with Resident #2's family member on 10/20/17 at 11:15am revealed: -The resident had been complaining of itching and had rashes under her breasts and in her groin area for about 2 months. -The resident perspired a lot and retained moisture in the folds of her skin. -The Health Service Director (HSD) discussed the use of detergent when the resident washed her clothes with the family member and the resident should use less detergent to decrease	D 273		

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D 273	Continued From page 15 itching (the resident washed her own clothes). -About 2 months ago, the resident's primary physician ordered medication for itching, but the resident refused the medication. -The family member did not know if the facility contacted the physician about the resident's complaint of continued itching. -After 2 months of itching, the family member took the resident to her primary physician and the resident received a steroid injection and several prescriptions to treat the rashes and itching. The resident was getting better. Interview with the HSD on 10/20/17 at 2:10pm revealed: -She was aware Resident #2 had been complaining of itching for several weeks. -The HSD talked with staff about the use of detergent since the resident washed her own clothes. -Because the family member was at the facility frequently (several times a week), the facility relied on the family member to communicate with the resident's physician, because he was an "outside" physician and did not make visits to the facility to see his residents. -The family member would follow-up with the physician and report any problems. -The family member transported the resident back and forth to all of her physician when needed and called the physician to report any problems or changes. -For residents who received medical care from an "in house" physician (the medical group who traveled to the facility and provided medical care to residents), any medical changes would be emailed to the physician by the HSD and the physician would respond immediately. - For residents who received medical care from an outside physician, changes would be reported	D 273		

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D 273	Continued From page 16 to the family by the HSD or medication aides (MA) and the family would follow-up with the physician. -Resident #2's family member transported her to her primary physician on 10/16/17 due to the resident continued to complain of itching. The resident received a "shot" and prescriptions for medications. -The family member had followed up with the physician 3-4 times about the resident's complaint of itching, but because of the resident's confusion, it has been difficult for the physician to come up with a treatment for the itching/rash. -The resident's family has not placed any stipulations on when and who could contact the resident's physician. -The facility would always contact the physician to report any medical emergencies. Interview with a 2nd shift personal care aide (PCA) on 10/20/17 at 2:55pm revealed: -Resident #2 had complained of itching for about 2 months. -When assisting the resident with showers, she complained of itching, but no rashes observed. -The resident always sweated when she was in her room because her roommate kept the heat on and the room was hot. -The PCA did not report the resident's itching to the MA because the MA was aware of the resident's itching. Interview with a 1st shift MA on 10/23/17 at 11:20am revealed: -Resident #2's family always transported her to medical appointments. -The resident complained of itching all over about 2 months ago. -In September 2017, the resident was ordered Nystatin powder (used to treat fungal skin	D 273		

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D 273	Continued From page 17 infections) but the resident refused the powder and it was stopped. - The resident continued to complain of itching. -The resident continued to complain of itching until her family transported her to her physician on 10/16/17 and the resident was started on new medications and a topical ointment. -The HSD was responsible for reporting resident changes/problems to the health care providers, but the MAs also reported if the HSD was not available. -The MA did not contact the resident's physician to report the itching because the resident's family member took the resident to all of her appointments Interview with a 2nd shift MA on 10/23/17 at 4:10pm revealed: -Resident #2 had been complaining about itching for about 2 months. -Her primary physician ordered nystatin powder the first of last month to be applied to the resident's back, under her breasts, on her feet, on her groin area and between her toes (which were areas the resident complained of itching) but the resident refused the treatment after only a few applications. The resident stated the powder did not help with the itching. -The MA did not report the resident's refusal to use Nystatin powder or continued itching to her physician. Review of a Physician Encounter report dated 9/01/17 revealed: -The Resident #2's chief complaint was itching under her breast and groin. -The resident complained of itching under her breast and in her groin. Stated she has been itching for the past month and has been using baby powder.	D 273		

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D 273	Continued From page 18 -The resident was diagnosed with candidiasis of skin and urinary tract infection. -The resident was ordered Nystatin Powder 100,000 unit/gram topical powder, apply to affected areas 2 times a day and 1 cup of plain vanilla yogurt to her morning tray to help prevent yeast infections. Review of a Physician Encounter report dated 9/14/17 revealed: -The resident was in to be evaluated for itching and to get urine checked to make sure the urinary infection was cleared up. -The resident was diagnosed with a rash and the Nystatin topical powder was continued 2 times a day to affected areas. Review of a Physician Encounter report dated 10/16/17 revealed: -The resident's chief complaint was itching. -Upon skin inspection, rash was noted underneath the resident's breasts and rash of right groin was worse than rash of left groin. -The resident was diagnosed with urticaria/hives (a kind of skin rash with red, raised, itchy bumps). -The resident was administered 4mg of Dexamethasone injection (intramuscular injection used to treat severe allergic reactions) and ordered Diflucan 150mg, 1tablet every day for 5 days (used to treat fungal and yeast infections); Zantac 150mg, 1 tablet 2 times a day (used as an antihistamine to treat rashes and hives) and Prednisone 10mg, 1 tablet every day for 5 days (used to treat allergic disorders). Interview with the Resident #2's primary physician's nurse on 10/23/17 at 7:05pm revealed: -On 9/01/17, Resident #2's family member brought her to the physician's office to be	D 273		

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D 273	Continued From page 19 assessed because of complaint of itching. The resident had been using baby powder to control the itching. -Nystatin Powder was ordered to be used on affected areas 2 times a day. The facility to keep medication in the medication cart. -On 9/14/17, the resident's family member brought her in for a urine screen to check for a urinary tract infection. The physician noted the resident was itching but did not change medication or assess for rash. -On 10/9/17, the resident's family member contacted the physician and asked for an order for A and D ointment to apply to a rash (no documentation of were the rash was located). -On 10/16/17, the resident's family member brought her into the physician's office to be treated for itching and multiple areas of rashes. The resident was administered a Dexamethasone injection in the physician's office, ordered Diflucan, Prednisone, Zantac and continue Benadryl cream (used as a topical treatment for itching). -There was no documentation in the resident's record of the facility's request to discontinue Nystatin Powder. -If the treatments for the resident's rash/itching were not effective, the physician expected the facility to report symptoms and keep him updated. -The physician would have referred the resident to a dermatologist or allergist if he was aware of failed treatment because the resident was allergic to multiple medications and continued itching/rashes could be an allergic reaction. Interview with another 1st shift MA on 10/25/17 at 11:15am revealed: -Resident #2 had order for Nystatin Powder on 9/01/17. The resident complained the powder did not improve the itching and after a few days, the	D 273		

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D 273	Continued From page 20 resident refused the powder. -On 9/13/17, the MA faxed a request to the resident's physician to discontinue the Nystatin Powder due to the resident refused treatment. -The physician never responded to the fax and the medication was not discontinued. The MA did not follow-up. -The resident continued to inform staff she was itching without relief, but the MA did not know if her physician was informed. Interview with the HSD on 10/25/17 at 1:00pm revealed: - Resident #2's primary physician referred the resident to a dermatologist on 10/24/17 and the physician's staff will make appointment. -The resident continued to complain of itching and she told the resident family member to contact the physician and report the itching. -The HSD nor the MAs had reported the resident's complaint of continued itching. Refer to interview with the facility's Administrator on 10/24/17 at 4:30pm. b. Review of a Physician Encounter report for Resident #2 dated 9/01/17 revealed: -The Resident #2's chief complaint was itching under her breast and groin. -The resident complained of itching under her breast and in her groin. Stated she has been itching for the past month and has been using baby powder. -The resident was diagnosed with candidiasis of skin. -The resident was ordered a treatment of 1 cup of "plain vanilla" yogurt to her morning tray to help prevent yeast infections. Review of Resident #2's electronic medication	D 273		

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D 273	Continued From page 21 administration record (EMAR) for September 2017 and October 2017 revealed the yogurt was not listed on the MARs. Observation in the facility's dining room on 10/25/17 at 8:25am revealed Resident #2 was eating breakfast and yogurt was not on the table. Interview with the Dietary Manager on 10/25/17 at 11:40am revealed: -If the dietary was given an order to place a cup of yogurt on a resident's tray, the order would be treated like other diet orders and would be given to the resident with her meal as ordered. -The Dietary Manager checked all orders and stated the yogurt order for Resident #2 was not given to the dietary staff and the resident has not received yogurt with her morning meal. Interview with Resident #2 on 10/25/17 at 12:05pm revealed: -The resident had never received yogurt with her meals at any time since the itching and yeast infection began 2 months ago. -The resident would eat the yogurt if it was provided if it would help the yeast infection/itching. Interview with Resident #2's primary physician's	D 273		

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D 273	Continued From page 22 -Since this order was a treatment it should have been faxed to the pharmacy and put on the EMAR. -The HSD would clarify the order today with the resident's physician and fax the order to the pharmacy. -The Administrator informed the HSD on 10/24/17, she would have to review all orders from all medical providers. 2. Review of Resident #3's current FL-2 dated 8/1/17 revealed a diagnosis of MS (multiple sclerosis). Review of Resident #3's Resident Register revealed he was admitted on 8/19/16. Review of Resident #3's physician's orders revealed: -There was an order written on 8/14/17 for Augmentin 500mg by mouth 2 times a day for 7 days (a medication used to treat infections).	D 273

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	d From page 23	D 273		
	office makes the referral to a s. cialist office then calls the facility to set ointment with the facility transporter. s a new staff doing the transportation at now. ty does not make the initial referral to a			
	with HSD on 10/23/17 12:20 p.m.			
	y had hired a new transportation 9/4/17 to take residents to their appointments. portation person was hired to work half s a PCA (personal care aide) and half s a transporter for resident nts. had not always let the facility know eduled appointments for residents. porter was just told today about 3 needing a urology appointment and appointment today. and Administrator share a resident nt computer calendar with the			
	ew order was received from a PCP the Aide (MA) would review it and fax any ation order to the pharmacy. If there is ppointment that needed to be made, let transporter know via text and			
	th the facility transportation person on 12:15 p.m. revealed: d at the facility about one and a half			

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D 273	Continue -The PC specialis - The sp up the a -There w the facil -The fac specialty Interview revealed: -The fac person c schedule -The tran the time the time appointm -The PCP about sch -The tran Resident will get th -The HSD appointm transporte -When a Medicatio new medi a doctor's the MA wi e-mail. Interview 10/23/17 -She starte months ag -She did n	D 273		

nurse on 10/25/17 at 10:35am revealed:
-The physician ordered 1 cup of "plain vanilla" yogurt on the resident's morning tray to prevent yeast infection.
-The order was ongoing and the resident should be receiving the yogurt every day. There was not a stop date for the yogurt.

Interview with the HSD on 10/25/17 at 1:00pm revealed:
-She did not know about the yogurt order.

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D 273	Continued From page 24 Resident #3 needing a urology appointment. -She would make Resident #3 a urology appointment today. -Transportation person reviews appointments with the HSD. Telephone interview with office organizer for the provider at PCP's office on 10/25/2017 at 11:10 a.m. revealed: -The facility should call to make the appointment once a referral was done by the PCP's office. -The PCP office would fax the facility with the name of the doctor that they are referring the resident to. Interview with a MA on 10/23/17 at 10:50 a.m. revealed: -The Transportation person was responsible to bring back any documentation from the medical provider to the MAs. -The MAs or the Transportation person would place referral appointments or follow up appointments on a board/calendar in the medication room so staff could keep track of appointments for the residents. -All appointments were given to the HSD after the MAs received follow up needs documentation from the Transporter. -Transportation would schedule "a lot of residents follow up appointments". Telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m. revealed: -He was the only Transportation person for the facility for many years (greater than 5 years). -He had transitioned into the MA role in June/July of 2017. -The Transportation person was responsible to bring all documentation back from the residents'	D 273		

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D 273	Continued From page 25 medical appointments and give it to the MA that was assigned to the hall the resident resided on. -The MAs were responsible to assure the documentation from medical appointments were filed in the resident's record. -The Transportation person was responsible for all follow-up appointments and to assure that the follow-up appointment was scheduled and done. -Scheduled follow-up appointments were recorded and kept in his appointment book. -The residents "appointment book was my bible". -If a resident was scheduled for a return visit in 6 months, one year or whatever was planned, it was Transportation's responsibility to track and keep up with that appointment to assure the residents' follow up was done. -MAs were not responsible to document follow-up appointments anywhere in the chart. -The Transportation person was required to take a form to the medical provider to fill out during the appointments. The form had to be returned to the MA when there were labs, medications changes or when there were no medication changes, new or changed orders. -If the resident only needed a follow up appointment then the form for the provider was not needed. -As a MA, no documentation was required for follow up appointments. Confidential interview with a staff revealed: -Follow up needs were not always communicated or documented which had been an issue for the past year. -The staff member felt there was a "disconnect" concerning follow up needs for the residents. -The staff thought changes in staff working at the facility, changes in management, supervisors and the current system in place had caused appointments to be missed.	D 273		

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OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

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D 273	Continued From page 26 -The staff felt that a 100 percent review of all residents' charts was needed. -The previous HSD audited resident's charts. -The current HSD had not been there long and had not had a chance yet to do a chart audit on all charts. -Processes for follow up appointments had been improving some since the current HSD started. Interview with the Administrator on 10/26/17 at 3:08 p.m. revealed: -The Transportation person was responsible for all follow-up appointments. -Transportation was overseen by the Administrator or the HSD when there was a problem reported by the Transportation person related to the follow-up appointment. -The Administrator did not have a system in place to assure all follow-up appointments were done. -The Administrator expected the PCP to "keep track of that" since they were the ones that needed the information. 3. Review of Resident # 4's current FL-2 dated 6/1/2017 included diagnosis of diabetes II, hyponatremia, hyponatremia, hyperkalemia, insomnia, heart murmur, and hypertension. Review of Resident #4's orders dated 9/18/17 included an order for Ciprodexotic drops 4 drops ot B/L ears bid x 7 days. Interview with Resident #4's on 10/18/17 at 10:45 a.m. revealed: -The resident was hard of hearing. -The resident had received ear drops after an appointment with his primary care provider (PCP) 2 months ago. -The resident had only received the ear drops twice and it was supposed to be for 7 days.	D 273		

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D 273	Continued From page 27 -The resident still had ear pain but not every day. -The resident does not remember if he told staff about the ear pain. -The resident did not know if he needed another appointment with his PCP after the ear drops. -The resident had not followed up with his PCP since receiving the ear drops. Interview with a medication aide (MA) on 9/20/17 at 9:07 a.m. revealed: -The MA had called the facility pharmacy to renew the ear drops when she could not find them on the medication cart on 9/23/17. -The MA did not document the call to the pharmacy. -The pharmacy would not refill them because his insurance would not pay for it. -The MA called the residents PCP to notify them the resident did not have enough ear drops to complete the 7 days. -The PCP office would not send another prescription to the pharmacy. -The MA could not remember if she had notified the Health Service Director. -Resident #4 had not mentioned to her that he has had ear pain since getting the ear drops. Interview with the Health Service Director (HSD) on 10/23/17 at 8:10 a.m. revealed: -The HSD would expect the MA to come to her if they were having trouble refilling a medication. -The HSD did not remember hearing about Resident #4 running out of ear drops. Telephone Interview with a nurse at Resident #4's PCP office on 10/25/17 4:55 p.m. revealed: -The PCP office had no record of receiving a call from the facility requesting a refill of Ciprodex ear drops. -The PCP office would expect to be notified of a	D 273		

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D 273	Continued From page 28	D 273		

medication not completed as ordered.
-It was possible that if the 7 days of Ciprodex ear drops were not completed and that the ear infection was not resolved that the resident could continue to have ear pain if the ear infection was not resolved.

4. Review of Resident #6's current FL-2 dated 03/02/17 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, schizophrenia, depression, urge incontinence, and hyperlipidemia.
-There was an order to call the primary care provider (PCP) for blood sugars greater than 400.
-There was an order for diabetic urine testing twice daily.

Review of a subsequent physician's order for Resident #6 dated 07/27/17 revealed there was an order to check blood sugars twice daily. Call MD if the blood sugar was greater than 400. If the blood sugar was less than 60 give 8 ounces of orange juice and repeat the blood sugar in 30 minutes. Call MD if blood sugar is still less than 60 scheduled for 7:30 a.m. and 4:30 p.m.

Review of Resident #6's electronic Medication Administration Records (eMARS) for August 2017 revealed:
-The Medication Aides (MAs) documented the resident's blood sugar was 409 on 08/04/17 at 7:30 a.m., 407 on 08/10/17 and 08/25/17 at 4:30 p.m.

Telephone interview with a MA on 10/26/17 at 1:33 p.m. revealed:
-The MA remembered occasional incidents that Resident #6's blood sugars were greater than 400.
-The MA had checked Resident #6's blood sugar

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D 273	Continued From page 29 on 08/04/17 at 7:30 a.m. -The MA did not call the PCP each time Resident #6's blood sugars were high because it was unusual for the resident's blood sugars to be over 400 and thought it could have been related to something the resident had eaten that day. -The MA remembered that she did speak with the PCP after she had noticed that her blood sugars had been high a few times a "while back". -The MA did not document when she had spoken with the PCP regarding the resident's elevated blood sugars. Attempted interview with the Health Service Director on 10/26/17 at 2:15 p.m. was unsuccessful. Telephone interview with the Administrator on 10/26/17 at 3:10 p.m. revealed: -The Administrator expected blood sugar parameters to be followed as ordered. -When Resident #6's blood sugars were out of the ordered parameter range the MA should have called the PCP and should have called the Administrator or the HSD for further directions. -The Administrator expected for the MA to document in the communication book when the PCP was notified regarding Resident #6's blood sugars greater than 400. Telephone interview with Resident #6's physician on 10/26/17 at 12:37 p.m. revealed: -The physician expected to be notified when the resident's blood sugars were greater than 400 as ordered. -The physician could not recall that she had been notified of the resident's blood sugars being greater than 400 however the blood sugars could have been reported to the Nurse Practitioner. -She expected the facility to follow the order and	D 273	D273 Type B Violation Health Care 1. Notification of Health Provider: *Facility health services director immediately audited all resident charts starting 10/26/17 to ensure outstanding concerns were addressed. *Facility health services director immediately updated on 10/23/17 provider visit form to enhance communication between facility and provider. Forms made avail. to families. (attachment E) *Staff were trained by the facility health services director and the administrator on how to use this form on 10/28/17. (attachment F) *Families were advised of this form using the facility newsletter. (attachment G) *Hot spot charting method was implemented by the facility health services director starting 10/26/17. Staff were given training on how to properly chart on 10/28/17 (attachment F) and 11/3/17 (attachment H). *Facility administrator implemented new documentation policy on 10/28/17, including policies for provider communication and in-facility charting (attachment I)	

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D 273	Continued From page 30 call at the time the blood sugar levels were outside of the ordered parameters so direction and possible medication adjustments could be given. 5. Review of Resident #5's current FL-2 dated 12/06/16 revealed: -Diagnoses included multiple sclerosis (MS), depressive disorder, hyperlipidemia, constipation and urinary incontinence. -The resident was intermittently disoriented and semi-ambulatory using a wheelchair. a. Review of a Neurology office visit report for Resident #5 dated 05/26/15 revealed assessment and plan included: no medication changes, refer to physical therapy, lab work for routine monitoring and return in 6 months and to call with questions in the interval. Review of Resident #5's medical care visit notes, primary care orders, and Resident Notes did not reflect a follow-up appointment with a Neurologist after 05/26/15. Interview with Resident #5 on 10/19/17 at 4:25 p.m. revealed: -She had seen a Neurologist in the past but could not remember when she was last seen. -The resident had daily pain and weakness in her legs and was taking medication for the pain which helped some. Telephone interview with Resident #5's family member on 10/24/17 at 7:45 p.m. revealed the family member was not aware of any Neurologist appointments for the resident. Interview with a Medication Aide (MA) on 10/23/17 at 10:03 a.m. revealed:	D 273	*All provider communication forms will be turned into the health services director for review, to ensure appropriate follow-up. *On 12/8/17 an action checklist was implemented by facility to ensure follow-through on provider instructions. The facility health services director will audit forms to ensure ongoing compliance. (Attachment K) *The facility health services director will monitor hot spot and provider communication sheets daily to ensure appropriate follow up and ongoing compliance. *Cape Fear LTC Pharmacy consultant will review MAR quarterly to ensure PRN medication usage is consistent with appropriate follow up to providers. *Med techs and health services director will monitor the MAR routinely and will report events as needed, according to policy (Attachment I) *Facility back into compliance 12/10/17. 2. Running out of medication(s): *On 10/26/17 facility Med Techs immediately audited the medication cart to ensure all medications were accounted for.	

