Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL028001 | A. BUILDING: _____ B. WING _____ | R 07/13/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SPRING ARBOR OF THE OUTER BANKS | 803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948 |

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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section and the Dare County Department of Social Services conducted a follow-up survey on July 9, 2018 through July 13, 2018 with an exit conference via telephone on July 13, 2018. | {D 000} | | |
| D 201 | 10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing<br><br>10A NCAC 13F .0604 Personal Care And Other Staffing<br>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.<br>(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:<br>(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) | D 201 | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ED (X6) DATE 9/24/18



Reviewed and accepted [signature] 9/24/18

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| D 201 | Continued From page 1 | D 201 | | |

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 10 of 48 shifts resulting in inadequate staff to meet the personal care and supervision needs of residents.

The findings are:

Interview with a resident on 07/09/18 at 3:00pm revealed:
-The facility was short of help especially the last few weeks.
-I don't need staff to help me, but other residents need help.
-I worry about the other residents not getting the help they need.
-I had my walker and I pushed another resident in her wheel chair so she could get down the hall because there is not enough staff.
-Management said they are looking for more help.

Interview with a second resident on 07/09/18 at 3:22 p.m. revealed:
-There were often not enough staff working at the facility.
-The facility was shorthanded all around.
-Personal care aides (PCAs) often had to help out in the kitchen and with other tasks.

Interview with a third resident on 07/09/18 at 3:40pm revealed, there was not enough help, when I ring my call light sometimes I have to wait

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| D 201 | Continued From page 2<br>a long time (shecould not remember exactly how long).<br><br>Interview with a personal care aide (PCA) on 07/10/18 at 9:40am revealed:<br>-She usually worked alone on the third shift in the assisted living section.<br>-There were rarely two PCAs on the schedule for the third shift.<br>-The lack of adequate staff was not safe for the residents.<br>-There were falls all the time on the third shift.<br><br>Interview with a PCA on 07/10/18 at 11:51 a.m. revealed:<br>-She usually worked first shift.<br>-Sometimes she worked twelve hour shifts because there were more issues with schedules on 2nd and 3rd shift.<br>-There had been a lot of admissions at the facility but there were not enough staff to cover the schedule.<br>-The Assistant Resident Care Director (ARCD) often covered holes in the schedule.<br><br>Interview with a medication aide (MA) on 07/10/18 at 4:20pm revealed:<br>-When staff called out, the policy was to call three people to cover that shift.<br>-If there was no response the manager would stay to fill the spot.<br><br>Interview with a different MA on 07/10/18 at 5:05 p.m. revealed:<br>-They did not have enough help at the facility.<br>-She worked all three shifts.<br>-On third shift, there was one aide in assisted living, one aide in special care, and one MA for the entire building on most nights. | D 201 | | |

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| D 201 | Continued From page 3<br><br>Interview with a PCA on 07/11/18 at 8:41 a.m. revealed:<br>-She usually worked all shifts at the facility and in both assisted living and special care.<br>-A lot of employees had left the facility in the last few months.<br>-On third shift, there was usually one PCA in assisted living, one PCA in the special care unit, and one medication aide (MA) for the entire building.<br>-The third shift schedule had been this way for about a month.<br>-The facility started scheduling staff for 12 hour shifts to help with the issue.<br>-There was a bigger problem with staffing on the weekends.<br>-The Interim Executive Director (ED) and the ARCD made the schedule for the building.<br>-There were several residents who were unsteady and often uncooperative.<br>-It was difficult for one PCA to assist all residents.<br>-There had been quite a few falls on the third shift.<br><br>Interview with a MA/Supervisor on 07/11/18 at 10:52 a.m. revealed:<br>-She sometimes worked third shift as a PCA.<br>-The last three times she worked as a PCA, she was the only PCA in the assisted living unit.<br>-There was one MA in the building.<br><br>Interview with a PCA on 07/13/18 at 3:15am revealed:<br>-There were 2 PCA's working the third shift.<br>-This was the first night in a long time that there were 2 PCA's working the third shift.<br>-There was usually only 1 PCA scheduled to work the third shift in the assisted living section at the facility.<br>-Two PCAs were needed on the third shift so staff | D 201 | | |

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| D 201 | Continued From page 4<br>could answer the call lights and help the residents when they called for assistance.<br><br>Review of third shift staff time records and the facility census for 06/24/18-06/30/18 revealed:<br>-There were 47 residents in the assisted living side of the facility on 06/25/18-06/26/18 which required 16 aide hours for third shift.<br>-There were 9 hours of aide hours for third shift on 06/25/18, leaving the facility short 7 hours of aide hours.<br>-There were 10 hours of aide hours for third shift on 06/26/18, leaving the facility short 6 hours of aide hours.<br>-There were 47 residents in the assisted living side of the facility on 06/29/18 which required 16 aide hours for third shift.<br>-There were 9 hours and 30 minutes of aide hours for third shift on 06/29/18, leaving the facility short 6 hours and 30 minutes of aide hours.<br><br>Review of the first shift staff time records and the facility census for 07/02/18 and 07/04/18 revealed:<br>-There were 51 residents in the assisted living side of the facility for 07/02/18 and 07/04/18 which required 24 hours of aide hours.<br>-There were 22.25 hours of aide time on 07/02/18, leaving the facility short 1.75 hours of aide hours.<br>-There were 22.75 hours of aide time on 07/04/18, leaving the facility short 1.75 hours of aide hours.<br><br>Review of the third shift staff time records and the facility census for the period of 07/01/18-07/09/18 revealed:<br>-There were 51 residents on the assisted living side of the facility from 07/01/18-07/09/8 which | D 201 | | |

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| D 201 | Continued From page 5<br><br>required 16 hours of aide hours.<br>-There were 9.25 hours on 07/03/18 leaving the facility short 6.75 hours of aide hours.<br>-There were 9.25 hours on 07/04/18 leaving the facility short 6.75 hours of aide hours.<br>-There were 9.25 hours on 07/06/18 leaving the facility short 6.75 hours of aide hours.<br>-There were 10.75 hours on 07/07/18 leaving the facility short 5.25 hours of aide hours.<br>-There were 7.75 hours on 07/ 08/18 leaving the facility short 8.25 hours of aide hours.<br><br>Interview with the Interim Executive Director on 07/12/18 at 11:30am revealed:<br>-Some staff had left the facility for better paying jobs.<br>-They were actively trying to recruit staff.<br>-They had hired two new staff that did not show up to work.<br>-The interim Executive Director was aware that the census was increasing due to daily admissions despite the facility being short staffed.<br>-There currently was not a plan to address the short staffing issue in the building. | D 201 | | |
| {D 270} | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A2 VIOLATION | {D 270} | | |

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| {D 270} | Continued From page 6<br><br>Based on these findings, the previous Type A2 Violation was not abated.<br><br>Based on observations, interviews, and record reviews, the facility failed to provide the necessary supervision of 1 of 1 sampled residents (#8) who exhibited erratic and sexually inappropriate behaviors toward residents and staff in the Special Care Unit(SCU).<br><br>The findings are:<br><br>Review of Resident #8's current FL-2 dated 01/02/2012 revealed:<br>-Diagnoses included Alzheimer's disease, unspecified, Insomnia, generalized muscle weakness, and iron deficiency.<br>-The resident had inappropriate behaviors of exposing himself in public.<br><br>Review of the Resident Register for Resident #8 revealed the resident was admitted to the facility on 11/02/2016.<br><br>Review of the assessment and care plan for Resident #8 dated 11/07/17 revealed:<br>-He was sometimes disoriented, forgetful, and required reminders.<br>-He required limited assistance with bathing and dressing.<br>-He was independent in ambulation, toileting, transferring, and eating.<br><br>Confidential interview with a staff member revealed:<br>-Resident #8 had exposed himself to a female resident in the SCU activity room about two months ago and Resident #8 said to the female resident "look at it and touch it." | {D 270} | | |

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| {D 270} | Continued From page 7<br>-Resident #8 was aware of his actions and Resident #8 was redirected to his room by staff.<br>-The incident was reported to the interim Executive Director immediately after.<br>-Resident #8 constantly made sexually inappropriate comments to female residents about their bodies.<br>-One female resident reported Resident #8 asked her to take her shirt off.<br>-Resident #8 tried to lure other female residents in the SCU to go into his room.<br>-At least 2 female residents had been found in Resident #8's room seated on the bed with Resident #8 in front of them.<br>-Resident #8 had also attempted to kiss female residents on the cheek and made kissing gestures towards them.<br>-Resident #8 had touched female residents' breasts and buttocks in an inappropriate manner several times.<br>-One female resident reported that Resident #8 had gotten into the bed with her but the staff were unsure if this actually occurred and could not recall the date this allegation was made.<br>-Staff tried to keep the female residents in the SCU away from Resident #8.<br>-Staff had reported all of these incidents to the interim Executive Director when they occurred.<br>-The interim Executive Director had told the staff to watch Resident #8 but no frequency had been given to the staff.<br>-There had been no change in the supervison of Resident #8 by the staff when the inappropiate incidents were reported.<br>-There was no facility policy as to how often residents should be supervised.<br>-Resident #8 did not have any special instructions on how he should be supervised.<br><br>Review of Resident #8's Resident Notes dated | {D 270} | | |

