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	HAL046019	A. BUILDING: _____ B. WING _____	09/24/2018

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PINEWOOD MANOR	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on September 5, 6, 7, 10 and 11, 2018 with an exit conference via telephone on September 24, 2018.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls in the dining rooms on the special care unit (SCU) and assisted living (AL) side, the facility kitchen, were clean, free of peeling and chipped paint and damage; four door frames were free of rust and damage; shower tiles in 5 common bathing and shower rooms were free of damage and stains and floors and base boards in the AL common shower and 3 resident rooms (10, 13 and 14), SCU hallway, dining room, common shower and bathing rooms, resident rooms and shared bathrooms were clean. The findings are: Observations on the special care unit (SCU) on 09/05/18 between 11:55am and 1:20pm revealed:	D 074		

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D 074	Continued From page 1 -The metal door frame to the common shower room was rotted and rusted on both sides covering approximately two inches from where the door frame met the floor. -There was dirt and dust accumulations and brown/black staining along the edges of the floors, in the corners of the floors and at the door frames on the floors in the special care unit (SCU) including the hallway, dining room, common shower room, common bathroom, resident rooms and shared bathrooms. -There was a 12 inch missing section of baseboard trim behind the entrance door in resident room P1. -There was a 12 inch loose section of baseboard trim behind the entrance door in resident room P7. -The floor tile was raised and warped approximately the size of half a lemon at the corner on the hinged side the door of the entranceway to resident room P3. Interview with the Special Care Coordinator (SCC) on 09/05/18 at 1:20pm revealed: -The housekeepers were responsible for cleaning the floors on the SCU. -There was a male housekeeper that stripped the floors at night; he had done some of the resident rooms within the last two months. -The male housekeeper did not work at the facility anymore; he stopped working last week. -There was a maintenance man also, but he was only part time. Interview with the Housekeeping Supervisor on 09/06/18 at 10:15am revealed: -The guy the facility had to "get all that gunk up just up and quit last week." -The corner areas did not come clean with mopping and needed to be scrapped up every	D 074		

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day.
-The housekeepers were responsible for cleaning the floors behind doors, in the corners and along the edges every day.
-She was responsible for checking resident rooms for cleanliness every day.

Telephone interview with the Administrator on 09/24/18 at 11:58am revealed she went over to the SCU every day and there was no dirt build up on the floors, it was wax from the floors being stripped.

Observations on the special care unit (SCU) on 09/05/18 between 11:55am and 1:20pm revealed:
-There were two areas of missing tile on the shower wall in the common shower room, each approximately 3 inches by 8 inches.
-The tile at the entrance to the shower in the common shower room was cracked leaving an open space of approximately one half an inch from the floor to approximately waist height.
-The tile at the entrance to the shower in the common bathing room was cracked leaving an open space of approximately one half an inch from the floor to approximately waist height.

Interview with the Housekeeping Supervisor on 09/06/18 at 10:15am revealed:
-The maintenance man was going to fix the bathroom tiles, but she did not know when.
-The maintenance man worked part time and she was not sure which days he worked.

Telephone interview with the Administrator on 09/24/18 at 11:58am revealed she was not aware of the cracked and missing tiles in the common bath and shower rooms; she would add the tiles to the repair list.

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D 074	Continued From page 3 Observations on the special care unit (SCU) on 09/05/18 between 11:55am and 1:20pm revealed: -There was a large brown stain on the floor in the dining room between the refrigerator and the wall. -There several areas of brown stains on the floor next to the medication cart, in front of the refrigerator and in front of the sink cabinet in the dining room. -There were orange and brown stains on the wall next to the refrigerator and the wall under the window facing outside in the dining room. Telephone interview with the Administrator on 09/24/18 at 11:58am revealed: -Staff cleaned the dining room after meals and the housekeeper cleaned the floors in the dining room daily. -If staff noticed drip marks on the walls they were expected to spray and clean the walls in the dining room. Interview with a housekeeper on 09/06/18 at 10:11am revealed: -She had worked as a housekeeper at the facility since May 2018; she was responsible for cleaning the hallway, resident rooms, bathrooms and the kitchen daily. -She reported any needed repairs to the Administrator. -The Supervisor was the one who would know about any repair and housekeeping concerns. Interview with the Housekeeping Supervisor on 09/06/18 at 10:15am revealed she was responsible for checking resident rooms for cleanliness every day. Interview with the Special Care Coordinator (SCC) on 09/05/18 at 1:20pm revealed there was a housekeeper that cleaned the SCU in the	D 074		

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morning each day, then after that SCU staff did spot cleaning.

Telephone interview with the Administrator on 09/24/18 at 11:58am revealed:
-The SCC did a walk through every day and made a list of any needed repairs.
-The SCC gave the repair list to the Administrator, the Administrator gave the list to the maintenance man and the maintenance man came and made repairs.

Observations on A Hall (men's hall) on 09/05/18 at 12:10pm revealed:
-The frame of the door to the first community bathroom was broken at the right base.
-There was dark grime around the commode base and the bathtub base in the first community bathroom.
-The shower stall floor in the first community bathroom was dirty and grimy and the drain cover was off and lying beside the drain.
-The door frames of shared bathroom between rooms #9 and #10 was rusted about half way up the frames.
There was dark grime around the commode base in the shared bathroom between rooms #9 and #10.
-The baseboard near the door of room #13 was pulled away from the wall and the door near the knobs was grimy.
-The door alarm device connected to the exit door was broken and was held together with duct tape.

Interview with a housekeeping staff member on 09/12/18 at 10:15am revealed:
-She was responsible to keep the residents' rooms on Hall A clean. .
-She had not noticed any grime on the bathroom

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floors or rusted door frames anywhere in the facility.
-She reported any needed repairs to the Administrator and the Administrator got someone to make the needed repairs.

Interview with the Administrator on 09/24/18 at 1:15pm revealed:
-The housekeeping staff cleaned the common shower rooms daily.
-She did not know it was a problem with the stains on the shower walls and floors.
-She did not know baseboard near the door in room #13 was pulled away from the wall.
-The grime on the floors in the bathrooms were built-up wax not dirt.

Observation of resident room #10 on the C Hall on 09/05/18 at 11:55am revealed an outlet cover by the closet door next to the bathroom door was missing.

Interview with the resident in resident room #10 on the C Hall on 09/05/18 at 11:55am revealed she had not noticed the outlet cover was missing.

Interview with the Administrator on 09/24/18 at 1:15pm revealed she did not know about the missing outlet cover in resident room #10.

Observation of the common shower room located next to resident room #12 on the C Hall on 09/05/18 at 12:17pm revealed:
-Both sides of the lower door frame had several areas of rust spots, peeling paint, and cracked areas.
-There were several black and gray stains with some puckered areas that measured approximately 3 feet long by 5 feet wide in the ceiling on the left side of the air flow vent over the

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toilet.
-Three of three baseboards had several brown stains and brown dust.
-The grout inside the shower walls had several black and brown stains.

Interview with a housekeeping staff member on 09/12/18 at 10:15am revealed:
-She was responsible for keeping the common showers rooms clean.
-She had not noticed any leaks, black spots, or rusted door frames anywhere in the facility.
-She reported any needed repairs to the Administrator and the Administrator got someone to make the needed repairs.

Interview with the Administrator on 09/24/18 at 1:15pm revealed:
-She would have to check to see about the peeling paint and black stains around the air vents in the common shower room on the C Hall.
-The housekeeping staff cleaned the common shower rooms daily on the C Hall
-She did not know it was a problem with the stains on the shower walls and floors on the C Hall.

Observation of resident room #7 on the C Hall on 09/05/18 at 12:30pm revealed there were black stains on the ceiling on the left side of the air vent closest to the window.

Interview with the resident who resided in room #7 on the C Hall on 09/05/18 at 12:30pm revealed she had not noticed the stains on the ceiling and denied any odors in her room.

Observation of resident room #8 on the C Hall on 09/05/18 at 12:57pm revealed there were black stains on the ceiling on three sides of the air vent

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closest to the window.

Attempted interview with the resident who resided in room #8 on 09/05/18 at 12:57pm was unsuccessful because the resident refused to be interviewed.

Interview with the Administrator on 09/24/18 at 1:15pm revealed she would have to check to see about the peeling paint and black stains around the air vents in the residents' rooms on the C Hall.

Observation of resident room #13 on the C Hall on 09/05/18 at 1:02pm revealed:
-There was a puckered area of drywall in the ceiling next to the window that had several areas of chipped and cracked white paint.
-The area had some separation from the corner of the ceiling and measured approximately 3 feet long and 1 foot wide.

Interview with the Administrator on 09/24/18 at 1:15pm revealed it had not been reported to her about any puckered areas of the ceiling or separation of drywall in any of the residents' rooms on the C Hall.

Observation of resident room #14 on the C Hall on 09/05/18 at 1:07pm revealed:
-There was a three inch area of peeling white paint on the right side of the light fixture in the middle of the room.
-The air vent closest to the window had black stains and peeling white paint around all 4 sides.

Interview with the resident who resided in room #14 on the C Hall on 09/05/18 at 1:10pm revealed:
-The peeling paint around the light fixture and air

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vent and the black stains around her air vent had been there for over a year.
-She had told the Administrator about it last year but it was not fixed.
-She would like for the ceiling areas to be fixed.

Observation of the common shower room located next resident room #14 on the C Hall on 09/05/18 at 1:14pm revealed:
-Three of three baseboards had several brown stains and brown dust.
-The shower walls and floor inside the shower stall had several brown stains scattered to the grout.
-The cabinet area outside of the walk-in tub had several scattered gray and black stains with brown dust.
-The air vent over the sink had chipped peeling paint on one side and brown dust on two sides.

Interview with a resident on 09/07/18 at 11:00am revealed:
-Housekeeping staff normally cleaned in her room by sweeping and mopping twice a day.
-Housekeeping staff cleaned in the common shower rooms about once a day.
-She had not noticed any black spots in the ceilings of the common shower rooms.