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D 273	Continued From page 31 -She was not sure if Resident #5 had any additional follow-up from her 05/26/15 appointment with the Neurologist. -Visit notes from medical appointments should be filed in the resident's record after each visit. A second interview with the MA on 10/23/17 at 10:50 a.m. revealed: -The MA called the Neurologist's office and was told that a follow-up appointment was scheduled for 11/23/15 but the Neurologist's office canceled that appointment scheduled for 11/23/15 and no appointment was rescheduled from that point. -She would follow-up with the PCP to see if Resident #5 still needed to go to a Neurologist if the resident had not been seen since 2015. -The previous Transportation person was now in a MA role and possibly could give additional information related to the residents Neurologist appointments. Telephone interview with a nurse from Resident #5's Neurologist on 10/23/17 at 9:40 am. revealed: -The resident was an active patient. -The resident had a scheduled follow up appointment on 11/23/15, however, this appointment was canceled. -There was no documentation who canceled the follow-up appointment on 11/23/15. Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37p.m. revealed: -The PCP was aware that the resident went back in 2015 to the Neurologist and had a MRI and all medications for the resident was kept the same. -The resident was referred to a Neurologist to manage her MS in 2014. -She was not aware that the resident had not	D 273	*On 10/28/17 and on 12/6/17 staff were re-trained on what to do when non-routine refills are necessary (Attachments F & J) *The med techs will review their medication carts daily to check for refill needs. *The facility health services director has ordered another medication cart to increase visability of meds in and out of inventory. New cart should arrive by 1/30/17. *Facility will be implementing new eMAR system to better manage refills. New system will be implemented by 1/30/17. *Med techs were trained on 12/6/17 to use their communication log in order to document difficulty receiving any medications. Med techs were also trained to "escalate" refill ordering issues to the health services director. *Health services director will read communication log daily. *Pharmacist will communicate as needed with the health services director or the administrator directly if meds are not able to be sent to the facility. *Medication ordering will be addressed at quarterly QA meeting	

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D 273	Continued From page 32 continued to follow up with the Neurologist and would have expected the facility to assure all follow-up appointments were done. Telephone Interview with a nurse at Resident #5's Neurologist's office on 10/25/17 at 12:30p.m. revealed: -Multiple Sclerosis was a progressive disease that required close monitoring of lab work, and medication adjustments. -It was important for the resident to follow up with her Neurology appointments in order to monitor the resident's symptoms and to improve the resident's quantity and quality of life as much as possible. -With proper oversight Multiple Sclerosis symptoms could be controlled and "kept at bay". Interview with the Administrator on 10/26/17 at 3:08 p.m. revealed the he was aware that Resident #5 had missed some Neurology appointments because the resident had refused to go to the appointments. Refer to a second interview with the MA on 10/23/17 at 10:50 a.m. Refer to a telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m. Refer to a confidential interview with a staff. Refer to an interview with the Administrator on 10/26/17 at 3:08 p.m. Refer to a telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37 p.m. b. Review of an Optometry office visit for	D 273	*Medication ordering will be addressed at quarterly QA meeting and at monthly Med tech meetings. Med tech meetings will begin in December 2017 and continue indefinitely. *Facility back in compliance by 12/10/17. 3. Follow up for vitals: *Med techs were immediately trained by the health services director on existing high/low blood sugar policy on 10/28/17 (Attachments F and L) *Administrator immediately on 10/27/17 setup alerts in eMAR system that will notify staff when vitals are outside of parameters. It will prompt staff to contact physician if necessary. *Health services director will review the vitals report weekly starting 10/30/17. *Med techs will be held accountable by the health services director and/or administrator if follow up documentation is not in place. Additional training may be required. *Blood sugars (and other vitals) will be monitored daily by med techs *Efficacy of policies/procedures will be discussed by the health services director and the administr	

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D 273	Continued From page 33 Resident #5 dated 08/14/15 revealed an eye exam was done and the resident should return in one year for a re-evaluation. Review of Resident #5's medical care visit notes, primary care orders, and Resident Notes did not reflect a follow-up appointment with an Optometrist office after 08/14/15. Review of an Optometry visit for Resident #5 on 08/29/16 revealed: -An examination was performed. The resident complained about cataracts in both eyes since 2011, severity was described as previously mild. The resident wore +2.50 readers continuously, the resident described the following signs and symptoms: blurred vision and headaches. -Diagnoses and plan included that the resident had mild cortical cataracts, no surgery was advised at that time and the resident should return in one year for re-evaluation. Interview with a Medication Aide (MA) on 10/23/17 at 10:03 a.m. revealed: -She was not sure if Resident #5 had any additional follow-up from her 08/14/15 appointment with the Optometry provider. -Visit notes from medical appointments should be filed in the resident's record after each visit. A second interview with the MA on 10/23/17 at 10:50 a.m. revealed the previous Transportation person was now in a MA role and possibly could give additional information related to the residents Neurology and optometry appointments. Interview with Resident #5 on 10/19/17 at 4:25 p.m. revealed: -The resident was having headaches off and on and felt like she needed new glasses.	D 273	*Efficacy of policies/procedures will be discussed by the health services director and the administrator at monthly med tech meetings and at quarterly QA meetings. Next meetings are in December 2017. *Facility back into compliance by 12/10/17. 4. Appointments missed: *Facility immediately audited resident charts starting 10/26/17 to reveal any missed appointments and/or labs. Chart audit was completed by 11/3/17. *Staff were trained by the HSD on 10/28/17 and by the admin on 12/6/17 on appointment and follow up procedures. (Attachments F and J) *Starting 10/30/17 all appointments are listed on a shared calendar. The transportation coordinator is responsible for managing this calendar. The health services director reviews this calendar daily to ensure residents make their appointments. *If/when residents refuses to go to an appointment, facility will ensure resident signs a form stating that he or she did not wish to go to the appointment. (attach R)	

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D 273	Continued From page 34 -The resident seen an "eye doctor" but did not know how long it had been since she last went. -She told someone (staff member) that she needed to be seen by her eye doctor for new glasses but did not know who or when she told them but thought it had not been that long ago. -The resident did not know if an appointment had been made. Telephone interview with Resident #5's family member on 10/24/17 at 7:45 p.m. revealed; -The family member was concerned that the resident was having headaches and needed new glasses. -The family member had spoken with someone in administration at the facility about a year ago concerning the resident's need to be evaluated for new glasses but was not aware of any follow-up. Telephone interview with a Clinical Organizer with Resident #5's Optometrist provider on 10/23/17 at 12:39 p.m. revealed: -The resident was last seen in August of 2016. -Someone from the facility called this morning (10/23/17) and scheduled and appointment for the resident. The appointment was made for 10/30/17 at 2:00p.m. Telephone interview with a Technician at the Optometry office for Resident #5 on 10/25/17 at 11:30 a.m. revealed: -It was important for the health of the resident's eyes and vision to follow-up with eye care when there was a history of cataracts and MS. -Headaches could be related to declined eye sight and possible need for a change in glasses. Refer to a second interview with the MA on 10/23/17 at 10:50 a.m.	D 273	*All follow up appointments/labs listed on provider communication forms, discharge summaries, physician notes etc will be first reviewed by health services director before being filed. *Facility back into compliance by 12/10/17.	

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D 273	Continued From page 35 Refer to a telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m. Refer to a confidential interview with a staff. Refer to an attempted to interview with the HSD on 10/26/17 at Refer to an interview with the Administrator on 10/26/17 at 3:08 p.m. Refer to a telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37 p.m. A second interview with the MA on 10/23/17 at 10:50 a.m. revealed: -The Transportation person was responsible to bring back any documentation from the medical provider to the MAs. -The MAs or theTransportation person would place referral appointments or follow up appointments on a board/calendar in the medication room so staff could keep track of appointments for the residents. -All appointments were given to the Health Service Director (HSD) after the MAs received follow up needs documentation from the Transporter. -Transportation would schedule "a lot of residents follow up appointments". Telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m. revealed: -He was the only Transportation person for the facility for many years (greater than 5 years). -He had transitioned into the Medication Aide (MA) role in June/July of 2017.	D 273		

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D 273	Continued From page 36 -The Transportation person was responsible to bring all documentation back from the residents' medical appointments and give it to the MA that was assigned to the hall the resident resided on. -The MAs were responsible to assure the documentation from medical appointments were filed in the residents chart. -The Transportation person was responsible for all follow-up appointments and to assure that the follow-up appointment was scheduled and done. -Scheduled follow-up appointments were recorded and kept in his appointment book. -The residents "appointment book was my bible". -If a resident was scheduled for a return visit in 6 months, one year or whatever was planned, it was the Transportation's responsibility to track and keep up with that appointment to assure the residents' follow up was done. -MAs were not responsible to document follow-up appointments anywhere in the chart. -The Transportation person was required to take a form to the medical provider to fill out during the appointments. The form had to be returned to the MA when there were labs, medications changes or when there were no medication changes, new or changed orders. -If the resident only needed a follow up appointment then the form for the provider was not needed. -As a MA, no documentation was required for follow up appointments. -He could not recall any specific information regarding Resident #5's Neurology or Optometry appointments. Confidential interview with a staff revealed: -Follow up needs were not always communicated or documented which had been an issue for the past year. -The staff member felt there was a "disconnect"	D 273		

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D 273	Continued From page 37 concerning follow up needs for the residents. -The staff thought changes in staff working at the facility, changes in management, supervisors and the current system in place had caused appointments to be missed. -The staff felt that a 100 percent review of all residents' charts was needed. -The previous HSD audited resident's charts. -The current HSD had not been there long and had not had a chance yet to do a chart audit on all charts. -Processes for follow up appointments had been improving some since the current HSD started. Interview with the Administrator on 10/26/17 at 3:08 p.m. revealed: -If a resident refused appointments, the MAs were responsible to document this on a physician communication report and have the resident sign the document. The information of the refusal should have been given to the provider to alert the provider of those refusals. -The Transportation person was responsible for all follow-up appointments. -Transportation was overseen by the Administrator or the Health Service Director (HSD) when there was a problem reported by the Transportation person related to the follow-up appointment. -The Administrator did not have a system in place to assure all follow-up appointments were done. -The Administrator expected the primary care provider to "keep track of that" since they were the ones that needed the information. Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37p.m. revealed: -There had been a problem with missed follow-up appointments with the facility in the past.	D 273		

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D 273	Continued From page 38 -Missed appointments were high and "made us feel like we were beating our head against the wall". -The facility currently had a new Transportation person and follow up appointments seemed to be improving, "you've got to be committed". The facility failed to assure contact with the Primary Care Provider (PCP) for acute care needs which resulted in untreated fungal infection/yeast infections and severe itching over multiple areas of Resident #2's body who endured the infections and itching for over 2 months and follow-up with an order for probiotic supplement; a urology appointment which was not scheduled for Resident #3, Resident #4 who continued to complain of ear pain after antibiotic ear drops ran out earlier than ordered, failed to assure follow up since 2015 with a Neurologist for monitoring of a progressive disease and an Optometry follow up appointment for Resident #5 who was having headaches and had complaints of needing new glasses, and failed to notify the resident's primary provider regarding finger stick blood sugar results obtained outside of the established parameters for Resident #6. The facility's failure was detrimental to the health and well-being of the residents, and constitutes a Type B Violation. Review of an unaccepted Plan of Protection revealed: -"Hot Box" charting would be implemented 10/24/17. Med Tech Training for that wing would be required to chart concerns and or changes in condition. "Hot Box" charts are typically stored in the medication rooms when a chart is "Hot Boxed". It is moved to a special location that alerts/triggers staff to an outstanding charting need. Charting can occur anywhere; however the	D 273		

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D 273	Continued From page 39 Health service Director (HSD) would ensure that any charted documentation was read, acted upon if necessary and ultimately filed in the resident record with the facility. -The HSD and Administrator would ensure that a full audit of all resident charts would be completed by 11/03/17. The audit would serve as a discovery for any referrals and or changes in conditions that require additional follow up or execution. -The HSD and Administrator would ensure appropriate follow up or execution was completed. -HSD would provide oversight of transportation coordinator to ensure she obtained and or delivered appropriate documentation from the physician offices. -Staff would receive "small group" training, starting today 10/24/17, until all nursing staff had been reached. All staff would be trained by 10/27/17. Training would include information on how to detect a "change in condition." Training would be led by the Administrator and the HSD. -Charting would continue until resolutions had been noted by a physician; charts would remain "Hot Boxed" during that time. -The facility began using the attached "Physician Communication Form" on Tuesday 10/24/17. -Transportation Coordinator Responsible for outside appointments, HSD for internal appointments. -Progress note sheets would be made available to staff 10/24/17 by Administrator. -Notes from the facility staff and from physicians would be kept in a designated location in the chart. -HSD would ensure charts were "Hot Boxed" when residents were scheduled for MD appointments. -Follow up appointments would be managed by	D 273		

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D 273	Continued From page 40 Transportation Coordinator and HSD. Refusals would be documented in the resident's chart, family and the primary MD would be notified. -HSD would ensure orders on Physician Communication form had been carried out and results documented accordingly. -RN Consultant would review sample of charts quarterly to ensure compliance. First review would be in January 2018. -Administrator and QA Team would review charts to ensure compliance. First review would be December 2017. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 10, 2017.	D 273		
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, interviews, and record reviews, the facility failed to assure the kitchen areas were kept clean and free from contamination related to a build-up substance/matter in the ice machine and stains and build-up on 2 metal shelves. The findings are: Observation of the ice maker in the kitchen on 10/18/17 at 4:47 p.m. revealed:	D 282		

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D 282	Continued From page 41 -There was a build-up of a wet, brownish black substance on the right inner wall and around the edges of an interior, upper white tilting shield that separated the ice bin from the upper vaulted section of the ice machine. -There were several pink and brown colored streaked areas on the right inner wall leading from the areas of the brownish black substance that was in a downward pattern, and approximately 1 inch from the ice in the machine. Observation of the ice maker in the kitchen on 10/19/17 at 8:40 a.m. revealed: -There was a build-up of a wet, brownish black substance on the right inner wall and around the edges of an upper, interior white tilting shield that separated the ice bin from the upper vaulted section of the ice machine. -There were several pink and brown colored streaked areas on the right inner wall leading from the areas of the brownish black substance that was in a downward pattern, approximately 4 inches from the ice in the machine. Interview with a Dietary Aide (DA) on 10/19/17 at 3:25 p.m. revealed: -The DAs wiped down the walls in the ice maker every other day, "possibly more than that". -Cleaning the mechanical parts of the ice maker was done by the Maintenance person. -She was not sure when maintenance last cleaned the ice maker. -The DA last wiped the inner walls of the ice maker with a damp cloth using dish detergent and water on Monday, 10/16/17. -The DA had not noticed any black build-up on the walls or the inner guard of the ice maker Monday (10/16/17). -When the walls of the ice maker were wiped down, she would use parchment type paper to	D 282		

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D 282	Continued From page 42 protect and cover the ice. Observation of the DA on 10/19/17 at 3:25 p.m. revealed the DA took a cloth dampened with water and removed the black brown substance on the inner wall, however, the pink colored area did not wipe off. Interview with a second DA on 10/ 19/17 at 3:46 p.m. revealed: -The DA had not noticed any build-up in the ice maker and was not told to inspect the inside of ice maker for build-up. -The Maintenance staff cleaned the ice maker and the DAs were responsible to wipe the inside of outside walls of the ice maker. Interview with the Cook on 10/19/17 at 3:55 p.m. revealed: -He could not remember the last time maintenance cleaned the ice maker. -There was not an assigned cleaning schedule for dietary staff. -The Marketing Director for the facility had told the Cook after the last inspection in September 2017 to "stay on top" of cleaning the ice maker more. Observation of the ice maker in the kitchen on 10/25/17 at 10:25 a.m. revealed: -A DA had removed the white interior guard and was cleaning the inside of the ice maker. -There was a thick tan colored matter adhered to the left inner wall that was approximately the size of a pencil's eraser. -The DA had collected the same thick brown colored matter that she had removed from the underside of the inner guard on her finger. The size of the brown colored matter covered the end of the DA's index finger.	D 282		

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D 282	Continued From page 43 -The inner tilting shield had been cleaned and was out of the ice machine on a cart. -There was no brownish black build-up or thick tan matter in the inner vaulted area of the ice maker. Interview with a DA on 10/25/17 at 10:25 a.m. revealed: -The DA had already cleaned the vaulted area of the ice maker and the inner guard. -The ice maker was new and the facility had only had it for a short time. -The thick tan colored matter adhered to the left inner wall was the same matter that covered the underneath side of the white interior tilting shield before she cleaned it. -The ice machine would be emptied and cleaned thoroughly. The ice would be discarded. -The facility had ice to serve to the residents in a portable cooler. -The DA never removed the white tilting shield to clean the ice maker before. -The DA's usually wiped down the inner walls of the ice maker daily. Interview with the Maintenance person on 10/25/17 at 10:31 a.m. revealed: -He cleaned the ice machine in the kitchen one time per week by cleaning the bin edges but did not remove any of the parts to do the cleaning. -He last cleaned the ice machine one day last week. -He did not notice any black build up on the inner walls and bin edges of the ice maker. Interview with the Dietary Manager (DM) in 10/20/17 at 9:07 a.m. revealed: -Dietary staff were not responsible for wiping down the ice maker's inner walls every day. "However, we need to be more vigilant about that	D 282		

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D 282	Continued From page 44 and probably should be wiped down every day". -It was expected for the ice machine to have the white guard removed and empty the ice maker, take drip tray and filter out and clean it with soap, water and sanitizer weekly by dietary staff. -It was possible that the weekly cleaning for the ice maker had been skipped some weeks. -The DM or the Cook were required to physically walk around the kitchen at the end of each shift to assure all cleaning needs had been done. Interview with the Administrator on 10/20/17 at 9:34 a.m. revealed: -The ice machine was recently replaced, "it's not even a year old". -The Administrator expected for the ice machine to be free of any build-up and should be clean at all times. -He expected the DM to assure the proper cleaning was done to the ice maker. Observation of a two- tiered metal table in the kitchen on 10/18/17 on 5:20 p.m. revealed there was 7 plastic cups stacked together, stored with the opening of the cups in a downward position, one box of individually wrapped straws and 2 coffee pot dispensers, stored on the lower shelf of the table. -The lower shelf had brown stains scattered across the surface of the lower shelf. Observation of two-tiered metal table in the kitchen on 10/19/17 at 8:41 a.m. revealed: -The metal table located beside the stove had ½ of a loaf of white bread wrapped in a plastic covering, closed with a twist tie, 2-3 pieces of white bread wrapped in a second plastic covering with the end of the bag opened, and 2 hamburger buns in a third plastic covering with the opening of the bag folded.	D 282		

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D 282	Continued From page 45 -The lower shelf of the table had several brown stains and a yellowish build-up scattered across the surface of the shelf. Interview with a Dietary Aide (DA) on 10/19/17 at 3:25 p.m. revealed: -The DAs and the Cook were responsible to keep the tables in the kitchen clean. -All of the tables were wiped down every other day and cleaned one time per week. -She had not noticed the yellow build-up and the scattered stains on the metal shelves. -Some of the areas were stains that could not be removed. Interview with a second DA on 10/19/17 at 3:46 p.m. revealed: -All areas in the kitchen were wiped down daily. -The cooks cleaned in the cooking areas of the kitchen and the DA's cleaned in the areas closer to the dishwasher. Interview with the Cook on 10/19/17 at 3:55 p.m. revealed: -There was not an assigned cleaning schedule for dietary staff. -Tables in the kitchen were wiped down with a soapy cloth daily and cleaned with a degreaser cleaner one time a week. Interview the Administrator on 10/20/17 at 9:34 a.m. revealed the Administrator depended on the dietary staff to keep all areas of the kitchen clean including the metal tables in the kitchen. Interview with the Dietary Manager (DM) on 10/20/17 at 9:07 a.m. revealed: -The DM had worked at the facility since 2013 and had been in his current role as DM since last year.	D 282	D282 Standard Def. Nutrition and Food Service *Facility immediately deep-cleaned the ice machine and the metal shelving on 10/20/17 during the investigation. *Facility administrator implemented routine deep-cleaning by the dietary manager and his team, weekly, beginning 10/20/17, until the new cleaning program is implemented on 12/22/17. *Beginning 12/22/17, the dietary department will have a check off system for daily, weekly and monthly cleaning items. This check off schedule will be posted in its respective area within the kitchen/dining room (Attachment A) *Staff will receive training by the dietary manager and the assistant executive director on 12/22/17 to include how/when to clean and who will be responsible. *Compliance will be monitored daily by the dietary manager and quarterly by the administrator at QA meetings. *Facility back into compliance by 12/10/17.	