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| {D 270} | Continued From page 8<br>03/11/18 revealed Resident #8 rammed his wheelchair into another resident's chair.<br><br>Review of Resident #8s Resident Notes dated 04/09/18 revealed Resident #8 hit a female resident in the chest.<br><br>Review of Resident #8's Resident Notes dated 04/18/18 revealed Resident #8 kept touching other residents.<br><br>Review of Resident #8's Resident Notes dated 04/30/18 revealed staff had to get the resident out of another resident's room.<br><br>Review of Resident #8's Resident Notes dated 06/26/18 revealed Resident #8 tried to urinate in the hallway while female residents were present.<br><br>Review of Resident #8's Resident Notes dated 07/02/18 revealed Resident #8 was observed holding a female resident's shirt in his hand while the female resident was only wearing a sports bra.<br><br>Interview with a medication aide (MA)/ Supervisor on 07/11/18 at 10:52 a.m. revealed:<br>-Last week, Resident #8 was holding a female resident's shirt and jacket when the MA exited the med room.<br>-Prior to the MA entering the med room, the female resident was wearing a shirt and jacket.<br>-The female resident was standing beside Resident #8 wearing only a sports bra when the MA exited the med room.<br>-Resident #8 reported to staff that he was trying to help the female resident.<br>-The interim Executive Director was made aware of this incident. | {D 270} | | |

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| {D 270} | Continued From page 9<br><br>Review of Resident #8's Resident Notes dated 07/09/18 revealed staff heard a loud scream from Resident #8's room and found him and a female resident in the room together.<br><br>Interview with a medication aide (MA)/ Supervisor on 07/11/18 at 10:52 a.m. revealed:<br>-She was on duty the other day when she heard a resident scream in Resident #8's room.<br>-A female resident was locked in the room with Resident #8 when staff responded.<br>-Staff had to unlock the door to enter.<br>-The residents were fully clothed.<br>-The female resident told staff Resident #8 was trying to fix something.<br><br>Resident #8's Resident Notes dated 07/10/18 revealed Resident #8 had demonstrated inappropriate behavior with another female resident by touching her rear end and making a kissing gesture.<br><br>Observation of Resident #8 on 07/11/18 at 10:05am revealed:<br>-Resident #8 wheeled himself into the activity room in the SCU.<br>-Resident #8 was alert and dressed appropriately.<br>-Resident #8 inquired about finding the current newspaper for him to read.<br>-When Resident #8 found out a current newspaper was not available, Resident #8 turned his wheelchair around facing toward the SCU main hallway.<br><br>Interview with a medication aide (MA)/ Supervisor on 07/11/18 at 10:52 a.m. revealed:<br>-Resident # 8 was often "fresh" with the female residents.<br>-He often touched other residents.<br>-The interim Executive Director was aware of the | {D 270} | | |

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| {D 270} | Continued From page 10<br><br>last two incidents on 07/02/18 and 07/09/18.<br>-Staff were told that Resident #8's medications were being changed to help with his behaviors.<br>-Staff were told to monitor residents and ensure no one enters another resident's room.<br>-If residents go into another resident's room, staff were told to guide them out.<br>-Staff typically "have eyes" on the residents most of the time and know where they are because most residents stayed in the common areas.<br>-Resident #8 spent most of the day in common areas.<br>-Staff did two hour checks on all residents at night and more frequent checks on residents who were fall risks every 30 minutes to an hour.<br>-Resident #8 was monitored every two hours.<br><br>Interview with a PCA on 07/11/18 at 1:10 p.m. revealed:<br>-She had not seen Resident #8 touch any other residents.<br>-She had not seen Resident #8 go into any other resident's rooms recently.<br>-She checked on residents about every 30-45 minutes but at least every hour.<br>-There had been no special instructions on how to monitor Resident #8 when he was aggressive or exhibited sexually inappropriate behaviors.<br><br>Review of the Physician's Order Form dated 06/11/18 revealed:<br>-The Resident Care Director (RCD) sent notification to the primary care provider (PCP) that Resident #8 was having increased sexual behaviors and more urinary incontinence.<br>-The PCP responded on 06/20/18 by requesting Resident #8 be scheduled for an appointment.<br><br>Interview with the interim Executive Director on 07/11/18 at 1:36 p.m. revealed: | {D 270} | | |

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| {D 270} | Continued From page 11<br>-Resident #8 had been inappropriate with other residents.<br>-Resident #8 often urinated in inappropriate places but she did not believe the resident was purposefully exposing himself.<br>-Resident #8 thought one of the female residents was his wife.<br>-She was aware of an incident in the activity room where the resident exposed himself but was not told Resident #8 had asked a female resident to touch him.<br>-This female resident had made an allegation that Resident #8 had tried to rape her on 03/17/18 around 1:30 p.m.<br>-The interim Executive Director told the Cottage Program Director to take statements from all staff persons on duty and to do an assessment on the female resident.<br>-She instructed staff to watch Resident #8 after that incident but did not specify a timed check.<br>-She was told that a second female resident was found in the room with Resident #8 but did not believe this incident to be sexual.<br>-She was aware Resident #8 had touched one of the female residents in the last month but she did not know the details of where he touched this resident.<br>-She planned to implement 30 minute checks on Resident #8.<br>-She had messaged Resident #8's PCP last month regarding his increase in sexually inappropriate behaviors.<br>-The resident was seen in the office.<br>-She was not aware of the resident having any behaviors since that time.<br><br>Interview with Resident #8's family member on 07/12/18 at 2:00 p.m. revealed:<br>-Resident #8 moved to the special care unit in January of 2018. | {D 270} | | |

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| (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 |
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| {D 270} | Continued From page 12<br>-She was told yesterday 07/11/18 that Resident #8 was being kicked out of the facility.<br>-She was told Resident #8 needed to be separated from a few of the female residents on the unit.<br>-One of the female residents thought she was Resident #8's wife.<br>-She thought Resident #8 had been "touching" other residents and had some sexual behaviors.<br>-She had seen Resident #8 frequently sitting with a particular female resident when she visited the unit.<br>-She accompanied Resident #8 to the PCP visit on 06/27/18.<br>-Resident #8 was put on a medication to suppress his sexual desires.<br>-She was told it would take a month for the medication to work.<br>-Resident #8 had lost his ability to rationalize due to his Alzheimer's diagnosis.<br>-She was not aware of Resident #8 having any sexually inappropriate behaviors in March of 2018.<br>-The female residents were at fault for the problems with Resident #8.<br>-She believed Resident #8 only started having sexually inappropriate behaviors about a month ago.<br><br>Telephone interview with staff at the PCP's office on 07/12/18 at 2:10 p.m. revealed:<br>-Resident #8 was seen in the office on 06/27/18 for inappropriate sexual behavior.<br>-The PCP prescribed medications to lower the resident's sexual drive.<br>-Resident #8 had been exhibiting sexually inappropriate behavior for a couple of weeks including groping others at the facility.<br>-There was no information in the office note that Resident #8 had been accused of sexually | {D 270} | | |

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| {D 270} | Continued From page 13<br>assaulting a female resident in March of 2018.<br>-The facility had not notified the office of any sexually inappropriate behaviors since the office visit on 06/27/18.<br>-The staff person was not sure how long it would take the medications prescribed on 06/27/18 to have effect on Resident #8.<br>-There was no information in the office note as to how often Resident #8 should be monitiored.<br><br>The facility's failure to supervise Resident #8, who had a documented history of exposing himself in public, resulted in at least 2 female residents in the Special Care Unit suffering physical and verbal sexual harassment for at least 4 months. This failure to provide supervision of these residents resulted in a substantial risk of serious physical harm and neglect; and constitutes a Unabated Type A2 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/18 for this violation. | {D 270} | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews the facility failed to notify the medical | D 273 | | |

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| D 273 | Continued From page 14<br>provider for 1 of 1 sampled residents (#4) with blood sugars over 250 for three days in accordance with physician orders.<br><br>The findings are:<br><br>Review of Resident #4's current FL-2 dated 06/25/18 revealed diagnoses included traumatic subdural hemorrhage, unspecified dementia, hypertension, and diabetes mellitus I with neuropathy.<br><br>Review of Resident #4's Resident Register revealed he was admitted to the facility on 6/25/18.<br><br>Interview with Resident #4 and his family member on 07/09/18 at 4:39 p.m. revealed:<br>-Resident #4 had only been residing at the facility for about two weeks.<br>-Resident #4 was not feeling well and had been sleeping all day on 07/09/18.<br>-Resident #4 had been sick since Sunday 07/08/18.<br>-His blood glucose reading was around 500 on Saturday evening 07/07/18.<br>-Resident #4's morning blood sugar reading on Sunday 07/08/18 was 319 and had dropped to 112 that morning of 07/09/18.<br>-She was unable to understand a lot of what Resident #4 had been saying today 07/09/18.<br>-She had requested assistance from staff to assess Resident #4.<br>-She believed Resident #4's high blood glucose was due to him missing one of his diabetes medications yesterday 07/08/18.<br><br>Review of Resident #4's Physician Order Form dated 07/03/18 revealed:<br>-The Resident Care Director contacted the | D 273 | | |

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| D 273 | Continued From page 15<br>primary care provider (PCP) requesting a protocol for instances of high blood sugar and low blood sugar because there were no monitoring system in place.<br>-The PCP ordered Resident #4 have finger sticks done for unusual somnolence.<br>-Resident #4's diabetic medication should be held for blood glucose readings below 110.<br>-The facility was to contact the PCP for blood glucose readings greater than 250.<br><br>Review of Resident #4's Resident Notes dated 07/08/18 revealed:<br>-Resident #4 seemed really tired and exhausted.<br>-The medication aide (MA)/ Supervisor checked the resident's blood glucose and a reading of 519 resulted.<br>-The MA administered the scheduled diabetic medication.<br>-The MA then contacted the PCP's office but was unable to reach the on call service.<br>-The MA rechecked Resident #4's blood glucose and the reading was 495.<br>-Resident #4's family member was present that day and reported that Resident #4 had an appointment at the PCP's office on Tuesday.<br>-Resident #4's family would notify the PCP of Resident #4's elevated blood glucose.<br><br>Interview with the MA/Supervisor on 07/12/18 at 4:12 p.m. revealed:<br>-Resident #4 was really tired on 07/08/18.<br>-Resident #4 was usually perky and pleasant and was not acting normally.<br>-The MA checked Resident #4's blood sugar and it was 519.<br>-She believed Resident #4 missed his morning dose of Januvia (Januvia is a medicine used to help lower blood sugar) due to leaving for church.<br>-The MA rechecked Resident #4's blood sugar | D 273 | | |