Observation of the A Hall dining room on the assisted living side of the facility on 09/06/18 at 9:50am revealed:
-The doorway leading into the dining room, closest to the kitchen, had several areas of chipped, peeling white paint along the right side of the door frame.
-Four of four walls had several areas of scraped, peeling white paint.
-The door frame leading from the dining room into the kitchen had several areas of chipped, peeling

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D 074	Continued From page 9 white paint. Interview with a housekeeping staff member on 09/12/18 at 10:15am revealed: -The kitchen staff was responsible for keeping the walls and floors clean in the dining room areas. -Sometimes, she volunteered and cleaned the A Hall dining room walls. -She reported any needed repairs to the Administrator and the Administrator got someone to make the needed repairs. Observation in the kitchen on 09/06/18 at 10:15am revealed: -An area of the brick baseboard and wall located on the left side of the back kitchen exit door that measured approximately three feet long and 3 inches wide was cracked and crumbling. -An area that measured approximately three feet long and two and half inches wide was missing from the left lower door frame of the back kitchen exit door. -Daylight was visible through the crack at the bottom of the back kitchen exit door. -The baseboard was missing from the wall on the right side of the back kitchen exit. Interview with the cook on 09/06/18 at 10:35am revealed: -She had not noticed any problems with the walls in the A Hall dining room. -Any problems dealing with painting, she would have to let the Administrator know. -The door leading in to the kitchen from the dining room had the peeling paint for the last several months (unable to specify exactly how many months). -The left side of the wall by the back kitchen exit door had been crumbling for at least 2 or 3 months.	D 074		

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-Water came in through the back kitchen exit door when it rained.
-Staff had put down towels on the floor by the exit door to keep water from coming inside the building when it rained.
-Rain water would come in through the back kitchen exit door about 2 feet if staff did put down towels to soak up the water.
-Standing water along the back side of the exit door was the reason why the lower wall area and baseboard by the exit door were crumbling.
-She had told the Administrator about the water coming in through the exit door about when it first started about 2 or 3 months ago.

Observation in the C Hall dining room on 09/06/18 at 11:45am revealed the lower right area of the metal door frame had chipped peeling paint and rust stains.

Interview with a medication aide on 09/06/18 at 11:55am revealed she had not noticed the rust stains or chipped paint on the door frame of leading into the C Hall dining room.

Interview with the Administrator on 09/24/18 at 1:15pm revealed:
-Housekeeping staff was supposed to clean the walls in C Hall dining room on Tuesdays.
-She knew there were a few places in the facility that needed touch-up painting and she had put it on the lists for maintenance.
-She did not know about the crumbling baseboard wall area by the back kitchen exit door.
-She knew water came in through the bottom of the back kitchen exit door when it rained.
-"It just started happening last week; it just needs a flap across the bottom to keep the water from getting in."
-She had put it on the repair list for the facility.

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D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure the facility was free of hazards as evidenced by live roaches observed in the kitchen, two resident rooms on the assisted living side and two resident rooms on the special care unit. The findings are: Interview with resident on 09/05/18 at 1:15pm revealed: -She saw large sized roaches about every two days in her room. -The facility had an exterminator that came out and sprayed in the facility once a month. -"The spraying had not helped because the roaches had been bad at the facility for years." -She did not see the point in complaining about the roaches if the facility already had an exterminator. Interview with another resident on 09/05/18 at 3:45pm revealed: -She saw roaches in her room on daily basis of	D 079		

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various sizes.
-She did not put any of her clothes or belonging in her dressers because of the roaches.
-She did not want the roaches to get into her clothes by putting them in the dresser.
-She had not seen any roaches in her closet.
-She had complained to the housekeeping staff and the Administrator about 2 months ago about the roaches.
-She was not sure how often the facility was sprayed for roaches.

Observation of room #8, on the men's hall, on 09/07/18 at 11:15am revealed there were 2 live roaches crawling on the wall near the door.

Interview with another resident on 09/07/18 at 11:25am revealed:
-There were roaches crawling in his room, but not too many.
-If he observed any roaches he killed them.
-The exterminator sprayed the facility but never came in his room to spray.
-The staff had seen roaches in his room every day/night.

Observation of room #1, on the men's hall, on 09/07/18 at 3:25pm revealed:
-There were multiple live roaches crawling inside the drawers of his bedside table.
-There were three live roaches crawling on the floor beside the bedside table near his C-PAP machine.
-There were two live roaches crawling on the wall in the corner of his room.

Interview with another on 09/07/18 at 3:30pm revealed:
-There were roaches in his bedside drawers and they usually crawled out at night.

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-When the exterminator came to the facility, he did not spray his room.
-Usually a staff walked with him and told him where to spray and would not let the resident show him the roaches in his drawers.

Observation of the dining room on the A Hall on 09/06/18 at 9:54am revealed:
-There was a small live roach crawling along the back corner wall of the dining room next to the kitchen.
-There were no staff or residents present in the dining room areas.

Observations on the special care unit (SCU) on 09/05/18 between 11:55am and 1:20pm revealed:
There was a live baby roach on the wall above the toilet in resident room P7.
There was a live adult roach inside the nightstand drawer and a live baby roach on the floor in resident room P1.

Interview with the resident in room P1 on 09/05/18 at 12:15pm revealed "Bugs be crawling on the walls biting you at night and you can't sleep."

Interview with the Special Care Coordinator (SCC) on 09/05/18 at 12:35pm revealed:
-She had seen a few roaches inside the facility, but there were no bed bugs.
-The facility did have an exterminator, but she did not know the name of the company or when the exterminator last treated the facility.

Confidential interview with staff revealed:
-The roaches were bad throughout the building.
-Roaches could be seen crawling on the wall, floors, out of residents' dressers, and closets.
-The exterminator came and sprayed the facility

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at least once a month.
-The spraying did not kill the roaches.
-"The roaches had been bad at the facility for years."

Interview with a housekeeping staff member on 09/12/18 at 10:15am revealed:
-She had not noticed any problems with roaches in the facility.
-The facility did have an exterminator who came out about once a month and sprayed the facility.
-The Administrator had her to routinely clean out residents' dresser drawers to help prevent roaches from getting into them.

Telephone interview with the exterminator on 09/24/18 at 9:24am revealed:
-A technician was at the facility every month to spray for roaches.
-Thirty rooms, the kitchen and common areas were sprayed each month.
-One wing of rooms was done each month and the wing rotated each month.
-The facility was informed to see how it went after each monthly treatment because there was no charge for the exterminator to return to the facility between monthly visits.
-He was not aware of the facility calling for any additional visits.

Telephone interview with the Administrator on 09/24/18 at 11:58am revealed:
-There was an exterminator that was contracted to come to the facility every month to spray for roaches.
-If staff saw any roaches the exterminator would spray wherever the roaches had been seen and sprays the whole building.
-The exterminator had advised not to use any store bought sprays in between exterminator

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D 079	Continued From page 15 visits, so she would purchase the roach boxes from the local store. -If the facility called the exterminator between visits the exterminator would come out and spray; she could not recall calling for additional visits.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up for 1of 5 sampled residents (#2) including referral to urgent care services for uncontrolled arthritic knee pain. The findings are: Review of Resident #2's current FL-2 dated 06/01/18 revealed: -Diagnoses included osteoarthritis, schizoaffective disorder, Vitamin D deficiency, hypertension, and chronic kidney disease. -There was a medication order for Voltaren 1% gel - apply 2 grams to knees two times a day (Voltaren 1% gel is used to treat osteoarthritis pain in the joint). -Resident #2 was ambulatory. Review of Resident #2's care plan dated 07/17/18	D 273		

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revealed:
-Resident #2 was ambulatory with a cane and required supervision with ambulation.
-Resident #2 was independent with transferring.

Review of Resident #2's physician's orders dated 06/04/18 revealed a medication order for Tylenol 325mg - 2 tablets two times a day for pain (Tylenol is medication used to treat mild to moderate pain).

Review of Resident #2's progress note dated 07/13/18 revealed:
-Resident #2 complained of pain in both knees.
-Resident #2 asked the MA to call her physician for pain medication.
-The MA called and left message for Resident #2's physician about Resident #2 complaints of knee pain and requests for pain medication.
-There was no documentation of any new medication orders received.

Review of Resident #2's progress note dated 07/16/18 revealed:
-Resident #2 was at her physician's office and seen by the family nurse practitioner.
-No new orders were given and Resident #2 to continue using Tylenol and Voltaren gel for knee pain.

Review of Resident #2's emergency room summary visit note dated 09/02/18 revealed:
-Resident #2 was seen for knee pain and had a diagnosis of localized knee osteoarthritis.
-Naprosyn 500mg twice daily was prescribed for 7 days (Naprosyn is a nonsteroidal anti-inflammatory medication used for pain management).
-Resident #2 was to follow-up with her physician as soon as possible.

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D 273	Continued From page 17 Observation of Resident #2 on 09/05/18 at 1:25pm revealed Resident #2 ambulated in her room and using a cane, sat in a chair, and rubbed her left knee. Interview with Resident #2 on 09/05/18 at 1:25pm revealed: -Resident #2 denied pain but she complained her left knee was stiff. -"I had to call the rescue squad for myself last Sunday (09/02/18)". -Resident #2 called 911 from her cell phone on 09/02/18 because her left knee was hurting "bad" and staff had only given her Tylenol for pain. -The Tylenol did not help her knee pain on the morning of 09/02/18. -The medication aide (MA) told Resident #2 there was no other pain medication ordered besides Tylenol and staff could not call 911 for knee pain. -Resident #2 had laid in bed all morning and afternoon on Sunday (09/02/18) because her left knee hurt so badly. -"I had complained about my knee hurting all week and all they (MAs) gave me was Tylenol." -"I told the staff (MAs) that the Tylenol was not working." -"Nobody did anything except keep giving me Tylenol." -"I was tired of my knee hurting and all they were giving me here was Tylenol; so I called 911 to take me to the hospital to get some relief." -Resident #2 did not tell the staff when she called 911 on 09/02/18. -She called 911 on 09/02/18 sometime after 3:00pm. -The new medication Resident #2 had gotten from the hospital had relieved her knee pain. -She had a follow-up appointment with her physician on 09/11/18 for her knee pain.	D 273		

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D 273	Continued From page 18 Interview with a MA on 09/07/18 at 1:45pm revealed: -She was the MA on duty on 09/02/18 when Resident #2 called 911. . -Resident #2 had complained about her left knee pain several times earlier during the week before. -Resident #2 had complained about pain in both of her knees a lot. -The MA had spoken with the RCC about Resident #2's left knee pain complaint at least once last week. -The MA was not sure what day that was she spoke with the RCC. -The RCC had called Resident #2's physician and left a voice message about Resident #2's knee pain last week; but the MA was not sure what day the RCC called. -The MA did not follow-up with RCC to check if Resident #2's physician called back. -Resident #2 only had Tylenol and Voltaren ordered for pain on 09/02/18 and the MA administered the Tylenol and Voltaren on 09/02/18 as ordered. -There were no as needed pain medications ordered for Resident #2 or any medication stronger than Tylenol on 09/02/18. -Resident #2 stayed in bed all day on Sunday (09/02/18); but Resident #2 had not complained about any pain to the MA on 09/02/18. -Resident #2 did not ask the MA to call 911 on 09/02/18. -She would have done something if she had known Resident #2 was in that much pain that Resident #2 called 911. -She did not know Resident #2 had called 911 until she saw the rescue squad arrived at the front door of the facility and the rescue team asked for the resident. -Resident #2 went to the emergency room.	D 273		

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-The MA had left the facility before Resident #2 returned from the emergency room.
-Resident #2 was scheduled for a follow-up appointment with her physician next week.