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D 282	Continued From page 46 -The DM and the cook were responsible to assure all cleaning was done in the kitchen at the end of their shift. -The DM had a laminated cleaning schedule for dietary staff to follow that was posted in the kitchen. -The DM or the Cook assigned the cleaning tasks. -The laminated cleaning schedule had been missing for about 2-3 weeks but the DM had planned to have the cleaning schedule re-posted as soon as possible. -All dietary staff had been instructed by him about the cleaning tasks for kitchen. -The DM or the Cook were required to physically walk around the kitchen at the end of each shift to assure all cleaning needs had been done. -The DM knew that some cleaning tasks were missed from time to time. Review of the DM's cleaning schedule notes revealed there was no documentation included for the cleaning of the metal shelves or the ice machine. Review of the facility's DA's and the Cook's job responsibilities revealed: -Clean kitchen, dishes, dining area and food storage areas daily assuring sanitation standards and protection from possible food contamination. -Ensure work area was cleaned before departing shift. -Perform other duties as assigned.	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,	D 338		

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D 338	Continued From page 47 Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, observations and record reviews, the facility failed to assure 2 of 8 sampled residents were free from neglect and treated with dignity and respect related to Resident #3 who was scolded by staff and left in urine soaked clothes and bed linens for extended periods, and Resident #10 who almost fell during transfer to commode while staff was using a cell phone. The findings are: 1. Review of Resident #3's current FL-2 dated 8/01/17 revealed a diagnosis of of the central nervous system. Revire of Resident #3's Resident Register revealed an admission date of 8/19/16. Review of Resident #3's Care Plan dated 8/01/17 revealed: -The resident ambulated with the use of a wheelchair. -The resident required limited assistance with toileting and transferring. Interview with Resident #3 on 10/18/17 at 11:45am revealed: -The resident had lived at the facility about 1 year. -The resident was non-ambulatory and used a wheelchair for ambulation.	D 338		

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D 338	Continued From page 48 -The resident required assistance with personal care which included assistance with bathing/showers, transfers and occasional incontinent care. -The resident used the urinal when he was in bed; because his hands were weak, sometimes he would spill the urine on his bed and on himself. -He had occasional incontinent episodes and required assistance with incontinent care. -Sometimes the personal care aides (PCA) complained when the resident asked them to change urine soaked clothes and change bed linen. -Earlier this week, the resident called a PCA (Staff B) to his room for assistance because he had urinated on himself. When the PCA (Staff B) walked in his room, the PCA (Staff B) told the resident "I'm not going to clean you up, I'm not here for that". -The PCA (Staff B) left the resident's room and came back after an extended time (greater than 30 minutes) to clean the resident and change his clothes. The resident did not call for assistance after the PCA (Staff B) left his room. -Yesterday (10/17/17) another PCA made him wait to change his linen after he had accidently spilled his urinal while using it. That PCA was just mean. "She sucks". -A few months ago, the resident reported the staff behaviors to the Administrator and was told they would do something, but nothing was ever done. -The resident had not reported any of the incidents to the Administrator or supervisors since. Interview with a 2nd shift medication aide (MA) on 10/19/17 at 3:20pm revealed: -Resident #3 had been living at the facility for about a year and required assistance with	D 338		

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D 338	Continued From page 49 transfers. -The resident had incontinent episodes and at times spilled his urinal and had required assistance with incontinent care and changing bed linen. -The resident had complained about the PCAs talking to him disrespectful when he ask them to change clothes/linen after incontinent episodes or spilling urine from the urinal on his bed. -The MA did not know if the resident reported his concerns to the administrator. -The MA did not report the resident's complaints to the Administrator. Interview with a 2nd shift PCA (Staff B) on 10/19/17 at 4:10pm revealed: -At times Resident #3 had incontinent episodes and spilled urinal in his bed. -Two days ago, the resident had an incontinent episode (urine and bowel movement) and the PCA (Staff B) provided incontinent care. -The resident also spilled urine in his bed and the PCA (Staff B) had to change his linen and change his clothes. -The resident joked around at times but the PCA (Staff B) did not argue with the resident or refuse to provide care when the resident called for assistance. He had never become upset when the PCA (Staff B) was providing care. -If the PCA (Staff B) got frustrated for any reason while providing resident care, the PCA (Staff B) would take a time out and go outside and smoke. -The PCA (Staff B) denied deliberately making the resident wait for incontinent care. Interview with a resident on 10/20/17 at 1:50pm revealed: -There were 2 PCA's who worked on 2nd shift who were not nice to Resident #3. -They argued with him when he called them to	D 338		

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D 338	Continued From page 50 help clean him up if he urinated on himself or spilled the urinal in his bed. -They were disrespectful and made Resident #3 feel bad about being incontinent. -Because of his diagnosis, Resident #3 was weak and at times needed more assistance. Interview with the Health Service Director (HSD) on 10/23/17 at 4:00pm revealed: -Resident #3 had reported an issue with a PCA (Staff B). -The resident reported that when he told the PCA (Staff B) he needed to go to the bathroom the PCA (Staff B) would respond "I have already taken you" and the resident was never taken to the bathroom. -The HSD was not aware the PCA (Staff B) was disrepectful, refused to provide immediate incontinent care and was argumentative when Resident#3 called for assistance. -The resident was placed on a schedule for toileting for several months but that did not work and the toileting schedule was placed on the electronic Medication Administration Record (eMAR). 2. Review of Resident #10's FL-2 dated 10/15/17 revealed: -Diagnoses included post-traumatic stress disorder, bipolar disorder, recurrent urinary tract infections, and allergies. -The resident was non-ambulatory and used an electric wheelchair to ambulate. Review of the Resident Register revealed Resident #10 was admitted to the facility on 11/18/16. Review of Resident #10's Care Plan dated 11/21/16 revealed:	D 338		

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D 338	Continued From page 51 -The resident required the use of a wheelchair to ambulate. -The resident required limited assistance for transferring, toileting, bathing and dressing. Interview with Resident #10 on 10/20/17 at 1:50pm revealed: -The resident had been living in the facility 11 months. -Most of the staff treated the resident well and took good care of him but there was always "bad apples in every bunch". -When the resident asked for assistance to transfer from the wheelchair to the commode, some of the staff acted as if "I'm bothersome". -The resident required minimal assistance to the bathroom. -The staff unstrap my feet and seatbelt and the resident could transfer himself. -The resident required assistance with cleaning up after having a bowel movement. -At least 2 times in the last month when the PCA (Staff B) was assisting the resident with transferring from his wheelchair to the commode, his hands slipped from the safety bar and he almost fell in the bathroom. The PCA (Staff B) was looking at her phone each time. -The bathroom issue was the only issue with a PCA (Staff B), who worked 2nd shift, who was not engaged (did not care and was attentive) when caring for the residents. -The Administrator and the Health Service Director (HSD) were aware of the problem and they may have addressed the problem but a few of the PCAs continue to neglect their duties when assisting the resident with transfers and it could be unsafe. Interview with a 2nd shift PCA on 10/19/17 at 4:10pm revealed:	D 338		

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D 338	Continued From page 52 -Resident #10 had certain staff he did not like. He stated there was 2 staff which talked mean to him. -He had complained some staff was neglectful when assisting him with transfers and he had almost fell more than one time recently. Interview with a another 2nd shift PCA (Staff B) on 10/20/17 at 2:55pm revealed: -Resident #10 required 1 person assistance when transferring to the commode. -The resident would hold onto the safety rails when transferring and staff stood near the resident to provide assistance if needed. -The resident had never fallen but his feet have slid while transferring and the staff had to assist him with transferring. -The PCA (Staff B) was not aware of staff using their cell phones while providing resident care. Interview with the Administrator on 10/23/17 at 4:00pm revealed: -Resident #10 had voiced concerns at one point (a few weeks ago) about a (named) PCA (Staff B) but now they are "BFF's". -The HSD did not feel the concern Resident #10 had was a "full blown grievance, just poor customer service". -Resident #10 had never mentioned any concerns about the staff using cell phones during care. -"That's not ok" for a resident to sit in wet clothes and not receive help from staff. -The HSD was concerned if that staff member would do that to an alert and oriented resident, then what would that staff member do to someone else. The facility failed to assure residents were free from neglect and treated with dignity and respect	D 338		

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D 338	Continued From page 53 as evidenced by Resident #3 who was scolded and shamed by Staff B and left in urine soaked clothes and bed linens for extended periods, and Resident #10 who almost fell during transfer to commode while Staff B was using a cell phone. The facility's failure to assure the rights of residents resulted in determient to the residents' safety and well-being, which constitutes a Type B Violation. Review of an unaccepted Plan of Protection received on 10/24/17 revealed: -The Administrator and of the Health Service Director (HSD) would immediately investigate grievances and if applicable, suspend any involved staff while investigation is taking place. -Any alleged resident rights violations would be reported to the county within 24 hours; HSD and or the Administrator would make these reports; resident rights issues involving staff would be reported to HCPR within 24 hours. -Staff would receive extensive resident rights training on 10/30/17 by the Administrator. -Staff would receive immediate resident rights training beginning 10/24/17 by the Administrator/HSD. Training would continue until all staff had been reached. -Ongoing compliance would be monitored quarterly by the Administrator and QA team using the following channels: Resident interviews, family conversations, review of incident reports. First QA will be December 2017. -Staff would continue to receive resident rights training quarterly, using an online education tool (named). -Staff with violent crimes on criminal background would not be hired. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	D 338	D338 Type B Violation Declaration of Resident Rights *Facility administrator immediately trained staff on residents rights, starting on 10/24/17 (Attachment N) *On 10/27/17 administrator interviewed 2 alert and oriented residents from each hall, asking if they had been mistreated in any way by any staff member. *Staff received extensive resident rights training using Relias learning systems. Training was assigned on 10/30/17 and due by 11/3/17. (Attachment O) *On 12/8/17 a letter was written from the facility to the residents/families explaining what to do if they have a grievance. (Attachment P) *Ongoing compliance will be monitored and discussed during facility QA meetings held by administrator and at resident council meetings held by activity director. The next meetings will take place in December 2017. *Facility back into compliance by 12/10/17 D338 addendum per telephone with Mr. Will Jowell, Administrator on 12/20/17: Resident Council meetings will be held quarterly by the Activity Director & QA meetings will be held quarterly, next one scheduled 12/21/17. Blankley	

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D 338	Continued From page 54 10, 2017.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based of observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 1 of 7 residents sampled, to include an as needed pain medication and a long acting insulin (#6). The findings are: 1. Review of Resident #6's current FL-2 dated 03/02/17 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, schizophrenia, depression, urge incontinence, and hyperlipidemia. -There was an order for Levemir 12 units (a long acting injectable insulin used to treat high blood sugar) every morning. Hold for blood sugar less than 70. a. Review of a copied prescription from a dental clinic signed for Resident #6 dated on 05/09/17 revealed Ibuprofen 800mg (a nonsteroidal	D 358		

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D 358	Continued From page 55 anti-inflammatory medication used to treat pain) take one daily every eight hours as needed for pain. Review of a physician's order for Resident #6 dated 07/27/17 revealed Ibuprofen 800 mg one every eight hours as needed for pain. Review of a Consultant Pharmacist Communication to Physician form for Resident #6 dated 08/09/17 revealed: -There was documentation from the pharmacist to the primary care provider (PCP) to please sign below to discontinue the short term order: ibuprofen as needed. -There was a section for the physician's response to the recommendation/finding with instructions to check one of the following: "I agree" or "other (Please write a brief statement below concerning the rationale for your response to this recommendation)". -On 09/11/17, the PCP signed the form. There was a check beside "I agree". -There was handwritten entry on the upper right corner of the document faxed (named) pharmacy with no initials or signature for the entry. Review of Consultant Pharmacist Progress note for Resident #6 dated 08/09/17 revealed there was documentation by a pharmacist that there were no medication related issues at the time of the review. Review of Resident #6's electronic Medication Administration Records (eMAR) for September 2017 revealed: -There was an entry for Ibuprofen 800 mg one tablet every 8 hours as needed for pain. -Ibuprofen 800mg was documented as administered on 09/19/17 for complaints of a	D 358		

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D 358	Continued From page 56 toothache, 09/23/17 for complaints of body pain, and 08/26/17 for complaints of a back ache, 08/28/17 and on 09/30/17 at 7:15 a.m. and 5:05 p.m. for complaints of a toothache. Review of Resident #6's eMAR for October 2017 revealed: -There was an entry for Ibuprofen 800 mg one tablet every 8 hours as needed for pain. -Ibuprofen 800mg was documented as administered on 10/03/17 for complaints of pain, 10/05/17 at 7:37 a.m. and 3:29 p.m. for complaints of a toothache/headache and for pain. Interview with a Supervisor/Medication Aide (MA) on 10/25/17 at 10:55 a.m. revealed: -The MAs were responsible to send all medication orders to the pharmacy by fax at the time the PCP wrote the order. -MA's could not add or change any medications on the residents' eMAR. -The pharmacy added medications to the eMAR. - After an order was written for a new or changed medication, the order was placed in a stackable tray in the medication room until the new or changed order "pops up in the system". MAs were responsible to check the orders in the stackable tray each shift. -The Supervisor/MA had given Resident #6 an Ibuprofen 800 mg yesterday (10/24/17) for a toothache. She would remove the Ibuprofen 800 mg from the medication cart for Resident #6 immediately and fax the order to the pharmacy so the medication could be discontinued. Attempted interview with the Health Service Director on 10/26/17 at 2:15 p.m. was unsuccessful. Interview with the facility's pharmacy provider on	D 358		

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D 358	Continued From page 57 10/26/17 at 9:51 a.m. revealed: -Ibuprofen 800mg one tablet every 8 hours as needed for pain that was ordered for Resident #6 was discontinued yesterday (10/26/17). -When residents' pharmacy reviews were done, the pharmacist would leave the Consultant Pharmacist Communication to Physician form with a designated person at the facility that same day and the facility would be responsible to have the form sent to the PCP for review. Telephone interview with the Administrator on 10/26/17 at 3:10 p.m. revealed the Administrator expected all medication orders to be followed as written. Telephone interview with Resident #6's PCP on 10/26/17 at 12:37 p.m. revealed she expected medication orders to be implemented and discontinued as written. b. Review of a physician's order for Resident #6 dated 07/27/17 revealed Levemir flex touch (a prefilled insulin device) inject 12 units subcutaneous every morning, hold for blood sugar less than 70 to be administered at 7:30 a.m. Review of a subsequent physician's order for Resident #6 dated 09/05/17 revealed to start Levemir 10 units subcutaneous at hour of sleep. Review of Resident #6's electronic Medication Administration Records (eMARS) for August 2017 revealed: -There was an entry for Levemir Flex pen inject 12 units subcutaneous every morning. Hold for blood sugar less than 70 to be administered at 7:30 a.m. -The Medication Aide (MA) documented on	D 358		

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D 358	Continued From page 58 08/17/17 at 7:30 a.m. Levemir was not administered because the medication was not on the cart. Review of Resident #6's eMAR for September 2017 revealed: -There was an entry for Levemir inject 12 units subcutaneous every morning, hold for blood sugar less than 70 to be administered at 7:30 a.m. to be administered at 7:30 a.m. The medication was discontinued on 09/06/17. -There was an entry for Levemir inject 12 units subcutaneous every morning and 10 units every evening, hold for blood sugar less than 70 to be administered at 7:30 a.m. and 8:00 p.m. -The MA documented on 09/01/17 at 7:30 a.m. Levemir "Site: missed med". Review of Resident #6's eMAR for October 2017 revealed: -There was an entry for Levemir inject 12 units subcutaneous every morning and 10 units every evening, hold for blood sugar less than 70 to be administered at 7:30 a.m. and 8:00 p.m. -The MA documented on 10/05/17 at 8:00 p.m. Levemir was not administered "out of stock". -The MA documented on 10/06/17 at 7:30 p.m. Levemir was not administered "med on order". Interview with a Supervisor/Medication Aide (MA) on 10/25/17 at 10:55 a.m. revealed: -The MAs were responsible to reorder insulin flex pens when the resident had one flex pen left on the medication cart. -Refills were done electronically through the eMAR system by selecting "reorder". -She was not aware that Resident #6 had ever ran out of her Levemir. Confidential interview with a staff member	D 358	D358 Standard Def. Medication Administration: *Facility health services director audited all medication orders immediately against the eMAR system on 10/27/17 to ensure accuracy. *Physician order sheets were signed for every resident by his or her physician immediately on 10/24/17 to ensure accuracy of medication orders *Staff were trained on 10/28/17 on importance of ensuring medication orders are accurate (Attachment F) *Health services director will verify all orders are sent to pharmacy when they are received, using the action checklist (Attachment K) *Ongoing compliance will be monitored by the health services director, who will ensure that physician order sheets are signed quarterly by the residents' primary care physician.	