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| D 273 | Continued From page 16<br><br>and it was 495.<br>-The MA contacted the Interim ED who instructed her to call the PCP.<br>-There was no on call number available for the PCP when she called the office.<br>-Resident #4's family member requested not to send Resident #4 to the emergency room due to him having an appointment with his PCP on Tuesday 07/10/18.<br>-Resident #4 should have been sent out but his family member declined.<br><br>Interview with a second MA/Supervisor on 07/10/18 at 2:52 p.m. revealed:<br>-Resident #4's family member had taken him to the doctor.<br>-Resident #4's blood sugar was 366 on the morning of 07/10/18.<br>-Resident #4 did not complain of feeling bad that morning.<br>-She did not call the doctor but sent a note with Resident #4 to the doctor.<br>-She was aware that the resident did not feel well on yesterday 07/09/18 and his blood sugar was 112.<br>-She was aware of the parameters to call the doctor if Resident #4's blood sugar was over 250.<br>-These instructions were listed on Resident #4's medication administration record (MAR).<br>-If a MA contacted the PCP, this would be documented in the Resident Notes.<br><br>Interview with the PCP on 07/10/18 at 4:23 p.m. revealed:<br>-He had previously managed Resident #4 at the skilled nursing facility prior to being admitted to the facility.<br>-Resident #4 was usually alert and able to answer questions.<br>-It was unlike Resident #4 to be tired or lethargic | D 273 | | |

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| D 273 | Continued From page 17<br>and that would be a sign of blood sugar issues.<br>-He had signed Resident #4's FL-2 to be admitted to the facility and provided the parameters for the insulin administration.<br>-He had not been notified of the blood sugar readings of 519 and 495 on Sunday 07/08/18.<br>-He would have instructed staff to administer 10 units of insulin an hour until the resident's blood sugar dropped below 200.<br>-If staff were unable to reach him, he would have expected them to send Resident #4 to the emergency room.<br>-Resident #4 ran the risk of diabetic ketoacidosis by not receiving treatment when his blood sugar was that high.<br>-The PCP was not notified that Resident #4 had missed a dose of his diabetic medication but believed that contributed to his high blood sugars.<br>-He had not been contacted by the facility since Resident #4 was admitted.<br><br>Interview with Interim ED and Assistant Resident Care Director (ARCD) on 07/10/10 at 3:55 p.m. revealed:<br>-The Interim ED did not remember being notified of Resident #4's specific blood glucose readings of 519 or 495 on 07/08/18.<br>-The MA/Supervisor had called the Interim ED and notified her that Resident #4's blood sugar was high.<br>-If a resident had a blood sugar of 500 or higher, she would expect the MA to send the resident out to to the hospital to stabilize the blood sugar if no physician was available.<br>-Resident #4's family member had reported to the ARCD on 07/09/18 that Resident #4 was feeling tired and so the ARCD checked his blood sugar and got a reading of 344.<br>-Resident # 4 had an appointment that day on 07/10/18 with a new PCP to get blood glucose | D 273 | | |

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| D 273 | Continued From page 18<br>monitoring orders clarified so the ARCD did not contact the PCP but sent a note to the new provider to obtain new parameters for Resident #4's blood glucose.<br>-The Interim ED was not aware Resident #4 had an order on the MAR to call the PCP for blood sugars.<br>-If MAs checked a resident's blood sugar and got a reading of 519, the Interim ED expected MAs to call her and 911.<br><br>The facility's failure to contact Resident #4's primary care provider regarding of blood sugars above 250 (519, 495, 344, and 366) for three days, placed the resident at risk of diabetic coma. This failure was detrimental to the health and welfare of the resident and constitutes a Type B violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/18 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 27, 2018. | D 273 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. | D 276 | | |

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| D 276 | Continued From page 19<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#$)with orders for blood glucose monitoring twice daily.<br><br>The findings are:<br><br>Review of Resident #4's current FL-2 dated 06/25/18 revealed diagnoses included traumatic subdural hemorrhage, unspecified dementia, hypertension, and diabetes mellitus I with neuropathy.<br><br>Review of Resident #4's Resident Register revealed he was admitted to the facility on 6/25/18.<br><br>Review of Resident #4's Physician Consult Visit-Notes & Orders dated 07/10/18 revealed:<br>-Resident #4's Levemir (Levemir is an insulin used to control blood sugars) was increased to 12 units daily at bedtime.<br>-Resident #4 was to continue taking Januvia (Januvia is a medicine used to help lower blood sugar) daily.<br>-Resident #4's blood sugar should be checked every morning before breakfast and before bed.<br>-Acceptable blood sugar ranges were 120-250 for Resident #4.<br><br>Review of Resident #4's Medication Administration Record dated July 2018 revealed:<br>-There was no order for a fasting blood sugar check in the morning or blood sugar check before bed.<br>-The insulin dose had been increased to 12 units at bed. | D 276 | | |

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| D 276 | Continued From page 20<br>-There was an order for the diabetic medication every morning at 8:00 a.m.<br><br>Interview with the Interim ED on 07/12/18 at 12:15 p.m. revealed:<br>-She had checked the orders for Resident #4 on the MAR.<br>-The order to check a fasting morning blood sugar and blood sugar before bed was in the pending folder of the Medication Administration Record.<br>-Medication Aides had to check the folder to approve new orders in order for them to be added to the MAR.<br>-She had approved those orders and they were now visible on the MAR.<br><br>Interview with the Pharmacist on 07/12/18 at 1:21 p.m. revealed:<br>-The pharmacy received new orders for Resident #4 on 7/11/18 at 10:32 a.m.<br>-These orders included increasing Levemir to 12 units at bedtime, take Januvia daily, and to check blood sugar before breakfast and before bed.<br>-The orders were received and entered into the computer.<br>-The orders then transfered to the electronic MAR as pending.<br>-The facility staff had to approve or reject the orders in order for them to show up on the MAR.<br>-Pending orders showed up in a red tab at the bottom of the screen with the number of orders.<br><br>Interview with the Nurse Practitioner on 07/12/18 at 3:59 p.m. revealed:<br>-She had seen Resident #4 on 07/10/18 to establish care with the practice.<br>-It was recommended that Resident #4's blood glucose stay in the range of 120-250 according to his age range. | D 276 | | |

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| D 276 | Continued From page 21<br><br>-She ordered an increase in Resident #4's daily insulin from 10 units to 12 units at bed.<br>-Resident #4's blood sugar should be checked in the morning prior to breakfast and before bed.<br>-She was not aware that Resident #4's blood sugar had not been checked since the order was written.<br>-She had been made aware of Resident #4's blood glucose readings from the weekend and the days prior to him being seen on 07/10/18.<br>-She was not concerned by the readings due to the resident being on insulin.<br>-She was more concerned about Resident #4 having low blood sugars due to him being a fall risk.<br>-She expected the facility to notify her if Resident #4's blood sugar readings dropped below 120 more than once or if the resident was unresponsive. | D 276 | | |
| {D 298} | 10A NCAC 13F .0904(d)(2) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(d) Food Requirements in Adult Care Homes:<br>(2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to offer snacks three times a day to residents in assisted living side of the facility.<br><br>The findings are: | {D 298} | | |

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| {D 298} | Continued From page 22<br><br>Interview with a resident on 07/09/18 at 3:00pm revealed:<br>-She was offered a snack one time a day but not in her room it was in the activity room.<br>-Staff have no time to pass snacks.<br>-She had her own snacks in her room.<br><br>Interview with a second resident on 07/09/18 at 3:40pm revealed:<br>-She stayed in her room most of the time due to back pain.<br>-Staff offered her a snack usually one time a day in the evening.<br>-If she asked for a snack the staff would bring her one.<br><br>Interview with a third resident on 07/09/18 revealed, staff never offered him a snack.<br><br>Interview with a fourth resident on 07/09/18 at 4:20pm revealed she only got a snack when she asked for one.<br><br>Interview with a fifth resident on 07/09/18 at 3:22 p.m. revealed snacks were out all day for residents in the front room.<br><br>Interview with a sixth resident on 07/09/18 at 3:56 p.m. revealed:<br>-Snacks were served midday or in the afternoon.<br>-There were always sandwiches in the refrigerator for residents.<br><br>Interview with a seventh resident on 07/09/118 at 4:22 p.m. revealed:<br>-She sometimes got snacks at the facility.<br>-She was not sure what time snacks were served.<br><br>Observation on 07/09/18 revealed, there was a table between the front door and the front desk | {D 298} | | |