Review of Resident #2's progress note dated 08/30/18 revealed:
-Resident complained of left knee pain.
-Resident Care Coordinator (RCC) called Resident #2's physician and spoke with the nurse.
-The nurse would follow-up with Resident #2's physician to see if anything could be given for breakthrough pain.
-An orthopedic referral was going to be made for Resident #2.
-There was no documentation of any new medication orders received on 08/30/18 or 08/31/18.
-There was no documentation of follow-up by staff with Resident #2's physician's office after 08/31/18.
-The progress note was written by the RCC.

Interview with the RCC on 09/10/18 at 3:00pm revealed:
-Resident #2's physician's office had been called regarding Resident #2's complaint of knee pain on 08/30/18.
-She had left a voicemail for the nurse but Resident #2's physician or nurse did not call the facility back.
-She did not get a chance to follow-up with Resident #2's physician's office after 08/30/18 because she just forgot.
-She did not know if Resident #2 still complained about knee pain on 08/31/18.
-"We would not let any resident just lay up and hurt without doing something."
-She did not know why Resident #2 called 911 on

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09/02/18.
-Staff could have called the on-call physician for pain medication for Resident #2.
-She would have to review Resident #2's record to see what happened on 09/02/18.

Telephone interview with the nurse with Resident #2's physician's office 09/10/18 at 3:31pm revealed:
-There was a voicemail left on 08/30/18 from the facility for the nurse regarding Resident #2's complaint of left knee pain.
-The nurse did not retrieve the voicemail left by the facility on 08/30/18 and the nurse was not in the office on 08/31/18.
-The nurse did follow up with facility on 09/04/18 when she returned to the office.
-Resident #2 did have a history of osteoarthritis and had been prescribed Tylenol and Voltaren for pain relief.
-It was the expectation of the physician for the facility to seek medical attention for Resident #2 if they were unable to reach the physician regarding Resident #2's complaint of knee pain.
-Resident #2 was scheduled for a follow-up with the physician on 09/11/18.

Interview with the Administrator on 09/10/18 at 4:05pm revealed:
-Resident #2 had a history of arthritis and walked with a cane.
-She wasn't sure why Resident #2 called 911 on her own on 09/02/18.
-It should have gone through the MAs first to make sure Resident #2 got the appropriate care.
-She did not know if Resident #2 had complained about left knee pain for at least a week.
-Staff would have gotten Resident #2 some help on 09/02/18 if Resident #2 had let staff know her knee pain was worse.

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D 273	Continued From page 21 The facility's failure to assure health care referral and follow up for Resident #2's uncontrolled knee pain resulted in the resident seeking emergency treatment for pain relief without staff assistance. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/18 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2018.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to keep the stove, 2 ovens, 2 metal racks, ice machine, and dry goods storage wall in the kitchen, walls of the A Hall dining room, walls and floors of the C Hall dining room, and a refrigerator in the Special Care Unit was clean and free from contamination of dust, stains, and grease. Observation of the A Hall dining room on 09/06/18 at 9:50am revealed:	D 282		

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D 282	Continued From page 22 -Four of four walls had scattered black and brown stains along the lower wall areas above the baseboards. -The wall area around the door frame leading from the dining room into the kitchen had scattered black and brown stains. Interview with the cook on 09/06/18 at 10:35am revealed: -She had not noticed any problems with the walls in the A Hall dining room. -Housekeeping was in charge of cleaning the walls. Telephone interview with housekeeping staff on 09/12/18 at 10:15am revealed the kitchen staff were responsible for cleaning the walls and floors in the A Hall dining room. Observation of the kitchen on 09/06/18 at 10:15am revealed: -The griddle of the stove and top of the stove had several brown stains. -The inside of both ovens were covered with black and brown stains had been lined with aluminum foil. -All of the knobs of the ovens were covered with a residue that was greasy to touch. -There were 2 three-tier metal racks, located at the right side of the back kitchen exit door, with all shelves rusted and was being used for cup/glass storage. -The area of the floor in front of the exit door had white dried stains built-up in the grout. Observation of the ice machine in the kitchen on 09/06/18 at 10:25am revealed: -There were grease stains and white residue on the sides and front of the machine. -There was brown dust accumulated on the	D 282		

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gaskets of the vent cover and the vent cover was held on with 2 pieces of beige masking tape.
-There were black smudge marks around the interior lip of the ice machine.

Observation of the dry goods storage area on 09/06/18 at 10:30am revealed the area of the wall around the light switch had several brown stains.

Interview with the cook on 09/06/18 at 10:35am revealed:
-The dietary staff cleaned the best they could in the kitchen.
-"It was hard keeping the kitchen clean and prepare the food for the entire facility with only 2 staff working."
-There was a weekly schedule for cleaning the kitchen that staff was supposed to go by.
-The weekly cleaning sheet schedules were kept in a book in the kitchen.
-Staff initialed the sheet after tasks were completed.
-The oven was last cleaned about two weeks ago and staff tried to wipe down the exterior of the stove every day.
-She wiped down around the interior edge and the exterior of the ice machine at least once a day
-She did not clean the vent cover and she did not know how long the masking tape had been on the ice machine.
-The storage racks for the cups and glasses were old and had some rust.

Observation in the C Hall dining room on 09/06/18 at 11:45am revealed:
-Two of four walls had scattered brown and black stains to lower third of the walls above the baseboard.
-The floor of the dining room had scattered black and brown stains.

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D 282	Continued From page 24 Interview with the medication aide on 09/06/18 at 11:55am revealed: -The medication aides and personal care aides cleaned the tables and the dishes in the dining room on the C Hall. -She had not noticed any problems with stains on the walls in the dining room. -The housekeeping staff were in charge of keeping the walls and the floors clean. -The housekeeping staff mopped the floors after each meal. -She did not know how often the walls were cleaned. Telephone interview with housekeeping staff on 09/12/18 at 10:15am revealed: -The housekeeping staff who worked on the C Hall mopped the floor after breakfast and lunch. -She was not sure about who cleaned the floor after supper. -The housekeeping staff who worked on the C Hall were responsible to clean the walls in the C Hall dining room. Observation of the refrigerator in the Special Care Unit (SCU) on 09/10/18 at 3:10pm revealed: -There was a sign posted on the outside of the refrigerator that read "11-7 need to clean the refrigerator out weekly on Monday" dated 05/27/17. -There were brown stains on the second shelf and in the bottom of the refrigerator. -There were brown stain and brown drip mark stains around the inside bottom gasket and bottom vent area. Interview with the Special Care Unit Coordinator (SCC) on 09/10/18 at 3:10pm revealed: -The sign posted on the refrigerator was old.	D 282		

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D 282	Continued From page 25 -The refrigerator was usually cleaned on Thursdays by the third shift staff. -She was not sure the last time the refrigerator was cleaned or who was responsible for cleaning the refrigerator. -She had not noticed the stains inside the refrigerator or torn gasket. -She would report the torn gasket to the Administrator on 09/10/18. Interview with the cook on 09/11/18 at 9:20am revealed: -The dietary staff was not responsible for cleaning the refrigerator in the SCU. -The staff in the SCU were supposed to clean the refrigerator in the SCU. Telephone interview with the Administrator on 09/24/18/ at 12:05pm revealed: -The dietary staff had a cleaning schedule and they knew what needed to be cleaned in the kitchen every day. -The dietary staff was expected to wipe down the walls in the kitchen and dining room of A Hall every day. -The outside and inside cover of the ice machine were supposed to be wiped daily and as needed. -The stove and oven were cleaned daily and "any burned stains must be from a spill". -Deep cleaning of the oven was done weekly. -The metal racks for the cup storage were old and no one had reported any problems with rust stains on the racks. -She did not know how old the metal storage racks were. -She was not aware of any issues with the cleanliness of the refrigerator in the SCU. -She checked the cleanliness of the kitchen and the dining rooms often but did not specify how often she checked those areas.	D 282		

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D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to label open food items with contents and date in the refrigerator in the Special Care Unit. The findings are: Observation of the refrigerator in the Special Care Unit (SCU) on 09/10/18 at 3:10pm revealed: -On the top shelf of the side door of the refrigerator, there was one quart of prune juice, one 20 ounce bottle of barbecue sauce, and one 20 ounce bottle of mustard that were all opened, and not dated when they were opened. -On the top shelf of the refrigerator, there was a two pound package of unwrapped sliced cheese that had been ripped opened and exposed. -There was a clear container with several half ham sandwiches individually wrapped that were not dated. -On the second shelf of the refrigerator, there was a gallon container half filled with a red liquid and an opened 26 ounce container of salt that was not dated when opened. -On the third shelf of the refrigerator, there was a twelve ounce opened package of oatmeal raisin cookies that sat on top of a plastic container that contained chocolate chip cookies and the container was not dated.	D 283		

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D 283	Continued From page 27 Interview with the Special Care Unit Coordinator (SCC) on 09/10/18 at 3:10pm revealed: -She didn't know anything about the open items in the refrigerator. -The dietary staff usually brought over whatever the residents needed and put it in the refrigerator. -The staff was supposed to send back whatever was not used to the kitchen. -She did not know how long the sandwiches or cookies had been in the refrigerator. Second observation of the refrigerator in the SCU on 09/11/18 at 8:10am revealed: -On the top shelf of the side door of the refrigerator, there was still one quart of prune juice, one 20 ounce bottle of barbecue sauce, and one20 ounce bottle of mustard that were all opened, not dated when they were opened. -On the top shelf of the refrigerator, there was a still a two pound package of unwrapped sliced cheese that had been ripped opened and exposed. -There was a clear container with several half ham sandwiches individually wrapped that were not dated, a tied-up white plastic bag that contained bottles of water, and a tied up gray plastic bag that contained a white foam covered plate. -On the second shelf of the refrigerator, there was a gallon container one-third filled with a red liquid that was undated and clear plastic bag that contained a white foam covered plate, with a red liquid spilled inside of it that was unlabeled and undated. -On the third shelf of the refrigerator, there was an opened 26 ounce container of salt that was not dated, an opened 12 ounce package of oatmeal raisin cookies that sat on top of plastic container with that still contained chocolate chip cookies in a container that was not dated.	D 283		