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D 358	Continued From page 59 revealed reordering medication was a simple process of clicking a button in the eMAR system. No residents should ever run out of a medication. Attempted telephone interview on 10/26/17 at 1:33 p.m. with the MA who documented Levemir was not administered on 10/05/17 and 10/06/17 was unsuccessful. Telephone Interview with the Administrator on 10/26/17 at 3:10 p.m. revealed: -MA's were responsible to reorder the resident's medications through the eMAR system. The timing of the reorder depended on the medication but should have been done 2-3 days in advance. -The Administrator expected the residents' medications to be on hand at all times and for medications to reordered timely to prevent missed doses. Telephone interview with Resident #6's PCP on 10/26/17 at 12:37 p.m. revealed: -The PCP expected for Levemir to be on hand at the facility and to be administered as ordered. -The PCP would also be expected to be called if a medication was not available to assess for an alternative on how to treat until the medication was available.	D 358		
D911	G.S. 1310-21(1) Declaration of Residents' Rights G.S. 1310-21 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. This Rule is not met as evidenced by:	D911		

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D911	Continued From page 60 Based on observations, record reviews and interviews, the facility failed to treat at least two residents (#3, #10) with respect and dignity and his or her individuality. The findings are: 1. Based on interviews, observations and record reviews, the facility failed to assure 2 of 8 sampled residents were free from neglect and treated with dignity and respect related to Resident #3 who was scolded by staff and left in urine soaked clothes and bed linens for extended periods, and Resident #10 who almost fell during transfer to commode while staff was using a cell phone. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type B Violation)].	D911	D911 Standard Def??? Resident Rights Duplicate??? See ID Tag D338 for plan of correction.	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were free of neglect related to health care. The findings are: 1.Based on observations, record reviews, and interviews, the facility failed to assure the health care needs of 5 of 7 residents sampled (#2 #3, #4, #5 and #6) were met by failing to notify the health care provider of Resident #2, who was experiencing continued itching and rashes, Resident #4, who continued to complain of ear	D914		

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D914	Continued From page 61 pain after antibiotic ear drops ran out earlier than ordered, Resident #6, with finger stick blood sugar results outside of the established parameters; failing to follow up with a Neurologist for monitoring of a progressive disease and to schedule an Optometry appointment for Resident #5; and failing to follow-up with a urology appointment for Resident #3. [Refer to Tag D237, 10A NCAC 13F .0902 Health Care (b) (Type B Violation)].	D914	D914 Type B Violation Declaration of Resident Rights Refer to ID tag D273 for plan of correction.	
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to respond to 1 of 2 sampled residents requests (Resident #5) to be moved to another room due to physical altercations and verbal arguments with her roommate. The findings are: Review of the facility's resident room assignment dated 10/04/17 revealed Resident #5 and Resident #6 were assigned to resident room 207. Review of Resident #5's current FL-2 dated 12/06/16 revealed: -Diagnoses included multiple sclerosis (MS), depressive disorder, hyperlipidemia, constipation and urinary incontinence.	D917		

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D917	Continued From page 62 -The resident was intermittently disoriented and semi-ambulatory using a wheelchair. Review of Resident #5's Resident Register revealed an admission date of 02/18/09. Interview with Resident #5 on 09/20/17 at 1:05 p.m. revealed: -Resident #6 hit her. The resident reported that Resident #6 slapped her every day, but had not hit her today (09/20/17). -Resident #5 told the "girls here" but was told to leave her (Resident #6 alone). -They had been roommates too long. Interview with Resident #5 on 10/18/17 at 11:20 a.m. revealed: -The resident had lived at the facility for 7 years and did not like living there. -Resident #6 (her roommate) does not pray, "I pray. I believe in God, she don't". -"I don't like it here because of her" (Resident #5 pointed to Resident #6). -She (Resident #6) called me a dummy, "I can read, she can't". Interview with Resident #5 on 10/19/17 at 4:25 p.m. revealed: -Resident #6 called her a [expletive] all the time. -Resident #6 called everybody "mama", "I'm not her mama, she is dark and I am white". -Resident #6 was mad because "I can read and she can't". Interview with Resident #5's family member on 10/24/17 at 7:15 p.m. revealed: -Resident #5 had reported to the family member that her roommate would slap her and called her a [expletive]. -The family member had seen one interaction	D917		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D917	Continued From page 63 recently when the family member was visiting. Resident #6 came into the room and said abruptly "what yall want". The family member stated "you could feel her attitude". -The family member remembered talking to the Administrator a year or so ago about getting Resident #5 moved to another room. The family member was not sure if it was the current Administrator or a prior Administrator. -Recently, the family member spoke with someone in Administration and asked where they were as far as adequate spacing to move the resident but still nothing had been done to move the resident to another room. -The family member was told by the resident that she had told the Administrator a few months ago that she could not get along with her roommate and wanted to be moved to another room. Interview with a Personal Care Aide (PCA) on 09/25/17 at 2:47 p.m. revealed: -Any little thing agitated Resident #5. -Resident #5 did not go out of her room a lot unless it was to smoke or eat. Interview with a second PCA on 10/19/17 at 4:04 p.m. revealed Resident #5 "starts stuff". Interview with the Health Service Director (HSD) on 09/25/17 at 3:12 p.m. revealed Resident #5 was overly dramatic. Review of Resident #6's current FL-2 dated 03/02/17 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, schizophrenia, depression, urge incontinence, and hyperlipidemia. -The resident was intermittently disoriented and semi-ambulatory with the use of a walker.	D917		

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D917	Continued From page 64 Review of Resident #6's Resident Register revealed an admission date of 02/18/03. Interview with Resident #6 on 09/20/17 at 1:53 p.m. revealed: -The resident did not like her roommate (Resident #5). -Resident #5 talked "junk" to her and pushed the door on her, and Resident #6 slapped her (Resident #5) in the face but Resident #5 slapped her first. -Resident #5 called her stupid and the resident told her "I'm not stupid like you". -The resident told Resident #5 "you [expletive] and pee in the bed". -Resident #5 had hit her twice. -Resident #5 hit her yesterday. -The resident hit Resident #5 when she messed with the fan. Resident #5 kept doing it; the resident hit Resident #5 on the back of the arm and she hit her back. -The resident did not tell staff. -The resident and Resident #5 fight a lot and the resident wanted a different roommate. Interview with a Medication Aide (MA) on 09/20/17 at 2:18 p.m. revealed: -Resident #6 "runs hot and cold with everybody". -Resident #6 could walk down the hall, pass 8 people and would have a problem with 3 of them. -Resident #6 would push and call people names. -Resident #6 initiated a lot with others but the MA could not think of a specific incident. Interview with the Administrator on 09/20/17 at 3:00 p.m. revealed: -Everyone loved Resident #6. -The Administrator would place Resident #6 on a waiting list for a new roommate. He did not have anywhere to move her.	D917		

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D917	Continued From page 65 Second interview with the Administrator on 09/25/17 at 2:19 p.m. revealed: -He had talked to Resident #6. -Resident #6 had never reported that anyone had hit her. Interview with Resident #6 on 09/25/17 at 2:29 p.m. revealed: -The resident did not like anybody, just the Assistant Executive Director (named). -She did not like her roommate (Resident #5). Interview with a third PCA on 09/25/17 at 2:47 p.m. revealed: -Resident #6 exaggerated a lot. She would say someone was going to do something to her but that was just her and it would not be true. -Resident #6 was playful and would say someone hit her at the same time she would be standing beside the PCA and nobody had hit her; she was childlike. Interview with a second MA on 09/25/17 at 3:00p.m. revealed: -Resident #6 would say random people would hit her a lot and somebody had cursed her out. -Resident #6 would pretend like somebody had done something to her but they had not done anything. Interview with a third MA on 09/20/17 at 2:18 p.m. revealed since the MA had worked at the facility Resident #5 and Resident #6 had been roommates. Interview with a fourth MA on 09/20/17 at 2:31 p.m. revealed: -Resident #5 and Resident #6 got along terribly. -Resident #5 and Resident #6 had their	D917		

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D917	Continued From page 66 arguments but she had never seen a physical fight between the two. -They both yell from time to time but Resident #6 would yell at anyone. -Resident #5 did not talk much. -Resident #5 and Resident #6 had been roommates for 2 years. -The MA had not reported any issues between Resident #5 and Resident #6 to the Administrator or to the Assistant Executive Director. -Resident #6 was usually walking out of the room when she would hear Resident #5 and Resident #6 arguing, then Resident #6 would go to the front Parlor (common area) and would start yelling. Interview with a fifth MA on 09/20/17 at 2:43 p.m. revealed: -Resident #5 and Resident #6 did not get along. -Resident #5 and Resident #6 would argue about the room, it was both of them, not just one. Interview with a fourth PCA on 09/25/17 at 2:47 p.m. revealed: -There was a lot of "bickering" that goes on between Resident #5 and Resident #6, they holler at each other, they did not get along. -Resident #5 and Resident #6 would yell at each other about the lights, about the door, it didn't matter. -The PCA had never seen Resident #5 and Resident #6 hit each other. -The PCA had heard Resident #5 say that Resident #6 was going to hit her but Resident #6 would be in bed. Interview with a sixth MA on 09/25/17 at 3:00p.m. revealed: -Resident #5 and Resident #6 fussed all the time. They were both like children.	D917		

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D917	Continued From page 67 -The MA did not think that they hit each other. -Resident #5 would tell the MA that Resident #6 had cursed her out. -Resident #5 never told her that Resident #6 had hit her. Interview with a fifth PCA on 10/19/17 at 4:04 p.m. revealed: -Resident #5 "bosses" Resident #6 around. -Resident #5 and Resident #6 had never gotten along since they had been roommates. -Resident #5 talked about Resident #6 a lot. -Resident #6 did not bother Resident #5, it was Resident #5 that would agitate Resident #6. -The PCA remembered a few months ago, Resident #5 told the PCA that Resident #6 had hit her (Resident #5). -Resident #5 told the PCA that Resident #6 could hit her but she could not hit Resident #6 back or she would get in trouble. The PCA told Resident #5 that did not make any sense. -The PCA reported Resident #5's concern that Resident #6 had hit her to the Medication Aide (MA). -Resident #6 was "spoiled" (by staff) and had a mind like a child and Resident #5 knew that. Interview with a Housekeeping staff on 10/23/17 at 12:18 p.m. revealed -Resident #5 and Resident #6 fuss a lot. -She often would hear Resident #5 and Resident #6 yelling at each other in the hallway. -She had not reported the yelling to anyone because everyone knew they argue a lot. Confidential interview with a resident revealed Resident #5 and Resident #6 argued and had never gotten along since they started being roommates.	D917		

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	HAL043016	A. BUILDING: _____ B. WING _____	C 10/26/2017

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D917	Continued From page 68 Interview with Resident #6 on 10/20/17 at 3:05 p.m. revealed the resident liked "living here" and liked her roommate (Resident #5). Interview with the Administrator on 09/20/17 at 3:00 p.m. revealed: -The Administrator was not aware of Resident #5 and Resident #6 fighting. -Resident #5 had complained about Resident #6 but not about anyone hitting. -Resident #5 had complained that Resident #6 was in the room and was naked when she had a visitor. -Staff had not reported anything about them fighting. Interview with the Assistant Executive Director on 09/25/17 at 2:15 p.m. revealed: -They had talked to Resident #5 and Resident #6. -Resident #6 reported that another resident had hit her and not Resident #5. -They were still planning to move either Resident #5 or Resident #6 when a bed became available. Interview with the HSD on 09/25/17 at 3:12 p.m. revealed: -Resident #5 and Resident #6 had issues. -Recently, Resident #5 complained that Resident #6 placed too much toilet paper in toilet and the HSD had to oversee that. -Both Resident #5 and Resident #6 have alleged that the other had hit the other one but the HSD had never witnessed it. -The HSD would take the residents seriously but she had observed them and there was no indication of anything physical. It was hard to find 100% proof. Telephone interview with the Marketing Director on 10/26/17 at 12:08 p.m. revealed:	D917		

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D917	Continued From page 69 -He was responsible for room assignments for the residents. -He was not aware of any issues with Resident #5 and Resident #6 until the AHS had reported some issues the end of September 2017. Interview with the Administrator, the Assistant Executive Director and the HSD on 10/23/17 at 4:00p.m. revealed Resident #5 and Resident #6 had arguments but the arguments were more like sibling rivalry. Telephone interview with the PCP for Resident #5 and Resident #6 on 10/26/17 at 12:37 p.m. revealed: -Resident #5 had talked to the PCP about "tiffs" she and Resident #6 had. -Resident #5 and Resident #6 both had intellectual disabilities. -Arguments between Resident #5 and Resident #6 were "more like grade school children". "It was not an issue that either one would had have been in agony" because of their relationship. -She would expect the facility to take action if a resident was being mistreated or had reported that they could not take it anymore staying in a room with their roommate; however, between Resident #5 and Resident #6, it was more of a need to redirect and tell them to ignore the other. -The PCP had never been told that Resident #6 had hit Resident #5. -The PCP did not think there had been anything dangerous between Resident #5 and Resident #6. -The PCP would expect for the facility to investigate all resident concerns. Telephone interview with the Administrator on 10/26/17 at 3:08 p.m. revealed: -Resident #5 reported to the Administrator once	D917		

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D917	Continued From page 70 several months ago that Resident #6 was naked and she did not like that. Resident #5 then laughed about it and asked for money for cigarettes. -Neither Resident #5 nor Resident #6 had asked to be moved into another room. -No staff had reported Resident #5 and Resident #6 were hitting each other. -No one had reported that Resident #5 wanted to be moved into another room. -When issues occur between residents, the Administrator would separate them and initiate an investigation, interview other staff, and other alert and oriented residents. Observation of Resident #5 on 10/25/17 at 6:38 p.m. revealed she had been moved to resident room #109B. Interview with Resident #5 on 10/25/17 at 6:38 p.m. revealed: -She liked her new room. -She was happy because she liked her roommate. Telephone interview with the Marketing Director on 10/26/17 at 12:08 p.m. revealed Resident #5 was moved to another room yesterday since a bed became available after two other residents were discharged. The facility failed to provide a reasonable response to Resident #5's requests to be moved to another room due to the resident's concerns related to physical altercations and verbal arguments with Resident #6, who had been her roommate for years. The facility's failure to respond to the request was detrimental to the safety and well-being of Resident #5 and Resident #6 which constitutes a Type B Violation.	D917	D917 Type B Violation Declaration of Resident Rights: *A room became available during the investigation. Facility maintenance staff immediately separated residents on 10/25/17 by moving one into a different room. *Resident requests will be logged on a grievance sheet and carried out in an approriate time frame. The administrator will delegate actions to department heads depending on the topic of the grievance. *Facility has developed a roommate policy and procedure (Attachment Q) *The marketing director and the assistant executive director will be responsible for room assignments and will use the grievance process to monitor roommate disputes. *Grievance process was implemented on 12/6/17 by the administrator. Staff were given training. *Families and residents received a copy of the grievance policy and flow sheet on or after 12/8/17. *Ongoing compliance will be monitored and discussed using stand-up meetings and quarterly QA meetings. All department heads will attend.	

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D917	Continued From page 71 Review of an unaccepted Plan of Protection received on 11/22/17 revealed: -The facility would follow up on any existing requests immediately. -Everyday ADL requests would be carried out by care staff without question. -Any requests outside the care staff's everyday scope of work would be referred the the supervisor in charge and/or administrative team. Non-routine requests (ie room changes) would be recorded in the chart. Follow up would be recorded in the chart by supervisor and/or administrative team. -The Administrator would educate staff on resident rights. Education would take place by 12/16/17. Education would include follow up actions staff should take when resident(s) make requests. -Facility would discuss resident requests in stand up meetings, quarterly QA meetings and resident council meetings. -Any requests would be promptly recorded and timely followed up on. Administrative team would ensure this occurred. -Ongoing resident rights and customer service training would occur throughout the year using an online education program (named). The Administrator would assign this training. -Grievance forms would be made available to residents at the next council meeting. The Activity Director would instruct residents how to use the form. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 10, 2017.	D917	*Department heads will receive training at first QA meeting in December 2017 on resident rights and roommate policies. *Facility back into compliance by 12/10/17 D917 Addendum per telephone with Mr. Will Durell Administrator on 12/20/17: The Marketing Director and Assistant Executive Director will be monitoring resident room assignment grievances or a care by care basis. The Administrator will monitor on a quarterly basis to ensure staff are documenting grievances on the grievance flow sheet. -DRainey	

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D935	Continued From page 72	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 73 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure 1 of 2 medication aides (Staff C) who administered medications in the facility had completed the 5 hour, 10 hour or the 15 hour state approved medication administration courses as required. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired on 7/28/14 as a Medication Aide/Supervisor. -Staff C passed the written medication aide exam on 1/20/2011. -Staff C complete the Medication Clinical skills check list on 8/18/14. -There was no documentation of Staff C completing the 5 hour, 10 hour or 15 hour state approved medication aide training. Review of sampled Resident #3's Electronic Medication Administration Record (eMAR) for October 2017 revealed Staff C documented the administration of medications 1 time. Review of sampled Resident #4's eMAR revealed Staff C documented the administration of medications 2 times in September and October 2017. Interview with facility's Administrator on 10/25/17 at 11:00 am revealed the Administrator was not	D935		

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D935	Continued From page 74 able to supply any further medication administration training documents for 5 hour, 10 hour or 15 hour state approved medication aide trainings.	D935	D935 Standard Def. Training and Competency *Facility administrator immediately enrolled employee into 15 hour class. Employee obtained training certificate on 11/3/17. *Administrator, assistant executive director or health services director will ensure employees have appropriate credentials before working at the facility. *Ongoing compliance will be achieved through quarterly employee record audits which will be discussed at quarterly QA meetings. All department heads will be in attendance. *Facility back into compliance by 12/10/17.	

CONSOLIDATE SNACKS/ TOSS UNNEEDED BOXES

FRI 2nd Shift Aide

Attachment A

COMPLETED BY	DATE/TIME	SIC Check

DETAIL BUTTER & CREAM CONTAINERS

WEDNESDAY 1^{st} Shift Aide

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

DETAIL COFFEE URNS

THURSDAY 1ST SHIFT AIDE

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

POLISH CHAIRS IN DINING AREA

SAT 2nd Shift Aide

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

DETAIL DISH MACHINE

MONDAY 2ND SHIFT AIDE

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

DETAIL DRAINS & BOTTOMS of PREP TABLES

TUESDAY COOK

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

DETAIL JUICE MACHINE INSIDE AND OUT

TUESDAY 2ND SHIFT AIDE

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

DETAIL STEAM TRAYS

SATURDAY COOK

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

DETAIL TEA MACHINE & URN

TUESDAY 1st AIDE

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

Attachment A

DINING ROOM BASEBOARD CLEANING & DETAILING LOG

	DATE	COMPLETED BY

DRIP TRAY UNDER STOVETOP

FRI COOK

Attachment A

COMPLETED BY	DATE/TIME	SIC Check

ICE MACHINE CLEANING, DISINFECTION & MAINTENANCE LOG

MONTH _____ YEAR _____

DAILY CLEANING

To be cleaned:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Ice Scoop																															
Ice Scoop Holder																															
Water Pitcher																															
Exterior Surface																															

WEEKLY CLEANING

To be cleaned:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Ice Storage Bin																															

MONTHLY CLEANING

To be cleaned:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Air Filter																															

Name	Initials	Name	Initials

12.12.17

Attachment A

POLISH CHAIRS IN DINING AREA

SAT 2nd Shift Aide

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

WALLS ABOVE DISH MACHINE

THURS 2nd Shift Aide

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

WALLS IN TRASH CORNER

THURSDAY 2ND SHIFT AIDE

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

WASH WALLS BEHIND OVEN AND GRILL

THURSDAY COOK

Attachment A

COMPLETED BY	DATE/TIME	SIC Check

WIPE DOWN LEFT SIDE WALK IN COOLER RACKS

WEDNESDAY 1st Shift Aide

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

WIPE DOWN RIGHT SIDE WALK IN COOLER RACKS

WEDNESDAY 2nd Shift Cook

Attachment A

COMPLETED BY	DATE/TIME	SIC CHECK

WIPE WINDOW LEDGES in DINING AREA

Attachment A

FRI 1st Shift Aide

COMPLETED BY	DATE/TIME	SIC Check

Attachment B

December 5, 2017

Marshall Flooring Company
8051 NC 210 North
Angier, North Carolina 27501
919-422-1550

I have ordered the vinyl composition tile (Armstrong Flooring, Color: Cool White, # 51899) to repair this floor in the dining room at Oak Hill Living Center.

The work will be done the week of December 10, 2017 and during the breaks between meal times.

Thanks.