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| {D 298} | Continued From page 23<br>against the wall with a basket of apples and oranges and a pitcher of water with cut up lemons in it and a stack of disposable cups.<br><br>Observation on 07/12/18 at 10:25am revealed the snack cart with snacks was in the dining room.<br><br>Observation during the survey on 07/09/18, 07/10/18, 07/11/18 and 07/12/18 revealed there were no snacks offered to residents in assisted living.<br><br>Interview with the kitchen manager on 07/10/18 at 9:20am revealed:<br>-The kitchen staff put items on the snack cart and left it in the dining room.<br>-The personal care aides (PCAs) were supposed to pass the snacks out to the residents at 10:30am and 2:30pm.<br>-The snack cart never left the dining room.<br><br>Interview with a medication aide (MA)/Supervisor on 07/11/18 at 10:52 a.m. revealed:<br>-Snacks were served at 3:00 p.m.<br>-If residents asked for a snack, the staff would get them something.<br><br>Interview with a personal care aide (PCA) on 07/11/18 at 2:30 p.m. revealed:<br>-She thought snacks had already been served.<br>-Snacks were supposed to be served at 2:00 p.m.<br><br>Interview with a second PCA on 07/11/18 at 2:45 p.m. revealed:<br>-Snacks were usually served between 2:00 p.m. and 2:30 p.m.<br>-She did not realize it was 2:45 p.m. and believed they were running behind on passing out snacks.<br><br>Interview with a resident on 07/12/18 at 12:40 | {D 298} | | |

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| {D 298} | Continued From page 24<br><br>p.m. revealed:<br>-PCA's didn't usually pass out snacks.<br>-She got a snack yesterday afternoon 07/11/18 some time after 2:00 p.m.<br>-She thought this was unusual as she typically did not get snacks.<br>-Snacks were supposed to be served two times daily but she did not know the times becuase they were not usually served.<br><br>Interview with a MA on 07/12/18 at 8:20 a.m. revealed:<br>-Snacks were served at 10:00 a.m. and between 1:00 and 2:30 p.m.<br>-PCA's passed out snacks down the hall.<br>-The kitchen staff prepped the snack cart daily.<br>-Residents in the front common area were able to get their own snack from the snack bar by the door.<br><br>Interview with a second MA on 07/12/18 at 8:59 a.m. revealed:<br>-Snacks were served between 6:30 p.m. to 7:00 p.m.<br>-The kitchen staff put snacks on the cart and the PCAs passed them out down the hall<br><br>Interview with the Activity Coordinator on 07/11/18 at 9:55 a.m. revealed:<br>-She sometimes served snacks with activities.<br>-She planned to serve a snack that day 07/11/18 with the 10:30 a.m. activity.<br>-Residents were still supposed to get a snack passed out by the PCA's.<br>-The snacks she served were always extra.<br><br>Interview with a cook on 07/12/18 at 9:00 a.m. revealed:<br>-Kitchen staff filled the cart with fruit, chips, fruit bars, and crackers. | {D 298} | | |

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| SPRING ARBOR OF THE OUTER BANKS | 803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948 |

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| {D 298} | Continued From page 25<br>-The cart was filled every morning.<br>-Staff did not pass out snacks and the snack cart stayed in the dining room.<br>-She had occasionally seen a PCA come get a snack off the cart for a resident.<br><br>Interview with the kitchen superviosr on 07/12/18 at 9:15 a.m. revealed the snack cart had only left the dining room once in three months.<br><br>Interview with the executive director (ED) on 07/12/18 at 9:05am revealed, the snack table by the front door and front desk was refilled at 10am and in the evening and as needed. | {D 298} | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observation, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident (#2) was protected after complaints of being afraid of a male resident in the Special Care Unit and being subjected to inappropriate touching.<br><br>The findings are: | D 338 | | |

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| D 338 | Continued From page 26<br><br>Review of Resident #2's current FL-2 dated 12/28/17 revealed:<br>-Diagnoses included unspecified dementia, primary hypertension, long-term use of anti-coagulants, and the presence of a pacemaker.<br>-Resident #2 was ambulatory and intermittently disoriented.<br>-The recommended level of care was the Special Care Unit (SCU).<br><br>Review of the Resident Register revealed Resident #2 was admitted to the facility on 01/11/18.<br><br>Review of Resident #2's care plan dated 04/09/18 revealed:<br>-Resident #2 was sometimes disoriented and oriented to person only.<br>-Resident #2 was forgetful and sometimes needed reminders.<br>-Resident #2 was ambulatory and liked to wander from room to room.<br><br>Review of the nurses' notes for Resident #2 revealed:<br>-On 03/19/18 during the 7:00am to 3:00pm shift, Resident #2 complained of a male resident saying nasty things to her and she (Resident #2) was afraid of the male resident.<br>-On 04/02/18 during the 7:00am to 3:00pm shift, Resident #2 stated a male resident asked her to lay in the bed and she said she didn't want to take her shirt off; the supervisor was aware and the male resident would be watched.<br>-On 07/02/18, Resident #2 was taking her clothes off in front of other residents during the 3:00pm to 11:00pm shift. | D 338 | | |

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| D 338 | Continued From page 27<br><br>Observation of Resident #2 on 07/09/18 at 3:30pm revealed:<br>-Resident #2 was led down the SCU hall from her room to the sit in the living room area of the SCU with other residents.<br>-Resident #2 was alert and dressed appropriately.<br>-Resident #2 sat with her hands in her lap and mumbled occasionally to herself.<br>-Resident #2 did not interact with the residents seated around her.<br>-Resident #2 did respond to staff when staff called the resident by name.<br><br>Interview with Resident #2 on 7/11/18 at 1:10pm revealed:<br>-She could not recall who the male resident was who said nasty things to her.<br>-She could not recall who the male resident was who asked her to lay in the bed or take off her shirt.<br>-She could not remember taking off her shirt in front of the other residents on 07/02/18.<br><br>Interview with a supervisor on 07/11/18 at 9:45am:<br>-She was the supervisor who wrote the nurses' note on 03/19/18 and 04/02/18.<br>-Resident #2 had complained about a male resident in the SCU who had said sexually inappropriate things and touched Resident #2 inappropriately on her breasts and buttocks<br>-Resident #2 complained she was afraid of a male resident and the supervisor reported Resident #2's complaint to the interim Executive Director in March or April 2018.<br>-The interim Executive Director told the staff to try keep the male resident away from Resident #2, but no other instructions were given.<br>-The male resident sometimes made-believe Resident #2 was his wife and tried to kiss | D 338 | | |

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| D 338 | Continued From page 28<br>Resident #2 and touch Resident #2's breasts.<br>-Staff had to watch the male resident because he often tried to get Resident #2 to come to his room alone.<br><br>Telephone interview with a second supervisor on 07/12/18 at 11:03am revealed:<br>-A male resident seemed to target Resident #2 and tried to get Resident #2 to go his room or touch Resident #2 in a sexually inappropriate manner.<br>-Resident #2 "will do whatever you ask her to do and the male resident knew that."<br>-The male resident tried to get Resident #2 to believe that "she was his wife and come to his room."<br>-"We try to keep an eye on her in the SCU because of the male resident".<br>-She was the supervisor who worked the 3:00pm -11:00pm shift on 07/02/18.<br>-Resident #2 was wearing a shirt and jacket seated next to a male resident in the living area of the SCU when the supervisor went inside the medication room for a minute.<br>-When the supervisor came out the medication room, Resident #2 was standing beside the male resident wearing only a sports bra and her shirt and jean jacket were in the hands of the male resident.<br>-The male resident reported to staff that he was trying to help Resident #2.<br>-"It happened so fast, I don't know what happened exactly."<br>-The supervisor assisted Resident #2 in putting her clothes back on and kept Resident #2 away from the male resident.<br>-The Administrator was made aware of the incident.<br><br>Confidential interview with a staff member | D 338 | | |

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| D 338 | Continued From page 29<br><br>revealed:<br>-Resident #2 had been subjected to a male resident exposing himself to her and making sexual advances to Resident #2.<br>-"A male resident has blown kisses, tried to kiss, talked fresh, and tried to coerce Resident #2 to come to his room on several occasions".<br>-Resident #2 said "a male resident had asked her to come to his room and lay in his bed (unable to specify the date)".<br>-There were concerns about Resident #2's vulnerability to the male resident and staff had found Resident #2 in the male resident's room alone several times (dates not specified).<br>-"Whatever you tell her (Resident #2) to do, she will do it without question because of her dementia".<br>-Staff tried to monitor Resident #2's interactions with the male resident, but it was hard to keep Resident #2 away from the male resident when their room assignments were side by side.<br>-Several staff had voiced their concerns about the male resident's interactions with Resident #2 in the SCU several times to the interim ED since April 2018.<br><br>Telephone interview with a family member regarding Resident #2 on 07/12/18 at 1:58pm revealed:<br>-Resident #2 had made an allegation that she had been raped by the same male resident in March 2018 but the family member did not believe the allegation.<br>-"Residents in the SCU are going to say and do things like that; that why they are in the SCU anyway".<br>-"The facility had investigated Resident #2's rape allegation and the family member did not believe any sexual assault had occurred".<br>-"As long as the staff are able to keep Resident | D 338 | | |

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| D 338 | Continued From page 30<br>#2 safe, I don't have a problem with her care.<br><br>Interview with a nurse with the physician's office for Resident #2 on 07/12/18 at 11:25am revealed:<br>-The physician was not aware of any reports from the facility about the Resident #2 being afraid of a male resident in the SCU.<br>-A family member of Resident #2 mentioned the rape allegation to the nurse with the physician's office in March 2018.<br>-Resident #2's family member did not believe anything had happened to Resident #2 and Resident #2 was never assessed by the physician.<br>-The nurse was unable to locate any notification or documentation from the facility regarding Resident #2's rape allegation or complaints of sexually inappropriate behaviors from a male resident.<br><br>Interview with the Interim Executive Director on 07/11/18 at 1:36pm revealed:<br>-She was aware of Resident #2's complaint of being afraid of a male resident in March 2018.<br>-Resident #2 reported to the SCU staff that a male resident had tried to rape her on 03/17/18.<br>-She had the SCU staff to provide written statements regarding Resident #2's allegation of being raped by a male resident.<br>-She instructed the SCU cottage program director to do a head-to-toe assessment on Resident #2 and there was no evidence of any type of assault was found on Resident #2.<br>-She spoke with a member of Resident #2's family regarding the Resident #2's rape allegation and she "instructed the staff to keep an eye" on Resident #2 and the male resident.<br>-Resident #2 was not further assessed by her physician and local law enforcement was not notified regarding Resident #2's allegations of | D 338 | | |