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D 283	Continued From page 28 -A label on the top of the container red "B Hall - Don't leave on B Hall". Interview with a medication aide on 09/11/18 at 8:55am revealed: -The prune juice in the refrigerator was being used for a resident in the SCU. -She did not know how long the prune juice had been opened. -Staff just probably forgot to label it when it was opened. -The cheese, mustard, barbecue sauce, and salt had been in the refrigerator for about a month since the staff had a cookout for the SCU residents. -Staff just forgot the items were in the refrigerator. -The sandwiches were probably from last night but she was not sure since there was no date on them. -The cookies were just opened last night and staff forgot to take the container back to the kitchen. -The foam trays in the plastic bags probably belonged to staff. -Staff sometimes kept their food in the SCU refrigerator because there was no other refrigerator in the SCU for staff to use. Interview with the cook on 09/11/18 at 9:20am revealed: -The dietary staff were responsible for labeling items in the refrigerators. -Dietary staff may have forgotten a few items. -She did not know about the leftover juice, cheese, barbecue sauce, mustard, and sandwiches that had been left in the SCU. -The dietary staff usually brought the food from the kitchen and the SCU staff served it to the residents. -The SCU staff was supposed to send back anything that is not used to the kitchen.	D 283		

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D 283	Continued From page 29 Telephone interview with the Administrator on 09/24/18/ at 12:05pm revealed: -She did not know food items were not labeled in the refrigerator in the SCU. -She did not know staff sometimes used the SCU refrigerator to store their personal food items with the resident food items.	D 283		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were treated with respect and dignity and resided in an environment free of verbal, physical, mental and emotional abuse and threats of retaliation for communicating complaints. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure all residents were free of verbal and physical abuse by three direct care staff, a housekeeper, the Resident Care Coordinator and the Administrator; for 4 of 9 sampled residents (#1, #3, #8 and #9) by being	D 338		

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D 338	Continued From page 30 placed on the special care unit in lieu of supervision (#3 and #8), staff taking and withholding food and drink (#1 and #9) and staff taking a resident's personal cellular phone (#3). [Refer to Tag 914 G.S. 131D-21(4) Residents' Rights (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to allow Resident #3 to exercise the right to chose her transportation to and from medical appointments because she was in the special care unit. [Refer to Tag 921 G.S. 131D-21(1) Residents' Rights (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled residents (Residents' #1 and #3) were free to voice concerns and complaints about care and services at the facility without retaliation as evidenced by a discharge notice given Resident #3 on 08/13/18 following a dispute with family members on 08/10/18 and threats to discharge Resident #1 if he complained or talked to the "state". [Refer to Tag 911 G.S. 131D-21(11) Residents' Rights (Type B Violation)].	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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This Rule is not met as evidenced by:
Based on observation, record reviews, and interviews, the facility failed to verify an electronic medication order for 1 of 5 sampled residents (#2) which resulted in staff administering Levemir without a physician's order.

The findings are:

Review of Resident #2's current FL-2 dated 06/01/18 revealed diagnoses included osteoarthritis, schizoaffective disorder, Vitamin D deficiency, hypertension, and chronic kidney disease.

Interview with Resident #2 on 09/05/18 at 1:25pm revealed:
-She had just started taking insulin injections this morning.
-She did not know the name of the insulin and she was surprised when the medication aide (MA) gave her the insulin on 09/05/18.
-Resident #2 did not know how much insulin she was given by the MA.
-She felt fine since the insulin injection.
-She had elevated blood sugar readings in the past and "maybe the doctor thought it was time for me to start on some insulin".
-The MA had checked Resident #2's blood sugar a few times on 09/05/18.
-Resident #2 was not sure how often she was supposed to get blood sugar fingersticks.

Review of Resident #2's progress note dated 09/05/18 revealed:
-The Resident Care Coordinator (RCC) was informed by the MA that Resident #2 had a new order for Levemir 100 units/ml - inject 32 units

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subcutaneously every morning (Levemir is an insulin used to treat diabetes).
-The RCC called the pharmacy regarding the medication order for Levemir at 8:40am on 09/05/18.
-The RCC spoke with the pharmacist and it was discovered the order for Levemir was sent for Resident #2 in error (A pharmacist had entered the medication order in error meant for another person outside of the facility).
-The pharmacist advised the RCC to notify Resident #2's physician about the Levemir administration to Resident #2.
-The RCC called Resident #2's physician at 8:55am and the physician was advised of the medication error.
-A physician's order was given to check Resident #2's blood sugar once every hour and to send Resident #2 to the emergency room if her blood sugar readings dropped below 100.
-Staff was supposed to make sure Resident #2 ate.

Review of Resident #2's September 2018 electronic medication administration record (eMAR) revealed:
-There was computer generated entry for Levemir 100 units/ml - inject 32 units subcutaneously every morning for diabetes mellitus scheduled for 8:00am (Levemir is an insulin used to treat diabetes).
-The 8:00am dose of Levemir 100 units/ml - 32 units was documented as administered on 09/05/18.
-Levemir 100 units/ml was documented as discontinued on 09/06/18.
-Hourly blood sugar readings ranged from 140 to 193 on 09/05/18.

Review of a medication error report for Resident

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D 358	Continued From page 33 #2 dated 09/05/18 revealed: -Levemir 32 units subcutaneously every morning was entered, verified, filled, and administered to the wrong patient. -Steps taken to correct the error included the pharmacy and facility to verify there was an order prior to verifying or administering any medications. -Actions taken to prevent the error from occurring again included notation to follow procedures in place to verify medications prior to dispensing and administering. -The report was signed by a pharmacist. Interview with the facility's pharmacist on 09/11/18 at 11:55am revealed: -The pharmacist had put the Levemir order in by mistake for Resident #2 on 09/04/18. -The insulin was sent to the facility with evening batch of medications on 09/04/18. -The medication order was meant for another person outside of the facility. Review of the facility's medication administration policy revealed: -Medications are administered in accordance with the written orders of the physician. -If a medication order seems to be unrelated to current condition or diagnosis, the MA calls the pharmacy for clarification prior to the administration of the medication. -The facility did not have a written policy that addressed new medication orders and the eMAR. Interview with a MA on 09/07/18 at 1:45pm revealed: -The MA were not supposed to administer medications unless the physician's orders for the medication were verified. -The RCC or Special Care Coordinator (SCC)	D 358		

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usually verified the medications orders as they came from physician's offices and the pharmacy.
-Sometimes, the MAs had to verify the medications orders when the RCC or the SCC were not in the building.
-If staff was unsure about a medication order, they were supposed to contact the RCC or SCC, pharmacy, or physician's office to clarify the order before administering the medication.

Interview with the Administrator on 09/07/18 at 3:55pm revealed:
-She was aware of the medication error with Resident #2 and the insulin on 09/05/18.
-"It had already been handled and it really was not that big of deal."
-It was the pharmacy's fault because they put in the wrong orders for Resident #2.
-She did not know who verified the Levemir order from the pharmacy to the eMAR.

Interview with a second MA on 09/11/18 at 8:55am revealed:
-She administered the Levemir injection to Resident #2 on the morning of 09/05/18.
-She did not check the medication order for Resident #2; she just gave the Levemir because the medication order had already been verified.
-Medication orders from the pharmacy had to be verified by the RCC, SCC, or a MA before it goes on the resident's eMAR.
-She did not know who verified the Levemir order or when it was verified.
-She did not think the medication order was strange until after she had already given the insulin to Resident #2.
-She went to the RCC about the Levemir order after she gave Levemir injection on 09/05/18.
-The RCC could not find the medication order for the Levemir in Resident #2's physician's orders

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and called the pharmacy.
-The pharmacist said Levemir order was put in for Resident #2 by mistake at the pharmacy.
-The pharmacist advised the RCC to call Resident #2's physician regarding the Levemir administration.
-Resident #2's physician gave an order to check Resident #2's blood sugar every hour for 09/05/18, send Resident #2 to the emergency room if her blood sugar dropped below 100, and make sure Resident #2 ate.

Interview with the RCC on 09/11/18 at 4:15pm revealed:
-She didn't know about the problem with the Levemir order until the MA after the MA had already given the Levemir to Resident #2 on 09/05/18.
-She could not remember a new order for Levemir coming from the physician's office for Resident #2 and she could not find a new order for Levemir on her desk or in Resident #2's physician's orders.
-She called the pharmacy to check if the order may have been faxed directly from the physician's office.
-The lead pharmacist said the Levemir order for Resident #2 had been put in by mistake at the pharmacy and advised her to call Resident #2's physician.
-She did notify Resident #2's physician and staff had to check Resident #2's blood sugar every hours for the rest of the day on 09/05/18.
-The medication error with Levemir for Resident #2 was the pharmacy's fault because they sent the order and the medication.
-When new medication orders come in from the pharmacy or the physician's office, the RCC, SCC, or MA are supposed to verify the medication orders exists prior to authorizing them

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D 358	Continued From page 36 to the eMAR. -If the medication orders are from the pharmacy, staff should call the pharmacy to verify the medication order. -All the MAs knew medication orders had to be verified before the medication orders were sent to the eMARs. -The Levemir order for Resident # 2 came in during 3rd shift on 09/04/18 and MA authorized the Levemir order from the pharmacy. -The Levemir was then authorized to be placed on the eMAR for Resident #2. -She did not know if the MA verified the Levemir order for Resident #2 with the pharmacy on 09/04/18. Interview with a third MA on 09/11/18 at 4:25pm revealed: -She was the medication aide who authorized the Levemir order that came from the pharmacy on 3rd shift on 09/04/18. -The Levemir order was pending in their eMAR system and she authorized the Levemir order without checking with the pharmacy to verify there was a physician's order for Levemir. -Staff did not double check with the RCC, SCC, or MD to verify medication orders when they came from the pharmacy. -"When it comes to stuff like that, we just approve it because it comes from the pharmacy."	D 358		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the	D 454		

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following, unless the resident or his responsible person or contact person objects to such notification:
(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the guardian for one resident (#5) who eloped from the Special Care Unit; had an unwitnessed fall with a head injury that required an emergency room visit; and had another unwitnessed fall with a questionable injury that did not require emergency room treatment.