Attachment C (1)

Budget Blinds
a style for every point of view

Budget Blinds of West Raleigh

125 Commerce Parkway, Suite 101
Garner, NC 27529
Phone: 919-521-5554
Fax: 919-521-5834
E-mail: westraleigh@budgetblinds.com
Web Site: www.budgetblinds.com/westraleigh

Quote
Quote: Q3064
Created: 07-Dec-2017
Consultant: Joshua

Bill To Address		
Towell, Will OakHill Living	Ph1:	919-342-8884
9767 NC Hwy 210 N	Ph2:	
Angier, NC 27501		

E-mail: will@oakhilliving.com

Ship to Address
Towell, Will OakHill Living
9767 NC Hwy 210 N
Angier, NC 27501

Estimated Delivery	Discount	Discount Amount	Payment / 75% Deposit	Balance
December 7, 2017	25%	$818.25	$0.00	$2,761.36

Line	Qty.	Room	Description	Retail	Total
1	1	FRONTPARLOR	Signature Series 2 inch Faux Wood, Standard Lift, FRONTPARLOR, Solids & Woodgrains, Premium Spice (92685), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$389	$389
2	1	DINING	Signature Series 2 inch Faux Wood, Standard Lift, DINING, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
3	1	DININGA	Signature Series 2 inch Faux Wood, Standard Lift, DININGA, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
4	1	DININGB	Signature Series 2 inch Faux Wood, Standard Lift, DININGB, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
5	1	DININGC	Signature Series 2 inch Faux Wood, Standard Lift, DININGC, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
6	1	DININGD	Signature Series 2 inch Faux Wood, Standard Lift, DININGD, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
7	1	DININGE	Signature Series 2 inch Faux Wood, Standard Lift, DININGE, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286

Attachment C (2)

Budget Blinds
a style for every point of view

Budget Blinds of West Raleigh
125 Commerce Parkway, Suite 101
Garner, NC 27529
Phone: 919-521-5554
Fax: 919-521-5834
E-mail: westraleigh@budgetblinds.com
Web Site: www.budgetblinds.com/westraleigh

Quote
Quote: Q3064
Created: 07-Dec-2017
Consultant: Joshua

Line	Qty	Room	Description	Retail	Total
8	1	DININGF	Signature Series 2 inch Faux Wood, Standard Lift, DININGF, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
9	1	DININGG	Signature Series 2 inch Faux Wood, Standard Lift, DININGG, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$187	$187
10	1	DININGH	Signature Series 2 inch Faux Wood, Standard Lift, DININGH, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
11	1	DININGI	Signature Series 2 inch Faux Wood, Standard Lift, DININGI, Smooth & Sandblast, Whisper White (85630), Inside Mount, Traditional Route, Tape:N/A, Cord Tilt w/Cord Lift (C), Tilt Left/Lift Right, Val:Stately Valance (O), Ret:No Valance Returns (N), Cleat:None, Pole:N/A	$286	$286
12	1	108	Signature Series Standard 1In Aluminum, Standard Rectangular, 108, Ghost (005), Inside, Wand Tilt, Tilt Left/Lift Right, Wand:Standard, Val:None, Ret:No, Inv slat:No, Cleat:No	$123	$123

Subtotal:	$3,273.00
Discount:	25% ($818.25)
	$2,454.75
Tax:	$174.61
Measure Charge:	$0.00
Shipping:	$0.00
Installation:	$132.00
Total:	$2,761.36
Payments:	$0.00
Balance:	**$2,761.36**

75%
$2071.02

Attachment C (3)

Budget Blinds
a style for every point of view

Budget Blinds of West Raleigh
125 Commerce Parkway, Suite 101
Garner, NC 27529
Phone: 919-521-5554
Fax: 919-521-5834
E-mail: westraleigh@budgetblinds.com
Web Site: www.budgetblinds.com/westraleigh

Quote
Quote: Q3064
Created: 07-Dec-2017
Consultant: Joshua

Comments

⚠ WARNING

Cords on window covering products present a potential strangulation hazard.

For child safety, consider cordless alternatives or products with inaccessible cords.

CAFLAB-1 (SCHOOL) ANSI/ WCMA 6.1.4

⚠ ADVERTENCIA

Las cuerdas y cadenas y personas presentan un peligro de estrangulación.

Para la seguridad de los niños, considere alternativas sin cuerdas o productos con cuerdas y cadenas inaccesibles.

CAFLAB-1 (HOGAR) ANSI/ WCMA 6.1.4

Limited Warranty _____ Length: _____ _____ Length: _____		5 Year - No Questions Asked Protection Y N _____		1 Year Service Guarantee
Blind Removal Y N _____	Yard Sign Y N	Installs 1 2	Sills Y N	Installers 1 2

Terms and Conditions

*Due to the custom measurements and resulting production for individual window treatments, and in recognition of the inability of Budget Blinds to resell the customized product, ALL SALES ARE FINAL AND ALL DEPOSITS ARE NON-REFUNDABLE. Any problems resulting from manufacturing, shipping, ordering, and/or production will be serviced and corrected by Budget Blinds as quickly as possible. Budget Blinds will not guarantee any refund, full or partial, to client for any such discrepancies or any other events or circumstances beyond its control. The parties agree that there are no warranties which extend beyond the descriptions on the face hereof. The contract balance is due upon delivery and/or installation. Any check returned to Budget Blinds for reason of insufficient funds will obligate client to immediate payment of the face value of the check plus the extent of all remedies available to Budget Blinds including all court costs and reasonable attorney fees. In the case of a quote, all prices quoted herein will be honored by Budget Blinds for 30 days from the date of the quote. This writing contains the entire agreement between the parties; any modification or rescission of this agreement is excluded unless contained in a writing signed by all parties. I have read and understand the above terms and agree to be bound by them.

Client's Signature _____ Order Date 12/7/17

Physician Visit Report

Attachment E

Oak Hill Living Center * 9767 NC 210 N, Angier, NC 27501
Phone (919) 639-9000 * Fax (919) 639-9435

MEDICATION CHANGES/ORDERS: Oak Hill Living Center is an assisted living community that is required by law to have physician orders and/or prescriptions for all medications and treatments (including over the counter medications). Please send prescription(s) to the community OR fax us copies for our records so we can ensure the best care. Please complete and return this form with any signed physician orders and prescriptions.

Appointment Date/Time: _____

Physician Name: _____ Physician Phone #_____

Name of Patient/Resident: _____

PURPOSE OF VISIT:

_____

_____

_____

_____

VITAL SIGNS: Temp:_____ Pulse:_____ Respirations:_____ BP: _____/_____

TREATMENTS/SIGNIFICANT FINDINGS:

_____

_____

_____

_____

FOLLOW-UP PLANS:

_____

_____

_____

_____

NEXT APPOINTMENT: _____

PHYSICIAN'S SIGNATURE and DATE: _____ _____

OAK HILL OFFICE USE ONLY: ACTION	DATE	INITIALS
Received at Facility		
Faxed to Cape Fear Pharmacy		
Faxed to Other Pharmacy (if applicable)		
Faxed to Provider(s): Physician, Therapist, Home Health, _____		
Delivered to Health Services Director		
Activated in Hot Spot		
Filed in Resident Chart		

Attachment F

October 28, 2017 Group Huddles

AGENDA:

Physician visit form. What is it?

>When residents go to an outside physician, we need that physician to fill out a form stating what occurred at the visit and what follow up he or she would like for us to fulfill. It is extremely important for this information to be given directly to the health services director immediately upon receiving the form.

Hot spot charting. What is it? How do I use it?

Hot spot charting is a method by which we chart all in one place. When a resident expresses a concern, a "hot spot" should be started and followed up on continuously until the health services director "closes" the case. After the "case is closed", the documentation becomes part of the resident's record. Hot spots can be used for a variety of different things- anything from minor ailments such as headaches to major incidents such as hospitalizations. When in doubt... chart anyway.

Blood sugar (BS) policy. What is important to know about it?

>You absolutely MUST abide by the parameters set forth by the resident's doctor. If the doctor did not indicate otherwise, the facility standard parameters are: if blood sugar falls below 60 and the patient is alert, give four ounces of orange juice, call the doctor and the family, and retest in 30 minutes. If BS remains below 60, call rescue and notify the physician and family. If blood sugar is above 450, give insulin if indicated and recheck in 30 minutes. If no insulin available, call physician and family. If blood sugar remains above 450 call rescue and notify the physician and family. All actions must be documented in the resident's chart.

Appointment follow up. Why is this important?

>When residents visit their primary care physician, he or she will often have that resident follow up with a specialist. It is very important that we keep these appointments, as specialists can sometimes take a while to get appointments with. When residents come back from the doctor, their physician visit sheet or their discharge summary should be given to the health services director for review. If a resident refuses to go to the doctor, you must fill out a refusal form and give it to the health services director.

Accuracy of medication orders. Make sure the pharmacy has the correct information!

To make sure the pharmacy has the most accurate information. You must continuously audit your medication cart. You must also pay very close attention to your screen to make sure you are administering exactly what is there. Because the pharmacy enters all our orders, we need to make sure we fax them the orders as soon as we get them in-house.

Hot Spot Communication Tool

Attachment F

	Resident Name:		Date and Time:
	Main Problem:		
	Person Initiating :		
Monitoring Report (Always record Date/Time, Person Notified and Recommendations, Follow-Up Plan			

10.22.17

Attachment G

UPCOMING DATES to ANTICIPATE

December 2: Oak Hill residents watch the Angier Christmas parade
December 5: Harnett Middle School Orchestra performance at Oak Hill (10:00am)
December 12: Lafayette Elementary School students caroling at Oak Hill (10:00am)
December 13: Quarterly Residents' Council Meeting (10:00am)
December 14: Bluegrass Concert by [redacted] nephew (10:30am)
December 22: Oak Hill Residents' Christmas Party (2:30-5:00pm)

CHRISTMAS MEMORIES

- [redacted]-First child old enough to enjoy Christmas
- [redacted]-First doll received
- [redacted]-Christmas with husband
- [redacted]-When her husband was living and invited family over
- [redacted]-Cooking and spending time with family
- [redacted]-Decorating the house and tree
- [redacted]- Decorating the tree with mom
- [redacted]- Decorating the tree with three sons
- [redacted]- Going to the Christmas parade
- [redacted]- Baking cookies with mom
- [redacted]- my third son was born four days after Christmas
- [redacted]- spending time with 3 children, 21 great grandchildren and 8 grandchildren

Physician Visit Form

Oak Hill Living Center is required by law to have physician orders and/or prescriptions for all medications and treatments (including over-the-counter medications). Please take a Physician Visit Form to be completed and returned for all medical appointments outside of Oak Hill. Return completed forms to the Health Services Director or fax to (919) 639-9435 after each appointment.

THANK YOU...

To everyone who has donated items for resident gifts, we really appreciate you! Donations include shampoo, condition, body wash, deodorant, lotion, new fleece sweatshirts and sweatpants, costume jewelry, deodorant, puzzles, books, word search puzzles, etc.

Attachment H

Section 1: Introduction

About This Course

As a caregiver you are the eyes and ears of the care team. You are often the person who sees individuals most often; the one who gives daily care and follows the care plan. You may be the first to notice gradual changes that happen as the individual's chronic illness progresses, such

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Attachment H

as the loss of range of motion due to arthritis. Because you see the individual regularly, you may observe that the individual is less active from one week to the next. Many times you notice changes that individuals do not even recognize themselves.

Think of yourself as a "breaking news reporter". You tell other members of the care team important, or "breaking" news about an individual's condition, and these team members depend on you to tell them this important information.

Consider the following situation: You are giving care to Ms. Redmond when she develops a high fever. You quickly report this to the care team. The care team examines Ms. Redmond and obtains orders for a urine specimen. The results of the urine test show that Ms. Redmond has a urinary tract infection. The care team works with the healthcare provider to start her on medication to treat the infection. Your observation and quick reporting had a direct impact on Ms. Redmond's health!

This scenario illustrates the importance of your role. When you bring these changes to the attention of the care team, the problems can be addressed. Treatment or care strategies can be put into place to help the individual be more active or, at the very least, more comfortable. Your observations are a key part of this process. In this course you will be given information on how to observe, what to observe, and what to report. This will include routine reporting, issues to report immediately, and documentation of what you observe.

Learning Objectives

After taking this course, you should be able to:

- Give examples of observations made using your senses.
- Distinguish between signs and symptoms.
- Distinguish between objective and subjective observations.
- Identify signs and symptoms that indicate a change in condition.
- Illustrate effective methods to report and document condition changes.

Section 2: Observation

Welcome text: Observation means using all of your senses to note any changes in an individual's condition. Observation is an ongoing process and should happen all the time while you are providing care. Your observations include signs and symptoms. In this section, you will learn about types of observations you can make when providing care.

Using Your Senses

Good observation requires the use of your senses -- sight, hearing, smell, and touch. Taste is never used in caregiving and has been omitted from this module. You usually think of sight alone when you think of observation. "I saw that Mrs. Smith's elbow was red and swollen". However, when you touch Mrs. Smith's elbow, you add another layer of observation. "Mrs. Smith's elbow is hot to the touch". Hearing is involved when Mrs. Smith says, "My arm hurts so much that I can hardly move it". Smell might be added if Mrs. Smith's elbow has a skin tear with a discharge. "Mrs. Smith's elbow has a skin tear with foul-smelling discharge". *Click on each icon to explore the types of observations you may make with each of your senses.*

Sight: Observations using the sense of sight include facial expressions, skin color, and swelling.

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Touch: Observations using the sense of touch include clammy skin, hot skin, or lumps under the skin.

Hearing: Observations using hearing include noisy breathing, crying, and statements made by the individual.

Smell: Observations using the sense of smell include foul-smelling urine, bad breath, or the presence of gas, which is also called flatulence.

Signs Versus Symptoms

Your observations will include both signs and symptoms. Signs and symptoms are guideposts in giving care. They point out the direction that the individual's condition is headed, and help the care team follow this direction. If you pay attention to signs and symptoms, you can help lead the individual to the best health possible. If you miss one of these markers, however, the individual can go down the path of disease and disability. Your goal is to observe for signs and symptoms in every part of your caregiving.

A **sign** is something you observe by using your senses. It is also something you can measure, such as vital signs, oxygen saturation, or fingerstick blood sugar reading, depending on your scope of practice. Signs are often a red flag that something is wrong, such as the red skin seen on Mrs. Smith's elbow.

A **symptom** is something individuals notice about how they feel. Examples of symptoms are fatigue, which is a general feeling of being tired, a stomachache, and thirst. Symptoms cannot be seen, touched, smelled, or heard by the caregiver. When Mrs. Smith says, "My elbow hurts", you cannot actually see, touch, smell, or hear her pain. You may see a facial expression that indicates she is in pain or feel that she pulls her arm away when you try to move it, but you cannot observe the pain itself.

Time to see if you can distinguish between a sign and a symptom. Place each item into either the sign or symptom zone.

Sign: 98% oxygen saturation, 20 respirations, Blue fingertips, Dark urine, Grimace

Symptom: Headache, Nausea, Tingling in the feet

Feedback: Signs are things that you observe. Vital signs, facial expressions, or changes in color, such as with urine, are signs. Symptoms are what an individual tells you. An individual may state that they have a headache, are in pain, are nauseated, feel lonely, or feel tingling in their feet.

Objective Versus Subjective

The way that observations are reported can be either objective or subjective. ***Objective*** observations are based on facts. Objective observations can be confirmed by others. For example, an objective observation is, "Mrs. Smith's elbow is reddened". Any member of the care team can look at Mrs. Smith's elbow and see the same thing. It is a fact. An objective observation is seen, smelled, touched, heard, or measured with a medical instrument.

Subjective observations, on the other hand, are based on feelings, ideas, thoughts, or opinions.

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If you cannot see it, feel it, hear it, smell it, or measure it, it is a subjective observation. Subjective observations are open to great interpretation depending on the observer.

Objective observation: Mr. Green only ate 25% of his lunch.

Subjective observation: Mr. Green was depressed, so he did not eat his lunch.

How do you know that Mr. Green is depressed? He could have been nauseous, tired, or may have eaten too much cake at the birthday party he attended!

The following are some objective observations you may make concerning Mr. Green.

Mr. Green is not engaging in conversation.
Mr. Green avoids making eye contact and is tearful at times.
Mr. Green has not been up to walk much today.
Mr. Green ate 25% of his lunch.

Remember to report what you have observed. You may have an opinion or an idea about what you have seen, but you must report facts, not opinions, to the care team.

Review

Identify whether the observation listed is subjective or objective.

I think Mrs. Smith fell because she was dizzy.

Objective

Subjective

Feedback: This is subjective. Instead of giving your opinion on what you think is the cause of the fall, you should give an objective report of your observations, such as "Mrs. Smith fell when walking to the bathroom. She stated that she was dizzy."

I noticed green sputum in a tissue next to Mr. Rodriquez's bed.

Objective

Subjective

Feedback:
This observation is something that any other person can observe so it is objective.

You palpate a Pulse rate of 87.

Objective

Subjective

Feedback: If you palpated a pulse rate of 87, you detected it directly with touch and so this is an objective sign.

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Mr. Brown looks thirsty.

Objective

Subjective

Feedback: This statement is subjective. Thirst cannot be observed. Instead report what you observed that led you to believe Mr. Brown is thirsty.

Summary

You will make countless observations throughout the day as you care for individuals. Observations can be signs or symptoms. When you report observations to the care team and record them in the medical record, remember to only report objective observations including signs you observe. You can also report symptoms, which include statements individuals make. The important thing to remember is that you not include your feelings or thoughts in the report or medical record.

Section 3: What to Report

Welcome text: It is not sufficient to simply use your powers of observation to identify changes in condition. You must also report these changes in a timely manner. In this section, you will learn about observations that indicate that the individual is not well or that their condition is worsening.

Changes in Condition

The goal of observation is to notice signs and symptoms that indicate a change from the individual's normal condition. These changes will often point to developing problems. Catching the problem early can prevent a larger problem. For example, a red spot on the individual's hip may appear to be a minor problem. The individual may not have been turned often enough. However, that red spot can develop into something much worse if the underlying problem is not addressed. The key factor is noticing the change. Think about differences in the individual as you observe.

To know if the sign or symptom is a change, you need to know what is normal for the individual. Every individual is different, for example, bowel habits vary widely. One individual may have a bowel movement every day. For another individual, "normal" is a bowel movement every two or three days. Knowing the individual's history is vital in order to know what is not normal. If you do not know what is normal, you will not notice the signs that point to a problem. You should always refer to the individual's plan of care to identify specific requirements regarding reporting of observations. If there is ever doubt in your mind about whether to report something, err on the side of caution and report it!

It is easy to see changes when there is complete information in the medical record. The data from your observations forms a picture of the individual's condition over time. This information is critical to record as it lets all members of the care team who are reviewing the medical record see how an individual's condition changes over time.

Consider the following situation: Today is your first day caring for Mr. Brown. Since you are

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Attachment H

unfamiliar with his care needs, you look at his plan of care and learn that he requires minimal assistance with transfers from bed to his wheelchair. However, while assisting Mr. Brown with getting out of the bed this morning, you notice that you actually have to do most of the work for him! Concerned with this, you review the ADL documentation in the medical record from previous caregivers over the last few weeks. You notice that the level of assistance Mr. Brown has needed to transfer from bed to wheelchair has increased over the last couple of weeks.

Even though this is the first time you have cared for Mr. Brown, the fact that the medical record provided a complete picture of his condition allowed you to identify a change. Your ability to see these changes are vital. Not only should you be closely watching Mr. Brown for changes, but you should also pay attention to any trends in the medical record, such as may be seen on ADL flowsheets, temperature records, and other documentation, that indicate gradual changes to the individual's condition.