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| D 338 | Continued From page 31<br>rape because we did not see any evidence an assault had occurred and Resident #2's family was satisfied with the outcome of our internal investigation.<br>-She did not know of any other staff reports or concerns regarding Resident #2 complaining of inappropriate sexual behavior from the male resident.<br>-She had not thought about the vulnerability of Resident #2 and her room assignment continuing to be next to the male resident's room.<br>-No staff had reported to her about Resident #2 disrobing in front of the male resident on 07/02/18 and she would have to further investigate the incident.<br>-Her goal was to maintain the safety and dignity" of Resident #2 and all the residents in the SCU.<br><br>The facility's failure to protect a Resident #2 who verbalized fear of a male resident after being subjected to inappropriate touching and verbal sexual comments from the same male resident including allegation of rape, resulted in substantial risk of serious abuse and neglect. This noncompliance constitutes a Type A2 Violation.<br><br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/12/18 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 12, 2018. | D 338 | | |
| D 375 | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications | D 375 | | |

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| D 375 | Continued From page 32<br>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:<br>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and<br>(2) specific instructions for administration of prescription medications are printed on the medication label.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 1 of 1 sampled residents (#3).<br><br>The findings are:<br><br>Observation of Resident #3's room during the initial tour on 07/09/18 at 4:20pm revealed:<br>-There was a Ventolin inhaler on her table next to the chair where she was sitting.<br>-There were 3 Duo-neb single use medication doses lying on her table next to her chair.<br>-There was a bottle of Zyrtec 10mg tablets in an open drawer next to her chair.<br>-There was a bottle of Gentle Iron 25mg tablets.<br><br>Review of resident #3's current FL2 dated 03/18/18 revealed:<br>-Diagnoses included hypertension, diabetes, chronic obstructive pulmonary disease, atrial fibrillation, sleep apnea, rheumatoid arthritis, anemia, history of cellulitis. | D 375 | | |

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| D 375 | Continued From page 33<br>-There was an order for Albuterol inhaler inhale 1 puff every 4 hours as needed may leave at bedside (generic for venolin used to treat chronic obstructive pulmonary disease).<br>-There was an order for Enbrel 25mg/0.5ml sub cutaneous syringe twice a week may self-administer with reminders (used to treat rheumatoid arthritis).<br>-There was an order for Duo-neb .5mg-3mg inhale via nebulizer 4 times a day (used to relax the muscles in the airway and increase air flow to the lungs).<br>-There was no order to self-administer the Duo-neb via nebulizer.<br>-There was an order for Zyrtec 10 mg daily as needed.<br>-There was no order to self-administer the Zyrtec.<br>-There was no order for Gentle Iron 25 mg<br><br>Review of Resident #3's Resident Register revealed the Resident was admitted to the facility on 03/16/18.<br><br>Review of Resident #3's Care Plan dated 04/11/18 revealed:<br>-Resident #3 was oriented and had adequate memory.<br>-There was no documentation Resident #3 self-administered any medications.<br><br>Review of the facility's Self-Administration review book revealed there was no Self-Administration Medication reviews completed by the nurse for Resident #3 for the Enbrel injection or the Albuterol inhaler.<br><br>Review of Resident #3's care notes revealed no documentation that Resident #3 had a self-administration assessment completed before self-administering Enbrel injection and Albuterol | D 375 | | |

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| D 375 | Continued From page 34<br>inhaler.<br><br>Interview with Resident #3 on 07/09/18 at 4:20pm revealed:<br>-She self-administered her Enbrel injection when the staff brought it to her.<br>-She took the Enbrel injection twice a week, she was not sure what days she took it.<br>-She had been giving herself the Enbrel injection for a long time.<br>-She used the Albuterol inhaler maybe 1 time a day when she was short of breath.<br>-She did not remember the last time she used the Albuterol inhaler, but it was not recent.<br>-She took the Zyrtec for allergies, she took it a few days ago but she was not sure what day.<br>-She took the Gentle Iron tablets when she remembered.<br><br>Interview with Resident #3 on 07/10/18 at 8:45am revealed:<br>-The Duo-neb medication on her table was brought from home.<br>-She did not want to give them up in case she needs it.<br>-She did not remember using any of the Duo-nebs she brought from home.<br>-The staff bring her the Duo-neb treatments 4 times a day.<br>-The staff watch her do the treatment.<br>-She did not remember being evaluated by the nurse for self-administration of the Enbrel injection or the Albuterol inhaler.<br>-She was not sure if the medication aides (MA) knew she had the extra Duo-nebs or the Zyrtec in her room.<br><br>Interview with a medication aide (MA) on 07/11/18 at 9:20am revealed:<br>-She remembers seeing 3 or 4 doses of Duo-neb | D 375 | | |

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| D 375 | Continued From page 35<br><br>next to Resident #3's nebulizer machine.<br>-Resident #3 does not have an order to self-administer the Duo-neb.<br>-Resident #3 brought the Duo-nebs on her table from home.<br>-Resident #3 did not want to give up the medication.<br>-She never observed Resident #3 using any of the Duo-nebs on her table.<br>-When she gave Resident #3 her Duo-neb treatments she never left it in the room, she watched her take it.<br>-She was not aware that Resident #3 had a bottle of Zyrtec in her room.<br>-Resident #3 does not have an order to self-administer her Zyrtec.<br>-She did not know Resident #3 had a bottle of Gentle Iron tablets in her room.<br><br>Interview with a MA on 07/12/18 at 8:20am revealed:<br>-She did not remember seeing any Duo-nebs in Resident #3's room.<br>-She knew Resident #3 did not have an order to self-administer her Duo-neb treatment.<br>-Resident #3 refuses her nebulizer treatment sometimes but she will leave it there for her to take when she is ready.<br>-She did not know Resident #3 had a bottle of Zyrtec in her room.<br>-Resident #3 did not have an order to self-administer the Zyrtec.<br>-Resident #3 did not ask for the as needed Zyrtec very often.<br>-Resident #3 did not have an order to self administer Iron tablets.<br><br>Interview with the Interim Executive Director (Interim ED) on 07/11/18 at 9:25am and 4:55pm revealed: | D 375 | | |

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| D 375 | Continued From page 36<br>-She knew about Resident #3 having an order to self-administer her Albuterol inhaler and Enbrel injection.<br>-She was not aware Resident #3 had a bottle of Zyrtec, Gentle Iron and 3 Duo-nebs in her room.<br>-She did not have any process for checking on residents to see if they have any new medications in their rooms.<br>-She had done a quarterly review and check off for residents who self-administer medications and she would do a review as needed if staff noticed a decline in a resident.<br>-She had not completed a self-administration review check off for Resident #3 for the Albuterol or the Enbrel injection.<br>-She was responsible for completing the self-administration reviews and check off.<br>-She was not sure why she had not completed the self-administration review check list for Resident #3 to self-administer medications.<br>-She was going to complete a Self-administration Medication review for Resident #3 as soon as soon as possible.<br><br>Review of the facility's policies and procedures for self-administration for medications revealed:<br>-The resident must have an order from their physician that "Resident may self-administer medications".<br>-The order must be updated quarterly.<br>-The physician must write an order for every medication the resident is taking, prescription and over the counter.<br>-At least quarterly, the Resident Care Director or designee must check the resident's medications for signs that medications may not be taken properly.<br>-It should be documented in the resident care notes what was found each time there was a check for appropriate self-administration. | D 375 | | |

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| D 375 | Continued From page 37<br>-A self-administration medication review would be completed with any new order to self-administer medications and at a minimum, every quarter thereafter and with any changes in condition. | D 375 | | |
| D 465 | 10A NCAC 13F .1308(a) Special Care Unit Staff<br><br>10A NCAC 13F .1308 Special Care Unit Staff<br>(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 7 of 48 shifts sampled from 06/24/18 through 07/09/18.<br><br>The findings are:<br><br>Interview with the supervisor on 07/11/18 at 9:25am revealed:<br>-First shift staff hours were from 7:00am to 3:00pm.<br>-Second shift staff hours were from 3:00pm to 11:00pm.<br>-Third shift staff hours were from 11:00pm to 7:00am. | D 465 | | |

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| D 465 | Continued From page 38<br><br>Review of the daily census report dated 06/24/18 revealed:<br>-The census for the special care unit (SCU) was 20 residents.<br>-20 hours of staff time was required for first and second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 06/25/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the staff schedule and the timecard reports revealed for 06/25/18.<br>-There were 10 staff hours provided on third shift but 16 hours were required.<br>-This resulted in a shortage of 6 staff hours for a census of 20 SCU residents.<br><br>Review of the daily census report dated 06/26/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the staff schedule and the timecard reports revealed for 06/26/18:<br>-There were 11.5 staff hours provided on third shift but 16 hours were required.<br>-This resulted in a shortage of 5.5 staff hours for a census of 20 SCU residents.<br><br>Review of the daily census report dated 06/27/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and | D 465 | | |