The findings are:

Review of Resident #5's current FL-2 dated 04/11/18 revealed:
-Diagnoses included dementia with behavioral disturbances, major depressive disorder, hypertension, and hypothyroidism.
-Resident #5 was intermittently confused and

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D 454	Continued From page 38 ambulatory. Review of the Resident Register for Resident #5 revealed: -Resident #5 was admitted to the facility on 04/12/18. -Resident #5's legal guardian was the department of social services in another county. Review of Resident #5's progress note dated 06/08/18 revealed: -Resident #5 activated a fire alarm in the Special Care Unit (SCU) so the doors of the SCU would unlock during the third shift. -Resident #5 got out the door of the SCU; walked approximately 25 feet; and attempted to go out the front door of the facility. -Staff locked the front door of the facility so Resident #5 could not get out. -There was no documentation Resident #5's guardian was notified of Resident #5's elopement from the SCU on 06/08/18. Telephone interview with Resident #5's legal guardian on 09/11/18 at 11:17am revealed: -Her county department of social services was the appointed legal guardian for Resident #5. -She did not know Resident #5 had eloped outside of the Special Care Unit on 06/08/18. -She did not see any record the facility had notified the legal guardian. -It was her expectation for the staff to notify her of all attempted elopements within 24 to 48 hours of their occurrence. Telephone interview with previous Special Care Coordinator (SCC) on 09/20/18 at 11:57am revealed: -She had called Resident #5's guardian about the resident getting outside the SCU door.	D 454		

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D 454	Continued From page 39 -She could not verify when she notified Resident #5's guardian regarding 06/08/18. -She was not sure if she documented calling Resident #5's guardian in resident's progress notes. -The SCC was responsible to notify SCU resident's guardians and family members when any injuries or incidents occurred as soon possible. Review of a progress note for Resident #5 dated 06/30/18 revealed: -Resident #5 was lying on her bed at lunch time with bowel movement all over her body, floor, and bed. -Staff noted Resident #5 had a knot on the left side of her forehead when they were cleaning her up. -Resident #5 was sent to the ER at 1:13pm after the on-call physician was notified. -There was no documentation Resident #5's guardian was notified that Resident #5 was sent to the ER on 06/30/18. Review of Resident #5's accident incident reports revealed there was no report dated 06/30/18. Telephone interview with Resident #5's legal guardian on 09/11/18 at 11:17am revealed: -Her county department of social services was the appointed legal guardian for Resident #5. -She did not know Resident #5 had an unwitnessed fall that resulted in a head injury that required an ER visit on 06/30/18. -She did not see any record the facility had notified the legal guardian. -It was her expectation for the staff to notify her of all injuries, falls, and emergency room visits within 24 to 48 hours of their occurrence.	D 454		

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Telephone interview with previous Special Care Coordinator (SCC) on 09/20/18 at 11:57am revealed:
-Staff had called Resident #5's guardian on 06/30/18 because Resident #5 was sent to the hospital.
-It may not have been documented in Resident #5's progress notes regarding the communication.
-The SCC or the MA always notified any resident's guardian or family member when a resident was sent to the emergency room.

Review of a progress note for Resident #5 dated for 07/20/18 during the 3:00pm-11:00pm shift revealed:
-Resident #5 was found on the floor holding her head (location not specified).
-The MA did not take any vital signs because of fear of possible "head damage".
-The MA called Resident #5's physician and was advised to "closely observe" Resident #5 and "to call back if any changes occur".
-Resident #5 was observed from 5:40pm until 7:10pm and "seemed normal".
-Resident #5 went to sleep at 7:10pm.
-There was no documentation Resident #5's guardian was notified of Resident #5's unwitnessed fall and possible head injury on 07/20/18.

Review of Resident #5's accident incident reports revealed there was no report dated 07/20/18.

Telephone interview with Resident #5's legal guardian on 09/11/18 at 11:17am revealed:
-Her county department of social services was the appointed legal guardian for Resident #5.
-She did not know Resident #5 had a second unwitnessed fall with a questionable head injury

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D 454	Continued From page 41	D 454		

without an ER visit on 07/20/18.
-She did not see any record the facility had notified the legal guardian.
-It was her expectation for the staff to notify her of all injuries and falls within 24 to 48 hours of their occurrence.

Interview on the medication aide (MA) on 09/13/18 at 3:55pm revealed:
-She was in charge of taking care of Resident #5 on the evening of 07/20/18.
-She called the physician but she did not call the Resident #5's guardian because she was not sure if Resident #5 had fallen and injured.
-She observed Resident #5 as the physician ordered and Resident #5 looked alright.
-She did not call the Resident #5's guardian because Resident #5 was not sent to the ER.
-She could not recall if she completed an incident/accident report for Resident #5 for 07/20/18.

Interview on the Administrator on 09/10/18 at 10:30am revealed:
-All events and contacts for residents' guardians or family members were documented in the residents' notes.
-The Special Care Unit Coordinator (SCC) and the MAs in the SCU were responsible to notify the guardians and the family members for all accidents or ER visits.
-She was not sure what happened with other dates except there had been a change with the SCC.
-She was sure the previous SCC had notified Resident #5's guardian about the ER visit and Resident #5's behavior in June if it was documented in Resident #5's notes.

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D 462	Continued From page 42	D 462		
D 462	10A NCAC 13F .1305 Special Care Unit Policies And Procedures 10A NCAC 13F .1305 Special Care Unit Polices And Procedures The facility shall assure that special care unit policies and procedures are established, implemented by staff and available for review within the facility. In addition to all applicable policies and procedures for adult care homes, there shall be policies and procedures that address the following: (1) the philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to, the following: (a) safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications; (b) a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities; (c) individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and (d) methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance; (2) the process and criteria for admission to and discharge from the unit; (3) a description of the special care services offered in the unit; (4) resident assessment and care planning,	D 462		

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D 462	Continued From page 43 including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition; (5) safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior; (6) staffing in the unit; (7) staff training based on the special care needs of the residents; (8) physical environment and design features that address the needs of the residents; (9) activity plans based on personal preferences and needs of the residents; (10) opportunity for involvement of families in resident care and the availability of family support programs; and (11) additional costs and fees for the special care provided. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to establish policies and procedures specific to the admission criteria and process, resident assessment and care planning including the opportunity for family involvement and safety measures addressing dementia specific dangers for the special care unit. The findings are: Observations on the special care unit (SCU) on 09/05/18 from 11:50am until 12:05pm revealed: -There were three staff on the SCU which included a personal care aide (PCA), medication aide (MA) and Special Care Coordinator (SCC). -There were 13 residents in the dining room for the lunch meal.	D 462		

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D 462	Continued From page 44 Interview with the SCC on 09/05/18 at 11:55am revealed: -She had been in the SCC position for approximately one month and prior to that worked as a MA in the SCU and on the assisted living (AL) side for three years. -She was still in the process of learning the routine and procedures for the SCU. Telephone interview with a family member on 09/07/18 at 10:05am revealed Resident #3 was placed on the SCU in May 2018 and no one had ever explained any of the rules or how things worked for the SCU to the family members and Resident #3's guardian. Telephone interview with Resident #3's guardian on 09/07/18 at 1:00pm revealed no one at the facility had explained policies and procedures specific to the SCU including admission, discharge and transportation to and from appointments. Review of an undated document titled "Special Care Unit for Alzheimer and Related Disorders" revealed the document was a copy of state rules and regulations for SCUs. Telephone interview with the Administrator on 09/24/18 at 11:58am revealed: -She was aware of the state rules and regulations specific to SCUs. -The facility's SCU policy and procedure addressed concerns specific to the admission of residents to the SCU and management of dementia specific behaviors. -The document titled "Special Care Unit for Alzheimer and Related Disorders" was one of two policies and procedures for the SCU.	D 462		

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D 462	Continued From page 45 -She must have provided the wrong policy and procedure for the SCU; she would provide a copy of the SCU policy and procedure. Upon request the facility's second copy of policies and procedures for the SCU was not available for review.	D 462		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure special care unit (SCU) policies, procedures and disclosure information were provided to the family members	D 463		

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D 463	Continued From page 46 of 1 of 3 sampled residents (#3) admitted to the SCU. The findings are: Review of Resident #3's current FL-2 dated 05/29/18 revealed: -There was a hand written "X" next to domiciliary (rest home) under recommended level of care. -There was a hand written "X" next to other and "SCU" hand written after other, under recommended level of care. -Diagnoses included Alzheimer's dementia with behavioral disturbances, schizophrenia, osteoarthritis, type 2 diabetes mellitus and hypertension. Review of Resident #3's current FL-2 dated 05/29/18 from Resident #3's physician's office revealed: -There was a typed "X" next to domiciliary (rest home) under current level of care. -There was no marking under recommended level of care. -Diagnoses included Alzheimer's dementia with behavioral disturbances, schizophrenia, osteoarthritis, type 2 diabetes mellitus and hypertension. Review of progress note dated 05/30/18 for Resident #3 revealed on 05/30/18 (no time) the former Special Care Coordinator (SCC) documented Resident #3's belongings were transferred to the SCU on 05/30/18. Review of Resident #3's "Alzheimer's Pre-Admission Screening Form" dated 05/30/18 revealed the form had been signed by the former SCC and initialed by the Administrator.	D 463		

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D 463	Continued From page 47 Observations on the special care unit (SCU) on 09/05/18 from 11:50am until 12:05pm revealed there were 13 residents in the dining room for the lunch meal including Resident #3. Interview with the SCC on 09/05/18 at 11:55am revealed she had been in the SCC position for approximately one month and was still in the process of learning the routine and procedures for the SCU. Interview with Resident #3 on 09/05/18 at 12:15pm revealed staff had brought her to this room last month (August 2018) and moved her over here (SCU) in May (2018), because she was trying to leave the facility to go see a family member. Review of a Special Care Unit Disclosure for Resident #3 revealed the form was signed by the resident's guardian and the Administrator on 05/30/18. Telephone interview with a family member on 09/07/18 at 10:05am revealed Resident #3 was placed on the SCU in May 2018 and no one had ever explained any of the rules or how things worked for the SCU to the family members and Resident #3's guardian. Telephone interview with Resident #3's guardian on 09/07/18 at 1:00pm revealed: -She never signed anything and never gave permission for Resident #3 to be put on the SCU when she was admitted to the SCU in May 2018. -No one at the facility had explained policies and procedures specific to the SCU including admission, discharge and transportation to and from appointments.	D 463		

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D 463	Continued From page 48 Interview with a family member on 09/10/18 at 10:20am revealed: -None of the family members "gave permission or signed anything about (Resident #3) being in the back (SCU)." -None of the family members signed a disclosure statement or went for a meeting for Resident #3 to be placed in the SCU in May 2018. -The Administrator said Resident #3 was put on the SCU for her safety. Telephone interview with the former SCC on 09/10/18 at 3:28pm revealed: -Resident #3 had already been placed on the SCU at the end of May 2018, when she came to work, so she did not know the exact day she was admitted or the reason. -It would have been a Monday that she came to work and Resident #3 would have been placed on the SCU sometime between Friday evening and Sunday night. -The paper work for admission to the SCU was already in Resident #3's record. -She did not know when the family had been notified of Resident #3's admission to the SCU. Telephone interview with Resident #3's physician's nurse on 09/10/18 at 4:30pm revealed: -Resident #3's doctor never gave an order to place Resident #3 on the SCU. -The FL-2 on 05/29/18 was completed to place Resident #3 at another facility; there was nothing marked on Resident #3's 05/29/18 FL-2 for placement in the SCU. -The doctor's office kept scanned copies of all signed documents and orders for the facility. -She spoke with Resident #3's doctor on 09/10/18, and he never gave an order for Resident #3 to be admitted to the SCU.	D 463		

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-"If anybody put her on the unit (SCU), it was probably for her safety and wellbeing."
-She was not really sure if Resident #3 had a history of wandering away from the facility.
-Resident #3 was always trying to leave the facility and never wanted to go back to the facility.
-There was an occasion where Resident #3 "jumped into to (a family member's) car and would not get out."