Abnormal Signs to Report

First report any abnormal symptoms or signs to your supervisor and then record them in the medical record. Remember to record the name of who you reported the abnormal signs to in the documentation. *Click on each number to learn examples of abnormal signs and symptoms that you must report.*

1) Neurologic observations include:

- Changes in orientation or alertness
- Changes in coordination or movement
- Numbness
- Tingling
- Facial drooping
- One-sided weakness
- Seizure activity
- Changes in mood
- Talk of self-harm or harm to others
- Difficulty or inability to awaken
- Abnormal movements
- Difficulty or inability to communicate
- Reports that the individual has the "worst headache of my life"
- Slurred or garbled speech
- Crying
- Violent outbursts
- Falls
- Sudden confusion or agitation

2) Cardiovascular observations include:

- Bounding or weak pulse
- Chest pain
- Pain radiating to the arm or neck
- Pulse above 100 or below 60
- Cold, clammy, blue or gray skin

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Attachment H

- Unable to take blood pressure or feel pulse
- Dizziness
- Blood pressure below 100/60 or above 140/90
- Increasing weakness
- Sudden weight gain or loss

3) Respiratory observations include:

- Respiratory rate below 12 or above 20
- Pursed-lip breathing
- Statements such as "I can't breathe" or "I can't seem to catch my breath."
- Abnormal breathing
- Noisy breathing
- Wet cough

4) Observations that may indicate infection include:

- Foul-smelling drainage
- Fever
- Cough with green sputum
- Hot or red skin
- Presence of pus or mucous
- Swelling of incisions
- Sweating
- Chills

5) Skin observations include:

- Bleeding
- Gray or blue mouth, ears, fingers or toes
- Bruises
- Redness
- Skin tears
- Lumps
- Cysts
- Open wounds
- Drainage
- Cracked skin
- Scratching
- Itching
- Swelling

6) Gastrointestinal observations include:

- Reports of nausea
- Vomiting
- Multiple watery stools
- Changes in appetite

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- Problems swallowing
- Food left in the mouth after eating
- Mouth ulcers
- Abdominal pain
- Abdominal swelling
- Bloody stools
- Hemorrhoids
- Cracked teeth
- "Coffee grounds" emesis or drainage from an NG tube
- Poor fitting dentures
- Thirst
- Fruity-smelling breath

7) Genitourinary observations include:

- Low or high urine output
- Dark, red, or cloudy urine
- Lower back pain
- Pain when urinating
- Incontinence
- Foul-smelling urine
- Abnormal discharge from the penis or vagina

Signs of Pain

It is important to use your senses to observe signs and symptoms of pain in the individuals in your care. While you generally rely on the individual to tell you when they are in pain, you can use your senses to observe the body language of the individual, which can indicate the pain they are in. The individual may grimace, or jerk their leg back when you try to help them out of bed. Other signs of pain include:

- Restlessness, such as plucking at the covers and squirming in the bed or chair
- Crying or crying out
- Holding a part of the body
- Holding their breath when moving
- Irregular or shallow breathing
- Sweating
- Withdrawal, fatigue, and lack of interest

In individuals with dementia, it is important for you to constantly be looking for these signs. However, don't count out an individual with dementia's ability to tell you if they are in pain when asked simple questions.

Pressure Injury

A pressure injury occurs when the skin and tissue over a bony prominence, such as a hip, is damaged from pressure or shear. You have likely heard the term 'pressure ulcer' used in the past. However, the National Pressure Ulcer Advisory Panel (NPUAP, 2016) changed the term 'pressure ulcer' to 'pressure injury' to more accurately describe injuries that involve both intact

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Attachment H

and non-intact skin. Your role in the detection of the signs of early pressure injuries is critical.

When you assist an individual to dress or bathe, you should pay attention to their skin. Pressure injuries can occur anywhere but are more likely to occur over bony prominences, such as in the buttocks area, on the back near the shoulders and spine, feet or heels, and elbows. Individuals can develop pressure injuries after an object puts pressure on the skin for too long such as when an individual uses a medical device like a splint. Even the back of the head can develop a pressure injury!

When observing an individual's skin, pay attention to any non-blanchable, reddened areas on the skin which indicates the beginning stage of a pressure injury. Non-blanchable means the skin does not turn white, but rather remains red, when you press on it with your finger. With individuals with darkly pigmented skin, areas of non-blanchable redness are difficult to identify. In these individuals, observe for a change in skin temperature, sensation, or firmness (NPUAP, 2016). If you notice areas of redness, open areas, or any other sign of pressure injury, report this to the care team.

Observing the Dying Process

Observations that indicate death is near are important in any setting. You may have experience in this area, or you may have never seen an individual close to death. The following are observations that may indicate death is near:

- The individual becomes less responsive.
- The individual loses muscle control.
- Breathing becomes shallow and irregular.
- Body functions slow down.
- Skin is pale, gray, mottled, or bluish.
- Hands and feet become cold.
- The jaw relaxes.
- You cannot detect the blood pressure or feel a pulse, but the individual is still breathing.
- The pulse is rapid and weak.
- The individual may void and defecate involuntarily.

Report these signs and symptoms to the care team. In a hospice setting, these signs are expected, but still need to be reported according to the hospice policy.

Functional Decline

Of all the members in the healthcare team, you likely spend the most time with individuals. You observe their habits and behaviors and notice even subtle changes. In older adults, these subtle changes can indicate functional decline over time. Functional decline is the gradual loss of ability to carry out everyday tasks such as bathing, dressing, continence, and feeding, as well as higher function tasks such as shopping, managing bills, and driving (Beaton, McEvoy, & Grimmer, 2015).

It is very important that you observe and report functional decline because it can lead to decreased quality of life due to injury such as falls, resulting in an increase in healthcare costs (Beaton, McEvoy, & Grimmer, 2015; Davis et al., 2015). When you observe and report functional decline, you just might help prevent a crisis situation that involves an ambulance or emergency room visit. You can help identify cognitive, physical, and sensory decline by making

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and reporting observations. *Click on each tab to learn about signs of decline in each of these areas.*

Cognitive: Signs of cognitive decline include individuals forgetting to take their medication or pay their bills. You may notice the individual is not completing hygiene tasks appropriately and may be wearing inappropriate clothing given the weather and situation. You may observe confusion, forgetfulness, disinterest in, or forgetting how to perform basic tasks, impulsiveness, and an inability to answer simple questions or follow directions. Family and friends may describe odd behaviors.

Physical: Signs of physical decline include more frequent incontinence episodes or an inability to chew and swallow food. Mobility decline would be included in this area. Signs of mobility decline include loss of coordination or balance, taking longer than normal to perform tasks, inability to perform tasks the individual was once able to perform, inability to handle things such as eating utensils, inability to support one's weight, and increased dependence on assistive devices such as a walker.

Sensory: Signs of sensory decline include a disinterest in favorite foods, inability to sense hot or cold, turning their head to the side to hear, inability to read a newspaper or book, and an inability to recognize faces across the room.

You should report any sign of functional decline that you observe so that the care team can update the individual's plan of care.

When to Report

Your organization will have specific policies and procedures outlining the time frame in which observations must be reported to the care team, so it is imperative that you are familiar with these policies. Some observations indicate a significant change in the individual's condition and must be ***immediately*** reported. These observations must be reported before you provide any additional care. Other observations are considered non-immediate and can wait to be reported until after the provision of care. If you are ever in doubt, it is best to report your observations right away!

Review

Today you are caring for Mr. Green, who is having difficulty brushing his teeth. He is having a hard time gripping the toothbrush and therefore keeps dropping it. When you look at his plan of care, you see that in the past Mr. Green was able to brush his teeth without difficulty or assistance. What is best course of action?

A) Discuss with other caregivers to see if they have noticed any changes.

Feedback: Actually, the best course of action at this time is to report the change to the care team. Once this is done, they can talk to other caregivers about the change to see if they can gain additional clues as to the potential cause of the change.

B) Update the plan of care with interventions to address the change.

Feedback: Actually, the best course of action at this time is to report the change to the care team. Once this is done, they can assess for potential causes of the change and update the plan of care to address the change.

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C) Verbally report the change to the care team.

Feedback: This is the FIRST step you should take when you notice any change in condition. Once reported, the care team will complete an assessment and identify changes needed to the plan of care.

D) Ask the family to help with daily activities.

Feedback: The family is a great resource, but in this situation having them help does not address the change in functional status. Instead, you should report the change to the care team so that they can complete an assessment and identify changes needed to the plan of care.

Summary

Observation and reporting is always important, but especially when it involves signs and symptoms that might indicate an emergency situation. Report these observations immediately. Remember that even routine observations can point to serious medical problems that can be addressed by the care team once reported.

Section 4: Reporting and Documentation

Welcome text: You report observations at work every day, and it is a key part of your work. Reporting isn't just a required aspect of your work; it's important to the health of those for whom you care. You want other members of the healthcare team to know what you have learned through observing and interacting with individuals. Reporting can be verbal or written, but must always be factual and timely.

Verbal Reports

When you give a report by talking to a member of the care team, this is called a verbal or oral report. Verbal reports are never stand-alone reports. They are always documented in written form in the medical record.

Verbal reports should be short, accurate, and objective. Give only the important points, not every detail of care. Use the individual's full name to be sure that the team does not misunderstand which individual you are reporting about.

Verbal reports are used mainly to relay changes in the individual's condition. Think for a few minutes before giving your report. What has changed in the individual's condition? What has changed in giving care? What has the individual told you that will be important for the next caregiver to know? You may want to make a quick list of facts to include in your verbal report so you do not forget them. Be specific. Instead of saying, "Mrs. Cloud has a pain in her side", say, "Mrs. Cloud said she has pain in her lower left ribs when she transferred to the wheelchair. The pain started this morning. She was given pain medication two hours ago, but it has not alleviated the pain yet."

After giving your report, wait for further instructions. The care team may ask you to perform a specific task, such as repositioning or giving extra water to the individual. Promptly carry out the task given to you. Be sure to report back any further changes. Be sure to document in the medical record your conversation with the team, what they instructed you to do, and the completion of the task.

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SBAR

Often healthcare professionals use a type of communication in verbal reports called SBAR to clearly and effectively communicate important facts. SBAR consists of four components: situation, background, appearance, and recommendation. The **situation** is a statement of the problem. It should be short, preferably one sentence. The situation includes the individual's name, which ensures other people can quickly put the report in context. **Background** includes anything that may have happened before the change. It can also include important history if you have that information. **Appearance** is what you observed, including signs and symptoms. **Recommendation** is what you want the care team to do. Most likely your recommendation will be that someone needs to see the individual.

Consider the following scenario then click on each tab to learn how to report the situation using SBAR.

Mr. John Parker has a history of asthma and uses an inhaler frequently. While helping him ambulate to the bathroom, you notice that his breathing is noisy and he tells you that he is having "problems breathing." His respiratory rate is 28.

Situation: "I'm concerned about Mr. John Parker's breathing."

Background: "It started when I was helping him walk to the bathroom."

Appearance: "His breathing is noisy and he told me he is having problems breathing. His respiratory rate is 28."

Recommendation: "I think he needs to be immediately evaluated."

Feedback During Report

Giving verbal reports is not a one-way process. Giving a report is part of the communication cycle. When you give a report, you are the communication sender. The individual you give the report to is the receiver. You will give information, and then the other individual will listen and analyze the information. They will then give you feedback.

Feedback is an important part of the communication process. Using feedback, you can be sure that what was heard was what you meant to say. The feedback can be a simple "Thank you; that was very clear", or it may be a question, such as, "Did I hear correctly that Mr. Brown walked 300 feet today? Yesterday he could only walk 100 feet". If someone has a question about a statement you made, you can make clear what you said by restating parts of the report. You might respond to the above with, "Yes, Mr. Brown walked 300 feet."

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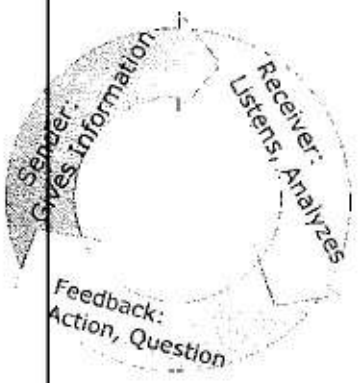
Communication Cycle



Closed-Loop Communication

You are trying to communicate important information to Nurse Jonathon about Mr. Sheedy. You make the following statement to the nurse: "Mr. Sheedy is having garbled speech." Which statement by Jonathon indicates that he used closed-loop communication?

Choice 1: "Ok, I heard you. I will be there soon."

Feedback: Jonathon has acknowledged that he heard you, but not if he understood what you said. Closed-loop communication involves the receiver restating what they heard the person sending the information say. If an individual does not appear to hear or understand what you told them, it is ok to ask, "Can you please repeat what I told you?"

Choice 2: "I'm busy now. Remind me later."

Feedback: Jonathon may be distracted or think what you have to say is not important. This does not make for effective communication. Closed-loop communication involves the person receiving the information restating what they heard the person sending the information say. If an individual does not do this, it is ok to ask "Can you please repeat what I told you?""

Choice 3: "Mr. Sheedy is having garbled speech."
Feedback: By repeating what you told him, Jonathon has used closed-loop communication. This shows that he has received the information. If Jonathon had not used closed-loop communication, it is okay to ask, "Can you please repeat what I told you?"

Documentation

Documenting your observations is just as important as making and reporting them. The medical record is a place to monitor the individual's condition and set out the plan of care. The medical record is also a legal document. It can be used in court if a family member thinks that good care was not given. It can also be used by state and federal surveyors to see if care was given in the correct way.

Surveyors and attorneys most often look for changes in an individual's condition to see if the correct steps were taken. Was the change noticed and documented quickly? Or was the change not noticed for days or weeks? Once the change was noticed, does the medical record show the

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steps taken to address the change, including notification to the healthcare providers, update of the plan of care, and documentation of the individual's response to the new care plan activities?

When documenting in the medical record, remember:

- Document using the proper forms as outlined in your organization's policies and procedures based on your specific job role.
- Document so that others can read your handwriting.
- Document the facts. Don't guess or document subjective observations.
- Be sure you are documenting in the correct individual's medical record.
- Use a black, non-erasable ink pen. NEVER ERASE or use correction tape. Draw a single line through errors and initial them.
- Document in sequence. Date and time all entries.
- Use short sentences or phrases.
- Use only approved abbreviations for your care setting.
- Make a note in your documentation about all reports you give to the care team.
- Fill in every space on forms. Draw a line through blank areas. Write "N/A" in areas that are not applicable.
- Document after giving care. Do not document in advance.
- Check to be sure you are filling in the correct space or line in a form. It is easy to lose your place on busy forms.
- NEVER document for another individual.
- If you forget to document something, follow your organization's procedure for adding a late entry. Don't just leave out the information. Late really is better than never.
- Sign flowcharts and other forms that use initials in boxes with your full signature in the space provided, usually at the bottom of the form.

Electronic Medical Record

Computerized medical record programs are time-saving, but sometimes they do not allow flexibility in documentation. If you cannot find where to document an important fact, ask your supervisor; do not leave the fact out of the record. Be sure to read and note the tips and reminders that many computerized medical record programs offer as you move from page to page, as these can be very helpful. To assure privacy, log off the program when you are finished. Do not give your I.D. or password to anyone else, even another co-worker.

Many parts of the medical record can identify an individual, so you must be careful to protect privacy when using the medical record. Printouts of the electronic medical record can lead to a violation of that individual's privacy. Ask your supervisor for your organization's policy about printing information from the medical record. Avoid printing information if it is not necessary. If you MUST print any information from the medical record, be careful not to throw it away in a trash can, or leave it where someone else can see it. Follow your organization's policy for disposal.

Incident Reports

Most healthcare organization have a separate incident report that documents accidents or injuries to individuals, visitors, or staff. If you observe an accident, or observe an individual just after an accident or injury, your first response should be to help with the safety of the individual.

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However, it is helpful if you can set into your memory what you saw and include it in the incident report.

Police who investigate crimes often block off the crime scene and then photograph it so they can see every detail. This helps to determine what happened. In the same way, see if you can store the mental image of what you saw for later documentation. Did the individual fall on their right or left side? Was the window open or closed? Was the television on or off? Details such as these can paint a picture of what happened before you entered the scene. This can lead to a better understanding of how the incident happened to help prevent it from happening again.

Follow your organization's procedure for incident reports. You may give a verbal report of your observations to a nurse or supervisor, who may then complete the incident report form, or you may fill out a form yourself. Be clear and concise. Use short phrases. Tell facts; be objective. If you need help in deciding how to word the report, ask your supervisor.

Review

You are caring for Mr. Tierney when you observe the following sudden changes: a large red rash on his back, an elevated temperature, and disorientation. All of the following are acceptable techniques to convey this information in a timely manner EXCEPT:

A) Use SBAR to describe your observations.

Feedback: SBAR provides structure to the information you provide and allows for concise communication. SBAR is a good communication tool to use in this situation. The technique that did NOT represent an acceptable way to convey information in a timely manner was making a note in the medical record, as the care team may not see it right away. However, it is still important to document, just do not use this as your method of communication.

B) Give a verbal report to the care team.

Feedback: When a sudden change makes you concerned about an individual, you want to get the attention of the care team. A verbal report is a good way to convey this information. The technique that did NOT represent an acceptable way to convey information in a timely manner was making a note in the medical record, as the care team may not see it right away. However, it is still important to document, just do not use this as your method of communication.

C) Use closed-loop communication.

Feedback: Closed-loop communication is a great way to make sure others have received important information. The technique that did NOT represent an acceptable way to convey information in a timely manner was making a note in the medical record, as the care team may not see it right away. However, it is still important to document, just do not use this as your method of communication.

D) Make a note in the medical record.

Feedback: When you notice an important change in an individual's condition, you want to let the care team know about it right away. If you only document it in the medical record with a note, they might not see if right away. However, it is still important to document, just do not use this as your method of communication.

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Summary

In the workplace, you report and document about individuals every day. When you report and document effectively, it allows the care team to understand the individual's condition, notice changes over time, and act quickly in emergencies. In this section you learned how to give an effective verbal report and how to document in the medical record. You were shown how to use SBAR and were given tips about documenting in the medical record. In the future, when you observe signs or symptoms, you will be able to communicate your observations effectively through a verbal report and in the medical record.

Section 5: Conclusion

Summary

Now that you have finished reviewing the course content, you should have learned the following:

Every day you observe changes in individual's conditions, comfort, and ability to complete daily activities. It is important that you use your senses to observe signs and symptoms, as they can detect important changes. When you observe something that should be reported, it is important that you use effective techniques to communicate that information, such as implementing SBAR and closed-loop communication to convey important information during verbal reports. You also learned to be sure to record your findings by documenting in the medical record. When you report and document, you must be objective when you convey your observations, leaving out personal thoughts and opinions. Observation begins the moment you begin care and ends when you are done providing care, and begins again on your next work day.

Contributor

Elizabeth Kellerman started nursing in 2007 after graduating from Samuel Merritt University in Oakland, California. Her work in the critical care unit of a community hospital provided significant experience caring for older adults. Her experience and knowledge led her to nursing education where she taught at a community college while working to receive her Master's in Nurse Education at Western Carolina University. As a nursing instructor, she spent time in many types of care settings including medical-surgical and community living centers. Her passion for education and training has most recently led her to a position as Subject Matter Expert and Content Writer for Relias Learning.

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Attachment I

DOCUMENTATION POLICY

PURPOSE: Create written record using the Hot Spot Communication Tool for a resident having a change in condition and track responses and resolution to the issues

DEFINITION: A change of condition is defined as an improvement or decline in their physical, mental and/or psychosocial status.

PROCEDURE:

1. When a change of condition or change from baseline is observed and reported, the Med Tech is responsible to evaluate the resident's condition. Examples of a condition change are as follows, but not limited to;

   a. Abnormal or change in vital signs
   b. Skin breakdown, open areas, rashes, and indications of bleeding
   c. Weight loss, gain or change in appetite, change in ability to chew
   d. Diarrhea, new diagnosis constipation, increased or new incontinence
   e. Nausea and vomiting (one episode would constitute a change
   f. Respiratory distress, nasal or lung congestion
   g. Signs and symptoms of an acute infection
   h. Falls
   i. Elopement, exit seeking, behavior changes, and/or changes in level of consciousness, increased confusion, hallucinations, anxiety or agitation, any change in mental status or memory.
   j. Talk of self-harm or harm to others.
   k. Change in gait, motor skills, decline in ADL's, muscle tremors twitching or jerking
   l. Hospitalization, Hospice admission or discharge, fracture
   m. Lethargy, hyperactivity, insomnia, somnolent, lack of interest in surroundings.
   n. New or increasing pain
   o. New diagnosis

2. Staff will notify the Health Services Director of any change in condition either short term change of condition or significant change in condition

3. If the resident appears acutely ill, contact 911 for Hospital transport and responsible party.

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4. When a change of condition has been observed, then the Medication Tech (MT) will indicate the "change" on a Hot Spot Communication page and file in the Hot Spot Notebook on the relevant hall so that all staff is aware that a resident has been placed on "alert."