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| D 465 | Continued From page 39<br>second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 06/28/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 06/29/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 06/30/18 revealed:<br>-The census for the SCU was 19 residents.<br>-19 hours of staff time was required for first and second shift.<br>-15.2 hours of staff time was required for third shift.<br><br>Review of the staff schedule and the timecard reports revealed for 06/30/18:<br>-There were 10 staff hours provided on third shift but 15.2 hours were required on 06/30/18.<br>-This resulted in a shortage of 5.2 staff hours for a census of 19 SCU residents.<br><br>Review of the daily census report dated 07/01/18 revealed:<br>-The census for the SCU was 19 residents.<br>-19 hours of staff time was required for first and second shift.<br>-15.2 hours of staff time was required for third shift. | D 465 | | |

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| D 465 | Continued From page 40<br><br>Review of the staff schedule and the timecard reports revealed for 07/01/18:<br>-There were 10.5 staff hours provided on third shift but 15.2 hours were required on 07/01/18.<br>-This resulted in a shortage of 4.7 staff hours for a census of 19 SCU residents.<br><br>Review of the daily census report dated 07/02/18 revealed:<br>-The census for the SCU was 19 residents.<br>-19 hours of staff time was required for first and second shift.<br>-15.2 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 07/03/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 07/04/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the staff schedule and the timecard reports revealed for 07/04/18:<br>-There were 15.75 staff hours provided on first shift but 20 hours were required.<br>-This resulted in a shortage of 4.25 staff hours for a census of 20 SCU residents.<br><br>Review of the daily census report dated 07/05/18 revealed:<br>-The census for the SCU was 20 residents.<br>-20 hours of staff time was required for first and | D 465 | | |

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| D 465 | Continued From page 41<br>second shift.<br>-16 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 07/06/18 revealed:<br>-The census for the SCU was 21 residents.<br>-21 hours of staff time was required for first and second shift.<br>-16.8 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 07/07/18 revealed:<br>-The census for the SCU was 21 residents.<br>-21 hours of staff time was required for first and second shift.<br>-16.8 hours of staff time was required for third shift.<br><br>Review of the staff schedule and the timecard reports revealed for 07/07/18:<br>-There were 11.5 staff hours provided on third shift but 16.8 hours were required.<br>-This resulted in a shortage of 5.3 staff hours for a census of 21 SCU residents.<br><br>Review of the daily census report dated 07/08/18 revealed:<br>-The census for the SCU was 21 residents.<br>-21 hours of staff time was required for first and second shift.<br>-16.8 hours of staff time was required for third shift.<br><br>Review of the daily census report dated 07/09/18 revealed:<br>-The census for the SCU was 22 residents.<br>-22 hours of staff time was required for first and second shift. | D 465 | | |

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| D 465 | Continued From page 42<br>-17.8 hours of staff time was required for third shift<br><br>Review of the staff schedule and the timecard reports revealed for 07/09/18:<br>-There were 16 staff hours provided on third shift but 17.6 hours were required on 07/09/18.<br>-This resulted in a shortage of 1.6 staff hours for a census of 22 SCU residents.<br><br>Review of the daily staff schedules for the SCU dated 06/24/18 - 07/08/18 revealed:<br>-The names of the personal care aides were typed in blocks in the top of the schedule.<br>-The names of the supervisors were written in blocks in the bottom of the schedule.<br>-There were no differential for the schedule to identify first, second, or third shifts.<br>-Employees' scheduled times were handwritten in the schedule adjacent to the block next to their names.<br><br>Interview with the interim Executive Director on 07/11/18 at 1:36pm revealed:<br>-There was no Special Care Coordinator (SCC) currently for the SCU.<br>-There had been a problem with short staffing for the entire facility, not just the SCU, since the end of the spring.<br>-She was responsible for managing the facility staffing schedule including staffing for the SCU.<br>-She made out the schedule according to the resident census.<br>-If there was a call-out, she would check with other staff to see if they could work in that slot.<br>-If she could not find another staff to work in the vacant slot, she would work in place of other staff in order to cover resident care.<br>-"I know we are sometimes working short-staffed in the SCU, but I don't know what else to do". | D 465 | | |

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| D 465 | Continued From page 43<br>-"The facility was in the process of trying to recruit more staff, but it was hard being financially competitive with other organizations in this area this time of the year".<br>-She was in the process of interviewing 2 new staff for the facility.<br><br>Interview with the Regional Director on 07/12/18 at 11:25am revealed:<br>-The facility was in the process of trying to recruit new staff through the local colleges and they had a recent job fair.<br>-"It was hard trying to find qualified staff this time of year and be competitive with other organization".<br>-He would continue to work with the interim Executive Director to hire more staff to ensure the needs of the residents, including the SCU were met at the facility. | D 465 | | |
| {D912} | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and | {D912} | | |

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| {D912} | Continued From page 44<br>health care.<br><br>The findings are:<br><br>Based on observations, interviews, and record reviews the facility failed to notify the medical provider for 1 of 1 sampled residents (#4) with blood sugars over 250 for three days in accordance with physician orders. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. | {D912} | | |
| D914 | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews the facility failed to assure residents were free of neglect as related to residents rights.<br><br>The findings are:<br><br>1. Based on observations, interviews, and record reviews, the facility failed to provide the necessary supervision of 1 of 1 sampled residents (#8) who exhibited erratic and sexually inappropriate behaviors toward residents and staff in the Special Care Unit(SCU). [Refer to Tag D270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Unabated Type A2 Violation)].<br><br>2. Based on observation, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident (#2) was protected after | D914 | | |

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| D914 | Continued From page 45<br>complaints of being afraid of a male resident in the Special Care Unit and being subjected to inappropriate touching. [Refer to Tag D338, 10A NCAC 13F .0909 Residents Rights (Type A2 Violation)]. | D914 | | |

PLAN OF CORRECTION for Follow Up Survey completed July 13, 2018 (XNGH12)

**Spring Arbor of Outer Banks**

**HAL-028-001**

**Dare County**

It is Spring Arbor of Outer Bank's policy and standard practice to comply with all North Carolina Adult Care rules and state regulations.

## 10A NCAC 13F .0604(e)(1)(A)(B)(C) Personal Care and Other Staffing

**(e) Homes with capacity or census of 21 or more shall comply with the following staffing.**

**(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:**

**(A) First shift (morning) 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents.**

**(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents.**

**(C) Third shift (evening) – 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census)**

It is Spring Arbor of Outer Bank's policy to comply with NCAC staffing regulations for a home with census of over 21 residents.

Plan of Correction

The Executive Director has created a staffing schedule which provides the appropriate number of staff hours per shift based upon resident census. A daily census log is reviewed and staffing is adjusted by the Assistant Resident Care Coordinator (ARCC) as needed based on current census. The Executive Director will review staffing hours per shift each day, to assure appropriate hours are anticipated and provided. The Regional Director will review a staffing hours report each morning to assure that actual hours worked each shift on the prior day are in compliance with regulations.

The Executive Director has increased recruitment, interviewing and hiring efforts to assure an adequate number of staff available to meet scheduling requirements. The Executive Director and Regional Director will continue to work together and utilize corporate Human Resources (HR) to assist with on-site Job Fairs, ongoing candidate screening, advertising open positions in local resources and on-line sites in addition to Spring Arbor (i.e. Indeed.com) sources.

The Executive Director worked with the Regional Director and corporate HR to address compensation and retention opportunities that include wage adjustments to be more competitive in this market and as a result, enabling Spring Arbor of Outer Banks to recruit and retain qualified caregiver teammates. Spring Arbor of Outer Banks currently has staff employed to meet the regulatory requirements for each shift.

Prevention of Re-Occurrence and Ongoing Monitoring

Following this survey, the Executive Director implemented a system where the Supervisor-in-Charge must immediately notify the Resident Care Director or Executive Director directly if any scheduled staff are not present at the beginning of the shift. This assures that staffing needs are addressed promptly and that the shift will not go without adequate coverage.

Spring Arbor has made arrangements with two local staffing agencies to ensure access to staff in the event of unplanned call-outs that cannot be covered with existing staff. The Spring Arbor management team will continue to utilize HR resources on an ongoing basis to develop and implement strategies to address market wages, recruitment and retention of teammates. These strategies will differentiate Spring Arbor by having a deliberate focus on our culture, benefits, innovative work practices and career development.

The Executive Director will monitor compliance by comparing staffing schedules and employee time records against census three times a week for three months, and then monthly thereafter for six months, and then quarterly. This is in addition the Regional Director review referenced above.

Plan of Correction Completion Date for Staffing Compliance: August 13, 2018

Plan of Correction Completion Date for Monitoring Compliance: August 15, 2018

## 10A NCAC 13F. 0901(b) Personal Care and Supervision

**(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.**

It is the policy of Spring Arbor of Outer Banks to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

Plan of Correction

Immediately following this Survey, the care challenges and needs of Resident #8 were reassessed and addressed in collaboration with his family and physician. Resident #8 was discharged from Spring Arbor of Outer Banks on Monday, July 16, 2018.

Prevention of Re-Occurrence

A review of current residents was completed by Executive Director and Resident Care Director, assuring that none are exhibiting socially and sexually inappropriate behaviors toward other residents or team members.

A training / education session was conducted for team members, addressing the need for prompt reporting to the Supervisor-in-Charge, Resident Care Director or other appropriate manager of any episode of inappropriate behavior by a resident. This training was conducted on August 9, 10 & 11, 2018 for all shifts by the Executive Director and an RN who is the corporate Senior Director of Quality & Education[1].