Telephone interview with the RCC on 09/13/18 between 9:30am and 11:00am revealed:
-Staff could not just decide to put a resident in the SCU, the staff would have to contact the RCC or the Administrator.
-The RCC or the SCC filled out the FL-2 on the computer for residents, then send it to the doctor's office for the doctor to sign and then the doctor's office sends the FL-2 back once the doctor has signed the FL-2.
-She had completed Resident #3's FL-2 dated 05/29/18, but the SCC had added the hand written entries ("X" next to other and "SCU" after other, under recommended level of care) after the doctor signed the FL-2.
-Staff had had conversations with Resident #3's family members and the resident's doctor more than once about Resident #3 going to the SCU; "I know it looks like we just threw that woman back there, but we didn't."

Telephone interview with the Administrator on 09/24/18 at 11:58am revealed:
-Resident #3 was admitted to the SCU on 05/30/18.
-Every resident had an FL-2; if a resident had a diagnosis of Alzheimer's or Parkinson's then the resident was placed in the SCU.
-"Placement in the SCU was based on diagnosis."

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D 463	Continued From page 50 -If a family member called about a person who had a diagnosis of Alzheimer's and behaviors, she would tell the family member we would have to get an FL-2. -The pre-screening was done when she went to wherever the resident was and did an assessment of the resident and the doctor completed the FL-2. -The diagnosis was based on whatever symptoms the person had to get the diagnosis; the doctor usually already had notes about symptoms. -For residents on the assisted living (AL) side moving to the SCU the process was she would ask the doctor if the resident needed a locked unit. -Changes in behavior were determined by the doctor based on the facility staff reporting their observations to the doctor. -The doctor completed a new FL-2 and the resident was then placed in the SCU. -The family members are contacted along with the doctor; usually when there are mental status changes the RCC was talking to the doctor and the family. -Consent for admission to the SCU from the family member was usually verbal. -Paperwork like the disclosure statement were completed at the time of admission to the SCU or a day or two later. -Completion of the SCU admission paperwork depended on when the family member was able to come in to sign. -She was aware of the state rules and regulations specific to SCUs. -Resident #3 was admitted to the SCU on 05/30/18.	D 463		

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D911	Continued From page 51	D911		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to allow Resident #3 to exercise the right to chose her transportation to and from medical appointments because she was in the special care unit. The findings are: Review of Resident #3's current FL-2 dated 05/29/18 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbances, schizophrenia, osteoarthritis, type 2 diabetes mellitus and hypertension. -.Resident #3 was ambulatory with a walker. Review of Resident #3's current care plan dated 07/06/18 revealed Resident #3 was ambulatory with a walker and required supervision with transfers and ambulation. Review of progress notes dated 08/09/18 (no times) for Resident #3 revealed: -The Special Care Coordinator (SCC) documented that Resident #3 had an appointment scheduled with her doctor at 3:00pm and the resident's guardian would be there to take Resident #3 to the appointment.	D911		

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D911	Continued From page 52 -The SCC documented that Resident #3 had scheduled her own doctor's appointment and a family member was taking the resident to the appointment. -Resident #3's guardian was contacted and wanted to attend the doctor's appointment. -The SCC rescheduled the appointment and explained to Resident #3 that in order for her to keep her transportation services she need to ride (name of ambulance service) for transportation. -The resident stated she did not want to ride (name of ambulance service) and had her own ride. -Resident #3 then called 911 and a sheriff came out to speak with her; Resident #3 continued swearing and yelling after the sheriff left. Review of a progress note dated 08/10/18 (no time) for Resident #3 revealed: -The SCC documented Resident #3's family came to speak with the SCC; the resident's guardian initiated the conversation regarding misunderstanding with how transportation worked. -Resident #3 "was not being held captive as used by the family." -The SCC explained to the family if Resident #3 was transported to appointments by a person other than (name of ambulance service), she would lose transportation services. Telephone interview with a family member of Resident #3 on 09/07/18 at 10:05am revealed: -Another family member went to pick Resident #3 up from the facility for a doctor's appointment on 08/10/18 while Resident #3's guardian waited at the resident's doctor's office. -Staff at the facility would not let Resident #3 leave with the other family member. -The family member went to the facility to see	D911		

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D911	Continued From page 53 what was going on and was told Resident #3 had to use (name of ambulance service) because there was a contract for (name of ambulance service) to take residents from the SCU to their doctor's appointments. -The family members were upset because "no one had informed them of the rules for back there (SCU)." -The family was supposed to meet with the Administrator about the rules on the SCU the week of 08/13/18, but the Administrator never called. -The Administrator "sent a letter to have a meeting and that we had 30 days to get (name of Resident #3) out of the facility." Interview with the SCC on 09/11/18 at 11:55am revealed: -All except one resident on the SCU were transported to their appointments using the ambulance service; one resident did not use the service because he was a veteran. -She had been instructed on use of the ambulance service for all SCU residents by the Resident Care Coordinator (RCC). -She was not sure of the process and if residents had to sign up for the service or if the service was automatic for being in the SCU. -She only knew that if a resident was supposed to utilize the ambulance transport service and the resident had someone else transport them to their appointment, then the resident might lose the ambulance transport service to go to and from appointments. -On 08/10/18, Resident #3's guardian came to her and wanted to discuss the rules on the SCU verses the rules on the assisted living (AL) side. -The SCC was explaining the transportation rules when another family member came in and was loud and belligerent.	D911		

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D911	Continued From page 54 -The RCC asked the family to leave and the family did leave. -She did not know if the differences between the AL side and SCU had been explained to the family members prior to Resident #3 being admitted to the SCU. -That was the first incident like that since Resident #3 had been on the SCU (05/30/18). -Resident #3 had been on the AL side prior to that and was used to scheduling her own doctor's appointments and having a family member pick her up. Telephone interview with a DSS worker on 09/11/18 at 2:26pm revealed: -She was never aware the facility was using an ambulance service for transport of residents to and from appointments until a family member of a resident had questioned her about it. -She had spoken with the Administrator at the time the family member brought the concern to her and the Administrator informed her that all of the SCU residents had to use the ambulance service. Interview with the RCC on 09/11/18 at 3:43pm revealed: -The ambulance transport service was not required; there were two residents on the SCU that did not use the service. -Some residents were on the ambulance transport service because they were wanderers. -The SCC was responsible for determining whether or not a resident on the SCU needed the ambulance transport service. -She did not know the SCC's process for determining a resident's need, contacting the family and initiating the ambulance service. -She was responsible for establishing the ambulance transport service on the AL side.	D911		

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D911	Continued From page 55 Interview with the Administrator on 09/11/18 at 3:27pm revealed: -Residents on the SCU were required to use the ambulance service for all of their appointments because some residents were blind, in a wheelchair or staff were not able to get them into the facility van. -Before the ambulance service was started, the RCC went over the ambulance service with the family members, then the ambulance service came out to the facility and conducted an assessment of the resident; this process had been done with Resident #3's family. -Once a resident had an appointment scheduled, the appointment was noted on the calendar and the ambulance service was notified for residents on the SCU and the facility van was used for the AL side. -Family members were allowed to take residents to their appointments. -Regarding the incident documented on 08/10/18 in the progress notes for Resident #3, the Administrator responded, "How many times had (Resident #3) made an appointment?" -She had no idea why the family would have been so upset since the rules about the ambulance service had been explained prior to initiating the service. The failure of the facility to respect Resident #3's individuality for transportation to medical appointments resulted in the resident's agitation, missed appointment and threat of discharge from the facility. This failure to treat Resident #3 with respect for individual preferences was detrimental to the resident's health, safety and welfare which constitutes a Type B Violation. The facility provided a plan of protection in	D911		

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D911	Continued From page 56 accordance with G.S. 131D-34 on 09/07/18 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2018.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and implementation of residents' rights. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' right which resulted in significant noncompliance with state rules and regulations related to health care and residents' rights. [Refer to Tag 980 G.S. 131D-25	D912		

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D912	Continued From page 57 Implementation (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up for 1of 5 sampled residents (#2) including referral to urgent care services for uncontrolled arthritic knee pain. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure all residents were free of verbal and physical abuse by three direct care staff, a housekeeper, the Resident Care Coordinator and the Administrator; for 4 of 9 sampled residents (#1, #3, #8 and #9) by being placed on the special care unit in lieu of supervision (#3 and #8), staff taking and withholding food and drink (#1 and #9) and staff taking a resident's personal cellular phone (#3). The findings are: 1. Confidential interview with a family member revealed: -The resident reported to the family member that staff talked "nasty" to her and the family member	D914		

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D914	Continued From page 58	D914		

had heard staff talk "nasty" to the resident.
-It wasn't specific staff, it was all staff that talked nasty.

Confidential interviews with a staff revealed:
-Most of the staff used negative and foul language toward residents every day.
-Staff were afraid to talk about things that happened at the facility and how staff treated residents because the facility was in a small community and staff feared being mistreated in the community.
-Residents at the facility were threatened by all staff including the Administrator and Resident Care Coordinator (RCC).
-Staff would threaten to take away food, snacks, and cigarettes if the resident did not take a shower.
-Staff threatened to put residents on the special care unit if a resident did not stop doing whatever they might be doing such as being at the RCC office or medication room too much.