5. All workers are instructed to document on active Hot Spot Communication forms during their shift to report changes in condition, services rendered and results of appointments regarding the alert condition. The length of time the resident will be on alert depends on the condition or the direction from the resident's physician and the Health Services Director.

6. Vital signs may be obtained via the discretion of the physician. Any reportable criteria must be communicated to the Health Services Director, primary care physician and responsible party promptly. Document all attempts to contact.

7. Individual alerts will remain active until the Health Services Director determines there is resolution of the condition and the form can be filed in the resident's chart.

Effective Date: 10/26/17

Attachment J

December 6, 2017 Mandatory In-Service:

AGENDA:

Dirt, bent blinds, other necessary repairs. What to do?
>These items are to be kept in good repair. If you notice something that is dirty or needs to be repaired, please report it to the administrator or maintenance director immediately. For items that are not urgent, you may submit a maintenance request form.

TB Tests for residents. What happens if I don't see it in the resident chart?
>Please make sure every resident chart has at least 2 TB tests. If you don't see two TB tests, please report it to your health services director ASAP. All residents must have 1 TB test before admission and another one within their first year living here.

Medications. What do I do if I run out of a medication and the pharmacy is unable to refill it?
>Escalate the issue as quickly as possible! It is not acceptable to chart "not on cart". We are responsible for having medications in-house. Make your health services director aware, so that she can call the pharmacy or so that she may utilize a backup pharmacy.

Med Tech communication log. What's it for?
>Utilize the med tech communication log to pass along information from shift to shift. This is especially useful when trying to reorder medications. It allows med techs working after you to know where exactly we stand in receiving a medication. It can also be used to communicate hot topics or non-routine items that may be happening within the facility.

Resident rights. What to do in the following scenarios...

>***Resident needs to use the bathroom more frequently than usual***: help them as often as they Need it without repercussion or judgment. Using the bathroom is natural and it should be Requests should be handled professionally and respectfully, without delay.

>***Roommates:*** If a resident has expressed a desire to have a new roommate. Please chart this Request and utilize the grievance policy. Also make a report to the marketing director and/or Assistant executive director.

Grievances. What does this mean?
>A grievance is a concern or complaint that a resident may have. It should be handled quick and professionally. All actions should be documented on the "Resident/Family Concern Grievance Form" until there has been a resolution.

Appointments. Why is this so important?
>When residents visit their primary care physician, he or she will often have that resident follow up with a specialist. It is very important that we keep these appointments, as specialists can sometimes take a while to get appointments with. When residents come back from the doctor, their physician visit sheet or their discharge summary should be given to the health services director for review. If a resident refuses to go to the doctor, you must fill out a refusal form and give it to the health services director.

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Resident Grievance Policy

PURPOSE: Ensure that each resident has the right to present grievances, complaints and/or suggestions without fear of reprisal, restraint, interference, coercion or discrimination.

Regardless of which supervisor/department head responds, the Administrator or his/her authorized representative shall review all complaints and agree with the actions taken towards resolution. Responses to resident/family shall be made as soon as possible and preferably immediately. Actions taken include contacting the resident and/or family with an explanation of the steps we are going to take to resolve the complaint and to ensure their satisfaction. Actions taken must be documented. It should be noted if the resident or resident's family continues to express a concern and in their view, the problem is not resolved, the Administrator must be apprised of the situation and the administrative team must be kept informed. The concern/grievance must always be handled first, followed by the appropriate reporting and trending of information. Responses may be written or verbal, depending on the situation.

PROCEDURE

Definition: a grievance is any written or verbal concern by a resident, relative or any other representative relating to resident care or the quality of services provided.

1. Complete a Grievance Form for any concerns/grievances reported.
2. The person receiving the concern is to complete Section I.
3. Refer the document to Department Head for review and actions to be taken. Record actions taken in Section II. The Administrator (or his/her designee) shall initial the form to confirm agreement with the action plan. The respective Department Head will follow up with the person generating the grievance to ensure resolution.
4. All concerns/grievances will be trended monthly by the administrative team and reviewed during quarterly QA meetings.

Effective Date: 12/12/97. Revised: 12/06/17; 12/26/07

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RESIDENT/FAMILY CONCERN/GRIEVANCE FORM

Resident Name _____ Room # _____

Date of Report _____ Time of Report _____

Person Generating Concern/Grievance _____

Check One: ☐ Resident ☐ Visitor ☐Family ☐Other _____

Contact Information _____

Employee Receiving Concern/Grievance _____

Department Responsible for Action/Follow-Up _____

STEP 1 Nature of concern:

STEP 2 Department Head Review and Action Taken:
Dept Head Signature _____ Date _____
Administration in agreement with above Action Plan _____ (Initial)

STEP 3 Follow Up with Resident and/or Person Generating Concern:
Employee Signature Completing Follow Up _____ Date_____
Administrator Signature _____ Date_____

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RESIDENT/FAMILY CONCERN/GRIEVANCE FORM

Resident Name _____ Room # _____

Date of Report _____ Time of Report _____

Person Generating Concern/Grievance _____

Check One: ☐ Resident ☐ Visitor ☐Family ☐Other _____

Contact Information _____

Employee Receiving Concern/Grievance _____

Department Responsible for Action/Follow-Up _____

STEP 1 Nature of concern:

STEP 2 Department Head Review and Action Taken:
Dept Head Signature _____ Date _____
Administration in agreement with above Action Plan _____ (Initial)

STEP 3 Follow Up with Resident and/or Person Generating Concern:
Employee Signature Completing Follow Up _____ Date_____
Administrator Signature _____ Date_____

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RESIDENT/FAMILY CONCERN/GRIEVANCE LOG

Resident Name	Concern/Grievance	Date Received	Date Resolved		Comments
			Verbal	Written	

Attachment T

Attachment K

ACTION	DATE	INITIALS
Received at Facility		
Faxed to Cape Fear Pharmacy		
Faxed to Other Pharmacy (if applicable)		
Faxed to Provider(s): Physician, Therapist, Home Health, _____		
Delivered to Health Services Director		
Activated in Hot Spot		
Filed in Resident Chart		

High/Low Blood Sugar Policy

Attachment L

Effective Date: 12/11/2007

Purpose:
To assure accurate monitoring and follow up of high and low blood sugars.

Procedure:

- All patients prescribed sliding scale insulin will have specific directions for sliding scale dosing including blood sugar range and amount of insulin to be given. If clear direction for sliding scale are not given, facility will attempt to contact prescribing physician for clarification.
- Insulin will be kept refrigerated and will be dated upon opening. Insulin will be discarded after being opened for 30 days.
- Blood sugar levels will be tested as often as deemed necessary by attending physician and documented on MAR.
- Blood sugar will be tested 15 to 30 minutes before meals. Insulin will be given according to sliding scale directions immediately after blood sugar is tested. If blood sugar is to be tested at bedtime, sliding scale can be given without regard to meals for the bedtime dose.
- Orders from physician should clearly state procedures to be followed when blood sugar is below 60 or above 450.
- If the doctor did not indicate otherwise, the facility standard parameters are: if blood sugar falls below 60 and the patient is alert, give four ounces of orange juice, call the doctor and the family, and retest in 30 minutes. If BS remains below 60, call rescue and notify the physician and family. If blood sugar is above 450, give insulin if indicated and recheck in 30 minutes. If no insulin available, call physician and family. If blood sugar remains above 450 call rescue and notify the physician and family. All actions must be documented in the resident's chart.
- If patient is found unresponsive check blood sugar and call emergency medical services, call the family, and notify the physician.

Attachment N

and family care homes are subject to licensure by the Division of Health Service Regulation.

(2b) "Assisted living residence" means any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102.

(3) "Exploitation" means the illegal or improper use of an aged or disabled resident or his resources for another's profit or advantage.

(4) "Facility" means an adult care home licensed under G.S. 131D-2.4.

(5) "Family care home" means an adult care home having two to six residents. The structure of a family care home may be no more than two stories high and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(6) Repealed by Session Laws 2001-209, s. 1(c), effective June 15, 2001.

(7) Repealed by Session Laws 1995, c. 535, s. 13.

(8) "Neglect" means the failure to provide the services necessary to maintain the physical or mental health of a resident.

(9) "Resident" means an aged or disabled person who has been admitted to a facility. (1981, c. 923, s. 1; 1981 (Reg. Sess., 1982), c. 1282, s. 20.2C; 1983, c. 694, ss. 2, 3, 5, 7, 8; 1995, c. 535, s. 13; 1997-456, s. 21; 2001-209, s. 1(c); 2007-182, s. 1; 2009-462, s. 4(h).)

Resident Rights Training
10/24/17

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§ 131D-21. Declaration of residents' rights.

Each facility shall treat its residents in accordance with the provisions of this Article. 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.

(2) To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(3) To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services.

(4) To be free of mental and physical abuse, neglect, and exploitation.

(5) Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.

(6) To have his or her personal and medical records kept confidential and not disclosed except as permitted or required by applicable State or federal law.

* (7) To receive a reasonable response to his or her requests from the facility administrator and staff. → Roommates!

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(8) To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.

(9) To have access at any reasonable hour to a telephone where he or she may speak privately.

(10) To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationery, and postage.

(11) To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.

(12) To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the resident, the administrator, or supervisor-in-charge.

(13) To manage his or her personal needs funds unless such authority has been delegated to another. If authority to manage personal needs funds has been delegated to the facility, the resident has the right to examine the account at any time.

(14) To be notified when the facility is issued a provisional license or notice of revocation of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. The resident's responsible family member or guardian shall also be notified.

(15) To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse such participation.

(16) To receive upon admission to the facility a copy of this section.

(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the Medical Care Commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The Medical Care Commission shall adopt rules pertaining to the transfer and discharge of residents that offer protections to residents for safe and orderly transfer and discharge. (1981, c. 923, s. 1; 1983, c. 824, s. 13; 1983 (Reg. Sess., 1984), c. 1076; 1997-443, s. 11A.118(a); 1999-334, s. 1.6; 2000-111, s. 3; 2011-272, s. 3; 2011-314, s. 5.)

§ 131D-21.1. Peer review.

It is not a violation of G.S. 131D-21(6) for medical records to be disclosed to a private peer review committee if:

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Section 1: Introduction

About This Course

We are granted certain rights, protections, and freedoms by our government. Our rights, protections, and freedoms enable us to make independent decisions regarding all aspects of our life. When individuals are admitted to a health care organization, they do not lose any of their rights, protections, or freedoms.

As a health care worker, you have the ethical and legal responsibility to protect the rights of individuals under the care of the health care organization where you work. In this course, you will learn about the rights the individuals you care for have and ways you can protect these rights.

Learning Objectives

When you complete this course, you will be able to:

- Describe and give examples of the rights of individuals cared for by your health care organization.
- Explain steps you can take to protect the rights of those cared for by your health care organization.

Section 2: General Rights in all Health Care Organizations

Welcome text: In this section, you will learn about basic rights of individuals receiving care in any type of health care setting and see examples of those rights. You will also learn about ways to protect these rights.

Healthy Environment

First all individuals receiving care have a right to a healthy environment. *Click each tab to learn more about an individual's right to a healthy environment in health care.*

Water: As part of a healthy environment, individuals have the right to have access to clean water for cleaning, bathing, drinking, and hand washing that meets governmental standards as set by the Safe Drinking Water Act.

Air: Individuals have the right to air that is free of infectious particles such as those transmitted in respiratory infections. Air should also be free of noxious particles such as smoke. To maintain this right, individuals with respiratory infections may be required to wear masks to prevent the airborne transmission of disease. Your organization must also develop policies regarding residents who smoke outlining locations where they can and cannot smoke.

Food: This is the right to food that is safely prepared and stored to prevent the spread of foodborne illness. Anytime you are handling food, you should follow the rules of basic food safety as outlined by the Food and Drug Administration, or FDA, including the need for frequent hand washing before handling food, after using the toilet, and anytime your hands become soiled. For storage, food should be refrigerated and not left at room temperature. This right also involves having an adequate amount of food to maintain proper nutrition and health. Not only is amount important, but the type of food must also promote nutrition and health.

Sanitation: A healthy environment is also a clean and sanitary environment. Individuals have

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the right to adequate sanitation including the removal of human waste and the proper cleansing of environmental surfaces and linens.

Follow your organization's policy on infection control, but there are some basic things you can do to keep the environment clean and sanitary. Keep surfaces clear of clutter, wipe down surfaces with disinfectant, and empty trash bins or linen hampers. Always perform hand hygiene at designated time points. Keep surfaces and linens clean through the use of hot water, detergents, and disinfectants (WHO, 2008).

Shelter: Individuals have a right to shelter that keeps out unwanted weather elements and provides adequate lighting, electricity, and ventilation. Buildings must adhere to the Americans with Disabilities Act by allowing individuals with disabilities who use assistance devices to have equal access to the building (Department of Justice, 2010). The right to adequate shelter in health care is also protected by national standards and building codes for the health care setting.

Safe Environment

Your organization must strive to protect the right to a safe environment. The building must have emergency procedures in place in the event of fire, tornado, floods, or other disasters. Hallways and emergency exits must be kept clear so individuals can escape during a fire. Walkways must be kept clear of ice and snow to prevent falls. You can protect this right by following your organization's emergency procedures.

Freedom from Abuse and Neglect

A healthy and safe environment includes the right of individuals to be free from abuse, mistreatment, and neglect (Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 2016). This can include coercion and seclusion. No one has permission to abuse, mistreat, or neglect any individual. This includes anyone working in a health care organization, family members, and volunteers. *Click on each tab to learn about these definitions.*

Abuse - Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. In this definition, willful means that the individual must have acted deliberately. It does not mean that the individual must have intended to inflict injury or harm.

Mistreatment - Mistreatment means inappropriate treatment or exploitation of an individual. Exploitation is taking advantage of an individual for personal gain using manipulation, intimidation, threats, or coercion.

Neglect - Neglect means the failure to provide goods and services to an individual that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Exploitation – Exploitation often comes in the form of financial exploitation. Financial exploitation of older adults includes prize scams, phony donations, and phony magazine subscriptions. These scams are often used to obtain financial information such as banking account numbers. One of the most common ways is through telemarketing where the caller obtains the individuals financial information fraudulently (National Institute for Justice [NIJ], 2015).

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Seclusion – Seclusion is defined as keeping an individual from social contact with others including friends, family, or even other residents (Centers for Disease Control and Prevention [CDC], 2016). Seclusion or isolation is cruel and inhumane. No one should ever be subjected to seclusion in a health care setting including assisted living communities. Seclusion can include locking someone in a room but it also can include withholding assistive devices that are necessary to interact with others (CDC, 2016).

If you suspect abuse, mistreatment, or neglect, you must report it immediately so your organization can take steps to prevent further abuse, mistreatment, or neglect of the individual and others as well as conduct an investigation. You may also contact your state ombudsman to report mistreatment of older individuals. If you would like to learn more about preventing, recognizing, and reporting abuse, mistreatment, and neglect, you can search the Relias Learning library for other course offerings on these topics.

Restraints

All individuals have the right to be free from restraints, both chemical and physical, used for the purposes of discipline or convenience AND not to treat a resident's medical symptoms. Restraint use is associated with multiple types of injuries and even death. Restraints must only be used as a last resort or when medically necessary for treatment of a medical condition (CMS, 2016).

To protect this right, you must understand the specific circumstances in which restraint use is allowed in your care setting along with the guidelines for appropriate restraint use. Many healthcare organizations are implementing restraint-reduction program to reduce the use of the restraints. Some have even become completely restraint-free.

Your organization can reduce the use of restraints by implementing general strategies such as:

- Creating a relaxing environment
- Providing close supervision when needed
- Paying attention to basic needs
- Using assistance devices such as hearing aids, visual aids, and mobility devices
- Using devices to help ensure proper positioning

If you would like to learn more about restraints, you can search the Relias Learning library for other course offerings on this topic.

Dignity and Respect

All individuals have the right to be treated with dignity and respect. Under this right, individuals are entitled to be treated in an appropriate manner. To uphold this right, an organization must accommodate an individual's needs by providing person-centered care.

Person-centered care is an approach to care that views individuals holistically so that they can achieve their highest level of well-being (Eliopoulos, 2015). Each individual has a unique identity composed of cultural, social, and religious components. Each organization should provide care that respects the individual, including their religious, cultural, and social preferences.

You can respect an individual's personal preferences when it comes to daily activities. Does the individual prefer to play cards or watch TV? Does the individual prefer to eat a large breakfast and small dinner or vice versa? Knowing the individual you care for is an important component

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of respect and person-centered care.

Mr. Ivanchenkov is an 89-year-old man who lives at your organization. He immigrated to the United States with his wife when they were younger from eastern Europe. Besides a few plants, his room does not have many personal belongings. He does, however, prefer to keep a picture of his family on his nightstand. While providing care you need to move the picture on his nightstand. What should you do?

A) Place the picture in the drawer of his dresser.

Feedback: This action violates the individual's right to be treated with respect. It is NEVER acceptable to move an individual's belongings without asking their permission first. Asking permission before moving the picture is one way that you can help protect Mr. Ivanchenkov's right to be treated with respect.

B) Ask him if it is ok to move it while you provide care.

Feedback: By asking permission before moving Mr. Ivanchenkov's picture, you are protecting his right to be treated with respect.

C) Give it to your supervisor so it won't get lost.

Feedback: This action violates the individual's right to be treated with respect. It is NEVER acceptable to move an individual's belongings without asking their permission first. If you are concerned about the picture getting lost or damaged during care, you should ask Mr. Ivanchenkov if you can move it to a safe location temporarily.

Treating individuals with respect and dignity is especially important when communicating. Speak in a courteous manner and call people by the name they wish to be called as indicated in their plan of care. Some individuals may prefer to be addressed using a formal title such as "Mrs. Redding" or "Dr. Sanders." Others may prefer you use their first name or a nickname. Do NOT use "pet names" such as granny, honey, or sweetheart. If you are unsure how to address an individual, the best practice is to ask them.

You must also treat individuals with dignity. Self-esteem and self-worth are indicators of dignity. According to Eliopoulos (2015), some practices to enhance individual's self-esteem and dignity include:

- Respecting individual's grooming and dressing preferences
- Safely promoting independence with activities of daily living
- Being respectful of private space and property
- Letting individuals do things for themselves
- Offering choices in daily activities
- Helping them be involved with friends and family
- Not laughing at their behaviors
- Learning and sharing their personal history

Access to Medical Treatment

All individuals in the health care setting have a right to the prevention and treatment of diseases.

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They have a right to quality medical treatment by competent licensed health care providers. Individuals have a right to know the names and contact information of their health care providers. No individual shall be denied emergency medical treatment due to inability to pay. Individuals have a right to any essential medical treatment needed to maintain life. Further, if your organization cannot provide the medical services, it must provide a referral to another health care organization which offers those services.

Free from Discrimination

Under the 1964 Civil Rights Act (2012), it is illegal to discriminate against anyone based on race, color, or national origin (Department of Justice, 2015). Everyone has the right to equal access to quality health care regardless of their race, color, or national origin. It is also unethical to discriminate based on age, sexual orientation, disability status, religion, gender, gender identity, marital status, or socioeconomic group. You must also prevent discrimination based on diagnosis, severity of condition, and payment source.

Decision Making and Choice

Each individual has a right to participate in their own care by making their own health care decisions and choices about their life. This right includes the right to choose their health care provider. The right to make decisions requires that individuals are thoroughly informed. It also requires that they make their health care decisions freely and of their own will.

In order to be informed and involved in the planning process, organizations must communicate health care information to those they serve. Individuals have a right to ask a qualified health care provider questions about their care. To do so, individuals must be given the name and contact information of their primary health care provider.