It is the responsibility of the Resident Care Director/designee to assess the resident, implement interventions to provide safety and security for all residents and team members, and/or to develop an appropriate plan of care in collaboration with the resident's physician and family. One-on-one training occurred between the Resident Care Director and the Senior Director of Quality & Education on August 9th and August 10th, addressing the need to consider, and implement where appropriate, specific interventions focused on frequency checks and details of increased supervision for any resident exhibiting ongoing inappropropriate behaviors until such behaviors are resolved by implementation of a long term plan.

A refresher training session was held for SICs regarding correct use of the *"Shift-to-Shift Report"* for internal communication about change in condition and/or behavior of any resident. This training also included a review on the community's *"Hot Box"* system that results in the resident's chart being placed in a designated area to alert all SICs & MedTechs on each shift that this resident requires additional attention and documentation. Training was conducted July 15th, 16th & 17th, 2018 and continued July 26th & 27th, 2018 by two Regional RNs[2].

[1] Christine Stempel, RN

[2] Carol Noonan, RN, Director of Quality & Education; and Sarah Bright, RN, Director of Quality & Education. The title Regional RN is used for reader ease.

Monitoring Responsibility & Frequency

The Resident Care Director will review the *"Shift-to-Shift Report"* each morning and *"Hot Box"* documentation daily to help determine needs for new assessment and/or interventions for individual residents. The Resident Care Director will also observe residents with identified behaviors and corresponding staff to ensure that interventions implemented are in place and effective. This will occur as needed based on the presence and number of residents with any identified behaviors and where such residents are identified, the RCD will check on these interventions at least twice weekly. In the absence of Resident Care Director, the Executive Director or Assistant Resident Care Coordinator will review these reports and this documentation and conduct these observations.

Plan of Correction Completion Date: August 11, 2018

Plan of correction for Follow Up Survey Completed July 13,2018 (XNGH12)

10A NCAC 13F .0902(b) Health Care

It is a standard practice at Spring Arbor of Outer Banks to provide referral and follow-up to meet residents' health care needs.

Plan of Correction

Resident #4 was seen by his physician twice during the period of this Survey, for medical reasons unrelated to elevated blood sugars (although the physician was made aware of these results). The second physician visit on July 13, 2018 resulted in immediate hospitalization and by July 17, 2018, Resident #4 was discharged to a skilled nursing.

Prevention of Re-Occurrence

Resident Care Director has reviewed blood sugar readings for all diabetic residents at Spring Arbor, to assure that readings are within acceptable ranges, and/or that timely communication and documentation is occurring with physicians for elevated blood sugar readings for any resident.

Refresher training was conducted on July 15th,16th &17th and continued July 26th&27th by two Regional RNs with Med Techs regarding prompt communication to Supervisor-in-Charge or Resident Care Director and the appropriate physician regarding blood sugar glucose results outside of ordered parameters for any resident, and documentation of this communication.

If the Med Tech contacting the Physician office is unable to talk directly with a health care professional, he/she will document the time of the message left for the physician. The RCD and/or Supervisor in Charge will be notified that a message was left for physician. If there is no return call within 2 hours, one additional call will be made to physician office. If the Med Tech is still unable to communicate with physician, the resident will be sent to the ER for assessment and orders as needed and this will be communicated to family and to the physician's office. Med Techs and Supervisors in Charge have also been educated that a diabetic resident demonstrating symptoms of hyperglycemia (e.g., lethargy, severe headache) will be sent out 911 to ER for assessment.

Going forward, the RCD or ARCC will review those residents who have orders for physician notification (when resident blood sugars exceed level identified by physician) and the documentation of communication to physician to ensure that appropriate notification has been made. This review will be performed twice weekly for the next 2 months the weekly thereafter.

Monitoring Responsibility & Frequency

Resident Care Director/Assistant Resident Care Coordinator will review blood glucose results recorded in E-Mar and will assure physician notifications referenced above. In addition, the RN consultant[3]or Regional RN will review and audit blood glucose testing results and documentation against physician orders quarterly on an ongoing basis to verify compliance with physician orders.

Plan of Correction Completion Date: Sept 24, 2018

[3] Gayle Michler, RN

## 10A NCAC 13F 0902(c)(3-4) Health Care

**(c) The facility shall assure documentation of the following in the resident's record:**

**(3) written procedures, treatments or orders from a physician or other licensed health professional; and**

**(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule**

It is the policy at Spring Arbor of Outer Banks to have documentation of all written orders for procedures or treatments in each resident's record.

Plan of Correction

Resident #4 was seen by his physician twice during the period of this Survey, for medical reasons unrelated to blood glucose monitoring. The second physician visit on July 13, 2018 resulted in immediate hospitalization and by July 17, 2018, Resident #4 was discharged to a skilled nursing facility, where he remains today.

Prevention of Re-Occurrence

Resident Care Director has reviewed physician orders for all diabetic residents, assuring that all medication and blood glucose monitoring orders are active and accurately documented in E-Mar and in resident health record. The Regional RN has conducted Refresher class (5-Hour Medication Course for AC Homes) for Medication Aides and has included the process of receiving pending orders from pharmacy and then approving each new order in E-Mar to assure prompt and timely administration of all new medications or treatments.

Monitoring Responsibility & Frequency

Resident Care Director/ARCC will review EMar with the Medication Aide daily for new orders, to assure that each order is promptly "approved" and available for administration as ordered. The RCD/ARCC will review medication and treatment orders for all diabetic residents on a monthly basis. The RN Consultant or Regional RN will review and audit blood sugar testing results quarterly on-going to verify compliance with physician orders.

Plan of Correction Completion Date: August 13, 2018

**10A NCAC 13F .0904(d) (2) Nutrition and Food Service**

**(d) Food Requirements in Adult Care Homes**

**(2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.**

Plan of Correction

Executive Director has collaborated with the Food Service Director (FSD) to ensure that snacks are available and set up to be offered three times each day to each resident. A snack cart is utilized to provide hydration and snacks throughout the community. Distribution of snacks is assigned to a team member between meals every day of the week. Assignment sheets have been updated with this task and an area to initial/sign for the completion of offering these 3 snacks each day.

Prevention of Re-Occurrence

All Resident Care staff were in-serviced August 1st at 2pm and 10 pm on the requirement to offer snacks to residents three times each day between meals. These inservices were jointly conducted by the Executive Director and Regional Director. The availability of snacks, use of the snack cart and updated daily assignment of a staff member to distribute snacks was also addressed. The Food Service Director will assure that snacks are available and has instructed all cooks and servers to prepare the snack carts 3 times a day each day.

Monitor Responsibility & Frequency

It is the responsibility of the Supervisor In Charge on each shift to assure that the assigned staff member is distributing snacks at the appropriate time and completing the assignment sheet. The RCD and/or ARCC will review the staff assignment sheets weekly. In addition, the ED/RCD/FSD will visually observe that snacks are being offered as scheduled at least twice per week for 6 week and then weekly for an additional 4 weeks or until management is satisfied that snacks are being made available and offered as scheduled.

Plan of Correction Completion Date: August 16, 2018

## 10A NCAC 13F .0909 Resident Rights

**An adult care home shall assure that the rights of all residents guaranteed under G.X. 131D-21 Declaration of Resident Rights, are maintained and may be exercised without hindrance.**

It is Spring Arbor of Outer Banks's policy and standard practice to comply with all rules and state regulations regarding resident's rights.

Plan of Correction

*10A NCAC 13F.0901.(b) Personal Care and Supervision:* Immediately following the Survey, the care challenges and needs of Resident #8 were reassessed and addressed in collaboration with his family and physician. Resident #8 was discharged from Spring Arbor of Outer Banks on Monday, July 16, 2018. Since the discharge of Resident #8, there is little change in the behavior or verbalizations from Resident #2. Her family has shared similar comments that she makes to them and her son has voluntarily provided the attached letter to demonstrate his understanding of his mother's delusions. Care staff attend diligently to Resident #2's needs and behaviors and make all efforts keep her feeling safe and protected in the Cottage environment.

Staff training on Resident's Rights was held for all shifts on August 9th, 10th & 11th, 2018. Training included examples and group discussion about how the entire care team and service team is responsible to assure that every resident at Spring Arbor lives in an environment that is free of fear for his/her safety and well-being, and free of mental and physical abuse, neglect and exploitation. Training included "what would you do" scenarios and group discussions of each. Training also addressed the importance of timely communication of concerns about a specific resident or on behalf of a specific resident to a Supervisor or Resident Care Director or other appropriate manager. Training was conducted by Executive Director and Senior Director of Quality & Education.

Quarterly *"Company Update"* meetings were held at Spring Arbor of Outer Banks on August 1, 2018. Content of this meeting included a review with all team members of the company's Brand Promises and Values which include trust and collaboration in our relationships with residents and families. These Values influence all team members' commitment to respecting all Resident Rights. Presenters of this message included the Executive Director, Regional Director and Director of HR.

Prevention of Re-Occurrence

The Resident Care Director and/or Executive Director will be vigilant in appropriate follow-up to staff communication of challenges which may negatively impact any resident's rights. This may include reassessment, developing new approaches for a resident, collaboration with staff, family and/or physicians, in order to determine a best solution which also respects the rights of all residents.

In addition, upon the identification by staff of any resident who is creating anxiety or fear in another resident, the RCD or ED will review the individual plan developed to resolve that issue to ensure that it is tailored to the unique circumstances, such as those that were present in the

cited example between R2 and R8, and will educate and monitor staff to ensure the plan is being implemented and is effective.

Resident Rights training will be conducted for all employees upon hire and annually thereafter. In addition, Resident Rights will be reviewed and reinforced regularly at staff meetings by the Executive Director/designee.