Confidential interview with a resident revealed:
-A medication aide (MA) and a personal care aide (PCA) had "talked smart" and yelled at the resident several times in the 2 or 3 months.
-The MA and the PCA told the resident that the resident smelled and needed to take a bath.
-The resident complained it made the resident mad the way that the MA and PCA spoke to the resident.
-The PCA talked about the resident's clothes and said the resident didn't know how to dress.
-The PCA made the resident angry several times referring to the style of clothes the resident wears.
-The resident had not complained to the Administrator because the resident was hoping things would work themselves out.

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D914	Continued From page 59 Confidential interview with a second resident revealed the MA and the PCA would "pull (two named residents) by their clothes and snatch them up." Telephone interview with the first named resident on 09/24/18 revealed: -She had left the facility because "the staff got on her nerves." -There were staff that had spoken to her in a "nasty" way and snatched her by her shirt. -She could not remember the name of the staff or what shift the staff worked, "It's been a long time." Attempted interviews with the guardian for the second named resident on 09/07/18 at 9:45am and 09/24/18 at 10:31am, were unsuccessful. Confidential interview with a second family member revealed: -The family member had witnessed the PCA "pull and drag" a third named resident down the hall in the SCU last week (09/03/18). -The PCA told the third named resident "come on" in a demanding and stern tone of voice. Based on observations, interviews and record reviews, it was determined the third named was not interviewable. Interview with the Administrator on 09/07/18 at 12:04pm revealed she was not aware of the MA or the PCA snatching residents by their clothing. Interview with a second MA on 09/11/18 at 3:13pm revealed: -She had never spoken harshly or disrespectful to a resident; she had never grabbed, pulled or dragged a resident.	D914		

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D914	Continued From page 60 -If a resident was being aggressive toward staff she would try to calm the resident down, ask another staff for help or walk away from the resident. Confidential interview with a second resident revealed: -Staff did not treat residents right. -A MA would "pull (residents) by their clothes and snatch them up." Interview with the MA on 09/11/18 at 8:15am revealed: -Whenever a resident was agitated she would try to talk to the resident, but sometimes she would just have to walk away and get out of the resident's way. -A resident might raise their voice and she would have to "bring them back down," speak to them so they would calm down. -She might have to grab a resident and hold them to keep the resident from hitting other residents. -Staff did not drag residents, two staff would each grab the resident by the arm (gestured upper arm) and hold the resident under each arm and walk the resident to their room. Interview with the Administrator on 09/07/18 at 12:04pm revealed she was not aware of the MA snatching residents by their clothing. Confidential interview with the first resident revealed: -The resident complained the Administrator yelled at the resident when the resident asked about their money. -The Administrator could not give the resident a reason why the resident was not getting their monthly funds and the Administrator yelled at the resident last month.	D914		

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D914	Continued From page 61 -A housekeeper raised her voice and threatened the resident. -The housekeeper told the resident, "I kill you, who is going to tell it". -The resident could not specify when the housekeeper said this. -The housekeeper comes into the resident's room like the housekeeper chose to. Confidential interview with a third family member revealed: -As a "punishment (the Administrator) would not give residents their money or make them wait until the end of the month." -The resident only complained about the Administrator, that "she would talk to (residents) mean and blow them off whenever they tried to say something." Interview with the Administrator on 09/11/18 at 3:27pm revealed: -The allegations that she was mean to residents, spoke rudely and disrespectful and used food to threaten residents was "ridiculous" and "a lie". -She did not understand how residents she had done so much for would turn around and say these things about her. Interview with the Administrator on 09/07/18 at 12:04pm revealed: -Staff being mean, rude and disrespectful to residents was a "touchy subject". -She was not aware any staff getting in residents' faces. -She expected staff to treat residents with respect in any situation. -She was at the facility 24/7 to make sure staff was doing what was expected and not being disrespectful to residents. -She did not believe any staff was grabbing,	D914		

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D914	Continued From page 62 snatching or pulling residents. Telephone interview with the Owner on 09/12/18 at 5:52pm revealed: -He had never witnessed any staff grabbing, pulling or dragging residents. -It was news to him that staff in general, including the Administrator, were mean, rude, disrespectful, withheld meals and took residents' personal items. -Residents being placed on the SCU without staff following the proper admission process was "absurd". -He was concerned about the allegations against the MA, the PCA, the second MA and the Administrator and would be at the facility on 09/13/18 to address these issues. 2. Review of Resident #3's current FL-2 dated 05/29/18 revealed diagnoses included Alzheimer's dementia with behavioral disturbances, schizophrenia, osteoarthritis, type 2 diabetes mellitus and hypertension. Review of Resident #3's previous FL-2 dated 04/07/18 revealed diagnoses included schizophrenia, dementia in chronic schizophrenia, osteoarthritis, type 2 diabetes mellitus and hypertension. a. Review of a progress note dated 03/02/18 at 4:33pm for Resident #3 revealed: -The RCC documented contact with Resident #3's family member "in reference to the resident's... phone being taken and put on the cart." -The RCC asked the family member if the family member would like the phone given back to the resident and the family member said no ... until the meeting with the family on Sunday.	D914		

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D914	Continued From page 63 -The family member "thanked staff for what they did to keep (Resident #3) safe." Review of a progress note dated 03/04/18 (no time) for Resident #3 revealed the RCC documented a meeting was held yesterday with Resident #3 and family members about her (the resident's) care/behaviors. Review of progress notes dated 03/02/18 through 09/07/18 for Resident #3 revealed there was no documentation of when Resident #3 was given her phone back. Review of progress notes dated 05/18/18 at 8:00pm for Resident #3 revealed staff documented Resident #3's guardian was asked if the guardian wanted the resident's phone taken because of calls to DSS, the police department and other family members, the guardian said no. Telephone interview with Resident #3's guardian on 09/07/18 at 1:00pm revealed: -The staff at the facility had taken Resident #3's phone because the resident was calling the police all the time saying the staff was trying to hurt her. -The first time the staff took Resident #3's phone the guardian had not given permission. -The guardian could not remember when the staff took Resident #3's phone or details of other incidents where the staff took the resident's phone. Telephone interview with a family member on 09/07/18 at 10:05am revealed: -Resident #3 got agitated and went across the street to call someone to come and help her, so the staff took the resident's phone. -The staff did not call any of the family members before taking Resident #3's phone.	D914		

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D914	Continued From page 64 -The family members had to meet with the staff to get Resident #3's phone back. Interview with a second family member on 09/10/18 at 10:20am revealed: -There was an incident where Resident #3 was in the special care unit (SCU) and staff had said if the family took Resident #3's phone from her, then she could go back to the assisted living side. -The family member told Resident #3 "just give them the phone," and had gotten the phone from Resident #3. -Staff then said it was too late because the Administrator had made up her mind and Resident #3 was staying on the SCU. -The family member could not remember which incident that was and when it happened. Telephone interview with the RCC on 09/13/18 between 9:30am and 11:00am revealed: -She could not recall the details of 03/02/18 and Resident #3 "going across the street" from the facility. -Resident #3's family members, including the guardian, came to the facility and the resident's phone was on the medication cart. -The guardian gave permission for staff to keep Resident #3's phone on the medication cart for 14 days. Interview with the Administrator on 09/07/18 at 12:04pm revealed: -She did not think Resident #3' phone had been taken on 03/02/18. -Resident #3 usually had a phone and used it to call a family member. -She did not know if Resident #3 had dropped the phone or what happened. -The RCC wrote the note and would know what happened with Resident #3's phone.	D914		

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D914	Continued From page 65 b. Confidential interview with staff revealed: -Resident #3 was on the SCU because she was "irate". -Resident #3's family members were not in agreement with Resident #3 being on the SCU, "it was forced on them." -There were a lot of residents that were placed "back there for all kinds of reasons" including being at the Resident Care Coordinator's (RCC's) office saying the same thing over and over again and being agitated. Review of a progress note dated 03/02/18 (no time) for Resident #3 revealed: -The RCC documented that Resident #3 left the building walking to the neighbor's house; staff went to the neighbor's house to get the resident. -Resident #3 was very upset/agitated and did not want come back to the facility. Resident #3 got in the Administrator's truck and was brought back to the facility; once back, the resident refused to get out of the truck. -Resident #3 began to walk away so the resident was put on the unit (special care unit) for her safety. -Resident #3's guardian was called and informed about the incident. Review of a progress note dated 03/02/18 at 4:33pm for Resident #3 revealed: -The RCC documented contact with Resident #3's family member "in reference to resident being put on the unit." -The family member said to keep Resident #3 on the unit until the meeting with the family on Sunday (03/04/18). -The family member "thanked staff for what they did to keep (Resident #3) safe."	D914		

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D914	Continued From page 66 Review of a progress note dated 03/04/18 (no time) for Resident #3 revealed the RCC documented a meeting was held yesterday (Saturday, 03/03/18) with Resident #3 and family members about her (the resident's) care/behaviors. Telephone interview with a family member on 09/07/18 at 10:05am revealed: -Resident #3 had several family members who visited her at the facility daily and assisted with transportation to and from appointments. -There was an instance where a family was at the facility to take Resident #3 to a doctor's appointment and the Administrator told staff not let Resident #3 leave. -They (staff) did not really explain to Resident #3 why she could not leave the facility with her family member. -It was how the staff stopped her (Resident #3) from leaving with her family member that got Resident #3 upset. -Resident #3 got agitated and went across the street to call someone to come and help her, so they put her in the Alzheimer's unit. -The staff did not call any of the family members before putting Resident #3 on the SCU. Telephone interview with Resident #3's guardian on 09/07/18 at 1:00pm revealed: -She was not called until after Resident #3 was on the SCU on 03/02/18. -She never signed anything and never gave permission for Resident #3 to be put on the SCU on 03/02/18 or when she was admitted to the SCU in May 2018. -The staff told her the doctor said to put Resident #3 in the SCU for her safety. -Resident #3 used to try to leave with other family members all the time; Resident #3 would call the	D914		

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family members and tell them to come and pick her up.
-She did not want Resident #3 leaving the facility unless the staff called and got the guardian's permission first.
-If the staff were not able to get in touch with her, then the staff were expected to contact the second contact person.
-None of the family members gave permission for Resident #3 to be put on the SCU on 03/02/18.