The individual has a right to be fully informed about their:

- Health status including medical, functional, nutritional, cognitive, oral health, and psychosocial status
- Plan of care, including medical and nursing care such as medications and procedures, and changes to that plan of care

(CMS, 2016)

The individual also has the right to participate in the care planning process including establishing:

- Goals and outcomes of care
- The type, amount, frequency, and duration of care
- Any other factors related to the effectiveness of the plan of care

(Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 2016)

All of this information must be provided in their preferred language and in terms that the individual will understand. Avoid the use of medical jargon and abbreviations. In addition, the health care provider must inform them of any alternative medical treatments available. If an individual refuses recommended care, they must be informed of any consequences as a result of their refusal. This education along with the individual's decision must be documented in the medical record.

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Everyone has the right to make independent choices about all aspects of their life including their health care. They have the right to choose activities and schedules that are consistent with their interests and personal preferences. They have the right to choose what and when to eat, what to wear, when to get up and go to bed, among many other aspects of life. They have the right to refuse any medical treatment they do not want as well as any basic care such as food or fluids that they do not want. Individuals cannot be forced to accept medical treatment or basic care.

If an individual refuses care, whether medical treatment or basic care, try to identify the reason for refusal. You may find that the reason the person is refusing care can be easily addressed. For example, if an individual is refusing to eat, maybe they need help eating or their dentures do not fit properly. If so, you can help them with these barriers. However, you cannot force individuals to eat or punish them for not doing so.

Some individuals may be asked to participate in research. Participation in any type of research is always voluntary and participants can withdraw at any time from a research study. If an individual is asked to participate in health care research, they have a right to refuse participation without fear that their access to or quality of care will be compromised. Any research that involves human beings must have clear protocols that protect the health and privacy of individuals.

If you are caring for an individual that is participating in a research study and they have questions or concerns about the study, direct them to the research coordinator or your supervisor. If you are concerned that someone is not participating in research voluntarily, report this to your supervisor. They will report this to the institutional review board of the organization that is conducting the research.

Self-Determination

Individuals have the right to create advance health care directives. Advance directives are legal documents with instructions for health care providers if an adult is not able to make decisions about their own health care. There are several different types of advance directives. A living will, for example, identifies the medical treatments an individual may or may not want in a particular situation. A durable power of attorney for healthcare assigns someone else the power to make health care decisions in the event the person is unable to do so themselves.

The Patient Self-Determination Act (2015) requires health care organizations to:

- Ask if individuals have an advance directive upon admission.
- Educate staff about advance directives.
- Give a written explanation of decision-making rights.
- Not discriminate against individuals if they do not have an advance directive.
- Not make individuals have an advance directive.

All individuals have the right to designate someone as their representative who can exercise their rights to the extend provided by state law, including a same-sex spouse. This representative can be:

- Any person chosen by the individual to act on their behalf
- Any person authorized by state or federal law, such as a power of attorney, to act on behalf of the individual
- Any legal representative or court-appointed guardian

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(Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 2016)

You must treat the decisions of an individual's representative as the decisions of the individual in accordance with applicable law. Additionally, you must involve the individual's representative as much as possible in the development and implementation of that individual's care plan.

For example, involve the decision-maker in discussions about medication for harmful behaviors, and include alternatives to medication to provide individualized care. Staff should document involvement with the appointed decision-maker including attempts to contact them by phone or email as well as conversations about the plan of care.

If you would like to learn more about advance directives, you can search the Relias Learning library for other course offerings on this topic.

Privacy and Confidentiality

In health care, individuals have the right to privacy. You must always maintain an individual's right to privacy and confidentiality.

Be sure to maintain an individual's physical privacy when providing care. Always discuss the care you will provide and explain to the individual that you might need to expose a part of their body. When providing care, it is important to avoid exposing parts of the individual's body that do not require care or exposing more than what is needed. You should also maintain privacy by closing all curtains or doors while providing care or assistance.

Additionally, ask visitors to step out of the room when you provide care that requires you to expose parts of an individual's body. Be respectful of the individual's wishes regarding visitors. Some may be okay with having certain visitors present during care while others may want to have privacy. All you have to do is ask! For example, if you are going to help Mrs. Smith with a bed bath and her daughter is present, you may ask, "Mrs. Smith, I'm going to help you with your bath today and will need to expose parts of your body. Would you prefer if your daughter left the room?"

In addition to physical privacy, all individuals receiving care have a right to have their health information kept private. Protected health information is any information that has an individual's specific identifiers such as name, medical record number, date of birth, address, and phone number. Protected health information includes the individual's physical or mental health condition, treatments, and payment for their treatment (U.S. Department of Health and Human Service, 2003).

All staff, regardless of their role, must help to secure protected health information. Protected health information can only be shared for treatment, billing purposes, and health care operations such as quality improvement and surveys. Even in these situations, only the specific information needed should be disclosed.

Individuals have the right to control their health information including the right to a copy of their medical records and the right to request corrections to their medical record. If an individual requests a copy of their medical record, you should direct them to your supervisor. You should be aware that some organizations are required by federal and/or state regulation to allow individuals access to their medical records within a designated timeframe. Therefore, it is

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imperative that you notify the management team immediately after this request.

Privacy Violations

Time to see if you can identify if the following scenarios violate a person's right to privacy.

Before entering someone's apartment, you knock on the door then immediately enter without waiting for a response. Is this a violation of privacy?

Yes
Feedback: You should always ask for permission and give the individual time to respond before entering the apartment.

No
Feedback: Actually, this IS a violation of the individual's privacy. You should always ask for permission and give the individual time to response before entering the apartment.

You only discuss an individual's care with approved family members. Is this a violation of privacy?

Yes
Feedback: Actually, this is NOT a violation of privacy because the individual has approved that certain family members may receive information about their care. If you are ever unsure of whether someone can receive protected health information, be sure to ask!

No
Feedback: If you are ever unsure of whether someone can receive protected health information, be sure to ask!

Informing Individuals of Their Rights

Each individual has the right to be informed about their rights. Your organization must give a written explanation of the individual's rights upon admission to the resident or their representative. They must also give a written explanation of the organization's policies pertaining to how they implement these rights. This notification must be given in a format and language the individual understands.

Your organization must also inform individuals before admission, during admission, and throughout out their stay of the cost of services. This means that the organization must inform the individual of the cost of services the individual will need to pay out of pocket. You should also notify the individual if there are any changes to coverage or cost of services.

Exercising Their Rights

Individuals have the right to exercise their rights freely and to the maximum extent possible including those given to an individual as a citizen of the United States. Your organization cannot punish, retaliate, interfere with, or discriminate against individuals because they exercise their rights. Additionally, you cannot persuade someone to act a certain way by using force or threats. Your organization must facilitate and support the implementation of these rights as much as possible.

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Review

Match each right with the action taken that protects that right.

Decision-making and choice – Upon request, a health care provider explains alternatives to a proposed treatment.

Privacy and confidentiality – You knock on a resident's door before entering.

Safe environment – You immediately report suspicions of abuse or neglect to your supervisor.

Access to Medical Treatment – You spend the same amount of time helping an individual to eat regardless of their race or religion.

Healthy environment – You thoroughly wash your hands to prevent the spread of infection.

Summary

Each individual who receives health care is entitled to certain rights. You should be aware of these rights and be respectful of them throughout the work day. Everyone who is employed at a health care organization is responsible for respecting an individual's rights when they provide care. You should consider each of the general rights that you learned about here as well as the rights that are specific to your care setting, which you will learn about in the next section.

Section 3: Rights of Residents in Assisted Living Communities

Welcome text: In addition to the many general rights discussed in the previous section, residents in assisted living communities are entitled to several more rights. In this section, you will learn about the specific rights of those in an assisted living community. However, it is important to remember that each state has specific requirements regarding resident rights in assisted living community, so be sure to refer to your community's policies and procedures for more information.

The Right to be Notified of Changes

Residents and their legal representative or designated family member should be notified of certain changes before they take place. This includes:

- Changes in policies and services
- Changes in the resident's health condition
- Changes in treatment
- Decisions to transfer or discharge
- Change in apartment
- Change in rights under State law
- Changes in smoking policy

Changes in rates or services must be communicated to the resident or their representative before the change is implemented. If a change in treatment is needed, the organization must contact the resident's health care provider and their designated family member or legal representative. Even when the resident is competent, your organization must notify the designated family member or legal representative of significant changes, because the resident may be unable to do so themselves (CMS, 2016).

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The following are examples of health changes that may need to be reported to the resident's health care provider and their designated family member or legal representative:

- Pain
- Changes in nutrition intake
- Changes in condition of feeding tube
- Decline in function
- Decline in cognition
- Incontinence pattern changes
- Worsening mood
- Unplanned weight loss
- Begin use of restraint
- New condition or unstable disease
- Pressure injury, previously called pressure ulcer
- Decline in overall condition

When a resident is to be transferred to a new apartment or different community, the organization must be sensitive to the stress this may cause by explaining the reason for the move. The individual's medical record must document all changes, including the date and reason for the change. Finally, documentation should include the names of caregivers or health care providers who were involved and that the resident was informed.

The Right to Manage Finances

The resident has the right to manage their own finances. The resident also has a right to ask the organization to manage their personal finances. So, if the resident requests it, the organization may manage their finances such as checking and saving accounts.

The organization must obtain and keep on file written authorization to manage the resident's funds. The authorization must be signed by the resident or their legal representative. The organization may have access to sensitive financial information such as account numbers and it must protect this information by keeping it private. The resident or their representative has the right to review account activity such as withdrawals and deposits. Depending on the state where you work, the person who manages the residents' finances must keep a certain amount of cash on hand that is available to the resident for daily expenses.

The Right to Voice Grievances

All residents have the right to voice grievances about their care including the health care organization in which they reside. This right empowers each resident to:

- Voice concerns and questions.
- Make complaints to or about staff members or other persons.
- Meet with and voice concerns to outside organizations, social service groups, legal advocates, and members of the public who visit the organization.
- Be informed of the grievance process.

Examples of grievances include concerns about the treatment or care received, handling of finances, lost personal property, and violation of rights.

Residents should **never** fear punishment or discrimination for voicing their concerns. If a

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resident reports a concern, the community must promptly attend to and resolve the matter.

You can protect this right by ensuring that you listen to residents' concerns and grievances and notify you supervisor or other member of the management team about these concerns. Even if you are able to address the concern, you must still notify management what the concern was and how you addressed it.

Residents and their families also have the right to organize and participate in resident and family groups or associations within the community. The association shall be open to all residents. Staff, visitors, and other guests can only attend if invited to do so by the group. This association may hold elections, make recommendations to management, and create policies and procedures that help to improve the quality of life for residents.

All grievances and recommendations provided by the groups concerning care and life in the community must be given prompt consideration by the management of the community. This does not mean that the management must implement every request but it must provide their response and the reason for said response to the group. (Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 2016)

The Right to be Informed of Licensure Status

Each assisted living community is granted a license by the state in which it operates. There are different types of licenses that a community may have depending on its status. For example, there are regular licenses or probational licenses. The resident has a right to see the community's license. The community can make the license available by posting it in a highly visible location or making it available upon request. If a change in licensure occurs, such as when a license becomes revoked or is on probation, the community must notify the residents and their family members or legal guardians.

The Right to Work or Not Work

Residents are never required to work for a community. If the resident chooses to work, certain conditions must be met:

- There must be a documented need for the work.
- Documentation must specify the type of work and if it is voluntary or paid.
- Compensation must be at or above the common rate.
- The resident must agree to the work conditions.

Documentation must address the medical appropriateness of the work assignment (CMS, 2016). After work begins, the resident may stop working or refuse to work at any time.

The Right to Privacy

In addition to the general privacy rights mentioned in the previous section, residents living in assisted living facilities have other privacy rights. Residents have a right to privacy in regards to communication, visitation, mail, and the telephone.

To respect the right to privacy, remember that all mail to residents must be delivered promptly and unopened. Outgoing mail must be sent to the postal service within 24 hours. Be sure to give any mail a resident gives you to the appropriate department.

During visitation, the resident has a right to privacy. This entails providing physical space for the

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visitor to talk with the resident without interference and without being overheard by others.

Each resident is to have access to a telephone. When the telephone is in use, the resident is to have privacy such that the conversation cannot be overheard. You are never allowed to listen in to residents' telephone conversations. Facilities must also provide access to the use of electronic communication such as email, video communication, and the internet, to the extent it is available in the community.

The right to privacy extends to photography of residents. If your organization plans to take photographs of a resident, they must consent before those pictures are taken. If your work is taking photographs for identification purposes, a consent is not required.

The Right to Have Personal Possessions and Visitors

Each resident should be encouraged to have personal belongings as long as the belongings do not hamper the health, safety, or rights of other residents (CMS, 2016). You must be respectful of personal possessions regardless of their monetary value. You **cannot** discourage a resident from having personal possessions. The community must also take reasonable care to protect the resident's property from loss or theft.

Residents of your community also have the right to have visitors. They have a right to see these visitors at the time and in the manner in which they want.

The following scenario demonstrates how you can correctly uphold the visitation rights for a resident:

Mr. Hill is a 72-year old African-American man. He is a widower who has been living in your community for a year. On Sunday, his grandchildren take Mr. Hill to church. After church, they come back to the community and visit.

One day Mr. Hill's family members stay in his apartment until after 8:00 PM. Around 8:30 PM, one of the grandchildren finds you and asks you if it is ok if they stay a little longer. You respond by telling them that visitation hours are not restricted for family.

It is important to remember that all communities have specific policies regarding visitation, so be sure you are familiar with them. If you ever have a question about visitation rights, be sure to talk to your supervisor or a member of the management team!

The Right to Participate in Activities

Residents have a right to decide how they want to spend their free time. The resident may choose to be alone in their apartment, socialize with other residents of the community, or attend activities. Residents have the right to choose and participate in activities. They should be allowed to participate in social events, religious observances, and even regular physical exercise. Each resident has the right, if medically approved, to regular exercise several times a week. They also have the right to be outdoors regularly (Department of Elder Affairs, 2013).

Residents also have the right to leave the community when they so choose. For example, a resident may choose to leave the community to go shopping or to see a movie. They can also return at any time as long as leaving and returning is consistent with the community's rules. The only exception to this may be residents who live on memory care units because of dementia.

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The Right to Share an Apartment with a Spouse

Spouses have the right to live in the same apartment if they are married, living in the same community, and they both consent to living together. This includes same-sex marriage, regardless of the location of the community in a state that prohibits same sex marriage.

The Right to Self-Administer Medication

If the heath care team deems it safe, residents have the right to self-administer their own medications. If a resident self-administers medication, the interdisciplinary team must decide where to keep their medications and where they are to be administered. This right is periodically reassessed as a resident's health condition changes.

If a resident becomes unable to safely administer their own medication, the community will then assume this responsibility. The decision to self-administer medication must be documented in the care plan according to your organization's policy and procedure.

The Right to Refuse Transfer

Your organization must notify residents at least 30 days in advance of an apartment transfer or discharge. Each resident has the right to appeal the transfer or discharge and stay in their apartment until a decision is made about the appeal. Each resident has a right to not be transferred unless it is necessary medically, for nonpayment, or because state or federal law requires it. Before transferring a resident from one apartment to another, always be sure the management team has approved this transfer to prevent a violation of rights.

Review

Mrs. Williams is a resident in Sunny Acres assisted living community where you work. This evening you notice that she hardly touched any of her dinner. When you ask her about it, she says, "Of course, I didn't. It's as cold as ice. It's like that every night! In fact, I'd like to file a complaint about that." What should you do?

A) Tell Mrs. Williams you will talk with dietary services about the problem.

Feedback: First, any time a resident voices a grievance, you should address that concern immediately, or if unable to address the concern find someone who can. Instead of simply telling Mrs. Williams that you'll discuss the problem with dietary services, you should offer to reheat her food or offer to get her another plate. Additionally, your action fails to address the fact that Mrs. Williams wants to file a complaint. Any time a resident requests to file a complaint, you should inform them of your organization's process for doing so and assist them if needed.

B) Notify Mrs. Williams of your organization's process for filing a complaint.

Feedback: Your actions support Mrs. Williams' right to file a complaint! You should also immediately address her concern by offering to reheat her food or offering to get her another plate. If you are not able to address the concern, you should find someone that can.

C) Tell her that next time the food will be warmer and record Mrs. William's confrontational behavior in her resident file.

Feedback: Your actions have violated Mrs. Williams' right to voice grievance. You should have informed Mrs. Williams your organization's process for filing complaints and assisted her if

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needed. Additionally, you should immediately address her concern by offering to reheat her food or offering to get her another plate. If you are not able to address the concern, you should find someone that can.

D) Tell Mrs. Williams that she is being too difficult and give an excuse for the cold food.

Feedback: Your actions have violated Mrs. Williams' right to voice grievance. You should have informed Mrs. Williams your organization's process for filing complaints and assisted her if needed. Additionally, you should immediately address her concern by offering to reheat her food or offering to get her another plate. If you are not able to address the concern, you should find someone that can.

Summary

Residents in assisted living communities have many rights. Every day, you act to protect those rights. Remember, you and your organization must not interfere with residents as they exercise their rights. Instead, you must empower residents to exercise their rights fully.

Section 4: Conclusion

Summary

Now that you have finished reviewing the course content, you should have learned the following:

Residents receiving health services have basic rights that you and your organization must ensure are protected. You should always consider whether the actions you take, or your inactions in certain circumstances, protect these rights.

Course Contributor

Elizabeth Kellerman started in nursing in 2007 after graduating from Samuel Merritt University in Oakland, California. Her work in the critical care unit of a community hospital provided significant experience caring for older adults. Her experience and knowledge led her to nursing education where she taught at a community college while working to receive her Master's in Nurse Education at Western Carolina University. As a nursing instructor, she spent time in many types of care settings including medical-surgical inpatient and community living centers. Her passion for education and training has most recently led her to a position as Subject Matter Expert and Content Writer for Relias Learning.

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Attachment P

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December 8, 2017

Dear Residents, Families & Friends:

Please take a moment to read our updated grievance policy. If you have any questions, feel free to ask anyone who works in administration:

PURPOSE: Ensure that each resident has the right to present grievances, complaints and/or suggestions without fear of reprisal, restraint, interference, coercion or discrimination.

Regardless of which supervisor/department head responds, the Administrator or his/her authorized representative shall review all complaints and agree with the actions taken towards resolution. Responses to resident/family shall be made as soon as possible and preferably immediately. Actions taken include contacting the resident and/or family with an explanation of the steps we are going to take to resolve the complaint and ensure their satisfaction. Actions taken must be documented. It should be noted if the resident or resident's family continues to express a concern and in their view, the problem is not resolved, the Administrator must be apprised of the situation and the administrative team must be kept informed. The concern/grievance must always be handled first, followed by the appropriate reporting and trending of information. Responses may be written or verbal, depending on the situation.

We take grievances very seriously. Please do not hesitate to express your concerns.

Regards,

Oak Hill Management

Roommate Policy

Attachment Q

Effective Date: 12/8/17

Purpose: To ensure residents' rights are maintained

Procedure:

- Roommate assignments will be made based on a variety of factors, including but are not limited to: availability, diagnosis, services required, and temperature preference.
- The facility will do it's best to accommodate a resident's preferences and requests, without infringing on others' resident rights.
- Residents may request a room change at any time and for any reason.
- The facility will make every effort to accommodate a room change within a reasonable time frame unless it infringes on others' rights.
- If a resident requests a change and no room is available, the facility will be happy to help the resident find accommodations at another facility.
- If the facility initiates a room change, notice must be given to all parties in advance.
- Requests for roommate changes should be submitted to the Marketing Director and/or Assistant Executive Director.

Oak Hill Living Center Attachment R

Resident's Name:_____ DOB:_____

Refusal of Treatment

I _____, understand that by signing this form I am refusing the recommended treatment written below in the space provided. Also, I am acknowledging that my healthcare provider and/or the staff at the facility where I live are recommending this treatment based on their observations and assessment of my current condition. By signing this form I am acknowledging the recommendations given to me, and I am releasing my healthcare provider and the facility staff from any liability related to my refusal to seek the recommended course of treatment.

Recommendations: _____

_____

_____

_____

_____

_____

_____

_____ _____

Witness Resident Signature

_____ _____

Date/Time Date/Time