Monitor Responsibility & Frequency

The Resident Care Director and/or Executive Director will review the *"Shift to Shift"* report and daily documentation in the *"Hot Box"* to assure that specific resident challenges are being managed properly and in compliance with rights for all residents.

The Regional RN or the Regional Director will review the records of residents identified as having special issues, such as R2 and R8 in the cited example, to ensure appropriate individualized plans have been developed and are being implemented and are effective. This will occur as part of each monthly visit by the Regional RN or Director.

The Resident Care Director/designee will monitor training records on a monthly basis to assure compliance with Resident Rights training requirements.

Documentation of attendance and completion of training will be maintained in employee records.

Completion Date: August 11, 2018

## 10A NCAC 13F .1005(a) Self Administration of Medications

**(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if he following requirements are met:**
**(1) The self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and**
**(2) Specific instructions for administration of prescription medications are printed on the medication label**

Plan of Correction

Immediately following this Survey, self-administration orders were reviewed and Spring Arbor's *Self Administration Medication Review* form was completed by the Resident Care Director for Resident #3 to assure this individual's competence and physical ability to safely and effectively administer her own medications and that all medications being self-administered by resident have corresponding orders for self-administration. Secure storage for the approved self-administration medications has been verified and implemented in Resident #3's personal room. Self-administration orders were communicated to Pharmacy for correct labeling on medication labels, and Resident #3's E-Mar was reviewed to assure correct documentation of self-administration directions

Prevention of Re-Occurrence

The *Self Administration Medication Review* form will be completed for prescribed and over-the-counter medications upon receipt of a self-administration order for a resident and in advance of any resident self-administering medications. This form will be completed on a quarterly basis, or as needed due to a change in condition.

A letter will be sent to all residents and/or Responsible Party/POAs, reviewing the Spring Arbor policy regarding self-administration of medications and storage of both prescription and over-the-counter medications in the resident's room.

Team members (Medication Aides, Resident Assistants, Personal Care Aides, Housekeeping) have been reminded during Staff meetings and daily Stand-Up meetings to immediately report to the Resident Care Director/Assistant Resident Care Coordinator about any unsecured medications they may observe in any resident's room. It is the responsibility of the Resident Care Director/Assistant Resident Care Coordinator to promptly follow up on this observation and to comply with the Spring Arbor *Self-Administration Policy.*

Monitor Responsibility & Frequency

On a monthly basis, the Resident Care Director will review self-administration orders, timely completion of *Self-Administration Medication Review* forms, pharmacy labeling and E-Mar documentation of self-administration orders. The RCD/ARCC will also conduct random spot-checks on 5 resident rooms each week to observe any medications present in those resident rooms.

RN Consultant and Regional RN will review and audit self-administration orders quarterly on an ongoing basis to verify that the resident can safely demonstrate self-administration and storage of their medications and that orders for self-administration are in place.

Date of Completion for Self-Administration Review: July 14, 2018

Date of Completion for Self-Administration Letter: August 17, 2018

## 10A NCAC 13F .1308(a) Special Care Unit Staff

**(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.**

It is the policy of Spring Arbor of Outer Bank to have staff scheduled and present in Cottage (Special Care Unit) at all times to meet the needs of the residents, in compliance with staffing ratio requirements.

Plan of Correction

The Executive Director and Resident Care Director will continue to work together and create a SCU staffing schedule which provides a sufficient number of staff hours to meet the needs of the residents. A daily census log is reviewed and staffing is adjusted as needed. The Executive Director will review staffing hours per shift each day, to assure appropriate hours are anticipated and provided. The Regional Director will review a staffing hours report each morning to assure that actual hours worked each shift on the prior day are in compliance with regulations.

The Executive Director has increased recruitment, interviewing and hiring efforts to assure an adequate number of staff available to meet scheduling requirements. The Executive Director and Regional Director will continue to work together and utilize corporate Human Resources (HR) to assist with on-site Job Fairs, ongoing candidate screening, advertising open positions in local resources and on-line sites in addition to Spring Arbor (i.e. Indeed.com) sources.

The Executive Director worked with the Regional Director and corporate HR to address compensation and retention opportunities that include wage adjustments to be more competitive in this market and as a result enabling Spring Arbor of Outer Banks to recruit and retain qualified caregiver teammates. Spring Arbor of Outer Banks currently has staff employed to meet the regulatory requirements for each shift.

Prevention of Re-Occurrence

Following this survey, the Executive Director implemented a system where the Supervisor-in-Charge must immediately notify the Resident Care Director or Executive Director directly if any scheduled staff are not present at the beginning of the shift. This assures that staffing needs are addressed promptly and that the shift will not go without adequate coverage.

Spring Arbor has made arrangements with two local staffing agencies to ensure access to staff in the event of unplanned call-outs that cannot be covered with existing staff. The Spring Arbor management team will continue to utilize HR resources on an ongoing basis to develop and implement strategies to address market wages, recruitment and retention of teammates. These strategies will differentiate Spring Arbor by having a deliberate focus on our culture, benefits, innovative work practices and career development.

The Executive Director will monitor compliance by comparing staffing schedules and employee time records against census three times a week for three months, and then monthly thereafter for six months, and then quarterly. This will be in addition to the Regional Director review referenced above.

Plan of Correction Completion Date for Staffing Compliance: August 13, 2018

Plan of Correction Completion Date for Monitoring Compliance: August 15, 2018

**G.S. 131 D-21-21(2) Declaration of Residents' Rights**

**G.S. 131 D-21 Declaration of Residents' Rights every resident shall have the following rights:**

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

It is Spring Arbor of Outer Banks's policy and standard practice to comply with all rules and state regulations regarding resident's rights.

Plan of Correction

*10A NCAC 13F.0902(b) Health Care:* Resident #4 was seen by his physician twice during the period of this Survey, for medical reasons unrelated to elevated blood sugar (although the physician was made aware of these results). The second physician visit on July 13, 2018 resulted in immediate hospitalization and by July 17, 2018, Resident #4 was discharged to a skilled nursing facility, where he remains today.

Staff training on Resident's Rights was held for all shifts on August 9th, 10th & 11, 2018. Training included examples and group discussion about how the care team provides care and services to residents and how and when to communicate concerns to a Supervisor-in-Charge and/or Resident Care Director. Training was conducted by Executive Director and Senior Director of Quality & Education.

Prevention of Re-Occurrence

Resident Rights training will be conducted for all employees upon hire and annually thereafter. In addition, Resident Rights will be reviewed and reinforced regularly at staff meetings by the Executive Director/designee.

Monitor Responsibility & Frequency

The Resident Care Director and/or Executive Director will monitor training records on a monthly basis to assure compliance with Resident Rights training requirements.

Documentation of attendance and completion of training will be maintained in employee records.

Completion Date: August 11, 2018

**G.S. 131 D-21-21(4) Declaration of Residents' Rights**

**G.S. 131 D-21 Declaration of Residents' Rights every resident shall have the following rights:**

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

It is Spring Arbor of Outer Banks's policy and standard practice to comply with all rules and state regulations regarding resident's rights.

Plan of Correction

*10A NCAC 13F.0901.(b) Personal Care and Supervision:* Immediately following the Survey, the care challenges and needs of Resident #8 were reassessed and addressed in collaboration with his family and physician. Resident #8 was discharged from Spring Arbor of Outer Banks on Monday, July 16, 2018. Since the discharge of Resident #8, there is little change in the behavior or verbalizations from Resident #2. Her family has shared similar comments that she makes to them and her son has voluntarily provided the attached letter to demonstrate his understanding of his mother's paranoia and delusions. Care staff attend diligently to Resident #2's needs and behaviors and make all efforts to keep her feeling safe and protected in the Cottage environment.

Staff training on Resident's Rights was held for all shifts on August 9th, 10th & 11th, 2018. Training included examples and group discussion about how the entire care team is responsible to assure that every resident at Spring Arbor lives in an environment that is free of mental and physical abuse, neglect and exploitation. Training addressed timely communication of concerns about a specific resident or on behalf of a specific resident to an SIC and/or Resident Care Director. Training was conducted by Executive Director and Senior Director of Quality & Education.

Prevention of Re-Occurrence

Resident Rights training will be conducted for all employees upon hire and annually thereafter. In addition, Resident Rights will be reviewed and reinforced regularly at staff meetings by the Executive Director/designee.

Monitor Responsibility & Frequency

The Resident Care Director and/or Executive Director will review *"Shift to Shift"* report and *"Hot Box"* documentation daily to assure that specific resident challenges are being managed properly and in compliance with rights for all residents.

The Resident Care Director/designee will monitor training records on a monthly basis to assure compliance with Resident Rights training requirements.

Documentation of attendance and completion of training will be maintained in employee records.

Completion Date: August 11, 2018

30 July 2018

Memorandum to Spring Arbor, Kill Devil Hills, NC

This memo is to acknowledge that I received notification and the results of investigation from Spring Arbor in a timely manner of an alleged rape incident in Mid-March reported to staff by [redacted] (my mother) a resident of Spring Arbor.

I believe the conclusion that a rape did not occur is well founded based on my mother's mental state and my daily conversations with her. She is often delusional and dreams are a reality. Many days when I visit she says I (meaning me) have been killed the night before. She will also say things like "They cut my (her) throat." Obviously not the case.

I am comfortable that Spring Arbor performed appropriately in their investigation and findings. I would add that Spring Arbor also immediately notified me when my Mom attempted to tailgate another resident out of the Cottage. In summary, I believe the staff makes every effort to watch out for resident safety which is why we have her living there.

I would be happy to discuss any further concerns related to this incident, but otherwise consider the matter closed.

Respectfully,

[redacted]

[redacted] son, POA