Interview with the second family member for Resident #3 on 09/10/18 at 10:20am revealed:
-The family member was not aware of any other incidents with Resident #3 leaving the facility except when she went across the street.
-Resident #3 had gone to staff and "asked about the rules and got upset;" Resident #3 went across the street to get some help because she said the "staff were not treating her right."
-She was not sure how long Resident #3 stayed on the SCU on 03/02/18; it may have been a week or just the weekend.
-After the 03/02/18 incident, there was an incident where Resident #3 packed up all of her clothes and sat on her walker in the parking lot, but never left the facility.
-She could not remember when that happened, but thought it was sometime over the summer.
-None of the family members "gave permission or signed anything about (Resident #3) being in the back (SCU)."
-The Administrator said Resident #3 was put on the SCU for her safety.

Telephone interview with the Resident Care Coordinator (RCC) on 09/13/18 between 9:30am and 11:00am revealed:
-She could not recall the details of 03/02/18 and Resident #3 going across the street from the

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D914	Continued From page 68 facility. -She did not remember how she, the former Special Care Coordinator (SCC), the Business Office Manager (BOM), and a medication aide (MA) got across the street to where Resident #3 was. -She got Resident #3 down from the neighbor's porch, someone flagged the Administrator down and Resident #3 got in the Administrator's truck. -Resident #3 did not want to get out of the Administrator's truck once they were back at the facility. -She could not get in touch with Resident #3's guardian so she contacted another family member (not the second contact person). -Resident #3 was still a little agitated once she was back inside of the building; she did not remember which staff walked Resident #3 back inside the SCU. -Resident #3's family members, including the guardian, came to the facility, the family members agreed to keep Resident #3 in the SCU until the meeting on Sunday (03/04/18); Resident #3 went back to the SCU on that Friday (03/02/18) and went back to the assisted living (AL) side on that Sunday (03/04/18). -She could not remember if she called Resident #3's doctor; the resident's doctor's office closed at 4:00pm on Fridays (03/02/18) and she would not have called the on call person. -She could not recall if Resident #3 had walked away from the facility prior to 03/02/18. -Resident #3 called people to come and pick her up all the time; staff had to call and get permission from Resident #3's guardian before the resident could leave. -Other than taking Resident #3 to the SCU, staff had tried talking to the family and different activities, but Resident #3 was "dead set on leaving, she just did not want to be here."	D914		

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D914	Continued From page 69 Review of progress notes dated 03/05/18 through 04/03/18 for Resident #3 revealed: -There was no documentation of when Resident #3 was taken back to the AL side. -There was no documentation of any interventions put in place for Resident #3's safety while on the AL side of the facility. -There was no documentation of contact with Resident #3's physician, Mental Health Provider (MHP) or guardian regarding admission to the SCU for Resident #3's safety. Interview with a MA on 09/11/18 at 8:15am revealed: -She was working on 03/02/18, when Resident #3 went across the street it was about 2:00pm. -Resident #3 came back in the building, called her family members and was calm "out there (AL side)." -Resident #3 was still on the AL side at the end of first shift (3:00pm); and was on the AL side when the MA came back to work the next day (03/03/18); she did not know anything about Resident #3 being on the SCU from 03/02/18 until approximately 03/04/18. -She could not say that staff "did anything differently after that first time (03/02/18)" Resident #3 left the facility; there were no interventions such as increased monitoring due to concern for Resident #3's safety. Telephone interview with the former SCC on 09/10/18 at 3:28pm revealed: -Resident #3 was placed on the SCU 03/02/18 because the resident was calling a taxi and trying to leave the facility. -She could not recall when the family was notified that Resident #3 was placed on the SCU. -She did not remember exactly how long	D914		

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D914	Continued From page 70 Resident #3 stayed on the SCU on 03/02/18; it may have been one day or a weekend. -Resident #3 was admitted to the SCU either on a weekend or on the 11:00pm to 7:00am shift and was back on the AL side before she came in for work on Monday (03/05/18). -The Administrator made the decision when Resident #3 was able to go back to the AL side. Telephone interview with Resident #3's physician's nurse on 09/10/18 at 4:30pm revealed she did not recall speaking with anyone from the facility regarding placing Resident #3 on the SCU on 03/02/18. Interview with the Administrator on 09/07/18 at 12:04pm revealed: -On 03/02/18, Resident #3 got upset because a family member and a friend came to pick the resident up and take her somewhere. -She did not tell Resident #3 that she could not leave; she looked inside the car and there was not enough room for the resident in the car. -She did not know if she had been at the facility or had been called, but Resident #3 was walking across the street. -She, the RCC, BOM, the former SCC and another staff went across the street to get Resident #3, talked to her and told her they were going to call her guardian. -When the staff called her, she drove across the street to get Resident #3; she did not remember Resident #3 getting in her truck, she thought they all walked her back across the street to the facility. -If Resident #3 was in her truck, then she and the staff got her out and walked her back into the facility and at that point Resident #3 was calm. -She was unable to say what specific interventions had been tried before taking	D914		

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Resident #3 to the SCU.
-She alone decided to put (Resident #3) back there (SCU); her main concern was Resident #3's safety.
-Once Resident #3 was on the SCU, her doctor was notified by the RCC.
-She did not know off hand how long Resident #3 was in the SCU after being placed there on 03/02/18, it was probably just for the weekend.
-She did not have a response to how it was decided and who decided that Resident #3 was able to return to the AL side.

Interview with the Administrator on 09/07/18 at 4:30pm revealed:
-There was a doctor's order for Resident #3 to be placed on the SCU on 03/02/18.
-The doctor's order for Resident #3 to be placed on the SCU on 03/02/18 was the FL-2 dated 05/29/18.

Review of a progress note dated 05/01/18 from 3:00pm until 11:00pm for Resident #3
-Staff documented Resident #3 became very agitated that evening and called 911 and the police came.
-Resident #3 was put in the unit (special care unit) for her safety, because she was threatening to leave the facility.
-The MA tried to call the guardian several times and there was no response.

Telephone interview with a second MA on 09/12/18 at 2:04pm revealed:
-She had written the progress note dated 05/01/18 for Resident #3.
-Resident #3 was put on the SCU because she was threatening to leave.
-Resident #3 "went outside and did not want to go back in, so we (staff) put (Resident #3) back

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there for her safety because we could not keep an eye on her."
-"It was late at night, I did not want her to leave and did not want her to just be standing outside. She (Resident #3) was calling around for someone to come and get her when she was outside."
-"I had a hard time getting her back in the building."
-She called the guardian; there were "a lot of times" staff would try to call the family members and would not get any answer.
-In response to being instructed to place residents on the SCU, the MA stated, it was "not expected to put them (residents) on the SCU, but there are some that will try to leave and they need supervision."
-"I try to do what's in their best interest for their safety."
-Resident #3 had tried to leave once or twice before 05/01/18.
-On one occasion Resident #3 tried to leave with a man, the MA was not sure if the man was a family member; she did not remember the date, but that it happened at change of shift from 1st to 2nd shift and the man was saying Resident #3 called for him to pick her up.
-Staff tried other things like going down to Resident #3's room and talking to her, but the resident would say things out of the way like staff was trying to poison her.
-Staff could usually calm Resident #3 down, but the resident would get very aggressive.

Telephone interview with Resident #3's physician's nurse on 09/10/18 at 4:30pm revealed the doctor's office had not been contacted on 05/01/18 regarding placing Resident #3 in the SCU.

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Review of progress notes dated 05/15/18 through 05/30/18 for Resident #3 revealed:
-On 05/15/18 from 3:00pm until 11:00pm staff documented Resident #3 was very agitated today, calling family members and arguing on the phone.
-On 05/18/18 at 7:30pm staff documented Resident #3 got very agitated and wanted to leave the facility.
-Staff called Resident #3's guardian who came to the facility.
-Resident #3 was put in the unit for her safety with permission of the guardian.
-On 05/18/18 from 3:00pm until 11:00pm staff documented Resident #3 said to the police that the facility was holding her against her will and wasn't giving her food, water or medications.

Telephone interview with Resident #3's guardian on 09/20/18 at 12:24pm revealed:
-She only knew of the one occasion (03/02/18) that Resident #3 was put in the SCU for about one week.
-She was not aware Resident #3 was put in the SCU on 05/01/18 or 05/18/18 and did not know how long she was on the SCU on 05/01/18 or 05/18/18.

Telephone interview with a second MA on 09/12/18 at 2:04pm revealed:
-She did not remember Resident #3 leaving the building except one time where she looked outside and saw the resident sitting on her walker in the parking lot with bags of clothes around her; this was the incident the MA had documented on 05/18/18.
-She contacted Resident #3's guardian and the guardian came to the facility; the police came to the facility too.
-Resident #3's guardian and the police officer

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walked with staff and Resident #3 to take Resident #3 to the SCU that night.
-Resident #3 was always calling family members trying to get someone to come and get her so she could leave.
-When Resident #3 wanted to leave and she couldn't, she would get agitated and talk ugly to the staff.

Interview with a third MA on 09/11/18 at 8:15am revealed:
-Resident #3 would sometimes "fuss, holler, get to the door (pointing to the SCU entrance door) and start banging and call the cops."
-"We (staff) just let her be because there was nothing we could do about it."
-"One of the reasons (Resident #3) was over here (on the SCU) was because she kept calling the police;" that was not the only reason, Resident #3 was "in the SCU because she kept trying to leave the building."
-Resident #3 left the building three times; she could not remember the specific of each incident.
-Resident #3 had went over across the street one time and then over there by the road walking.
-Staff would go out and talk to Resident #3, sometimes in the facility van and Resident #3 would get in the van.
-Staff would then call Resident #3's family members and "let them handle it."
-When Resident #3 was outside of the building refusing to come back in, staff would "try and talk her back in."
-Staff tried to engage Resident #3 in activities to distract her, but the resident did not want to do anything.

Telephone interview with the RCC on 09/13/18 between 9:30am and 11:00am revealed:
-She did not recall Resident #3 being put on the

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SCU on 05/01/18 or 05/18/18; the MA may have called the RCC or the Administrator, but she could not remember.
-Staff were not able to just put a resident on the SCU, the staff would have to contact the RCC or the Administrator and if the RCC was contacted the RCC contacted the Administrator who made the final decision.
-If the facility did not have a SCU, staff would have to "do more monitoring and if what the staff was doing was not working, we would call the doctor."

Telephone interview with the Administrator on 09/24/18 at 11:58am revealed:
-She was aware of the rules and regulations specific to SCUs.
-She vaguely remembered Resident #3 being placed on the SCU 05/01/18 and 05/18/18.
-If a resident was upset and trying to run away she was concerned for that resident's safety.
-She "knew the facility was an ALF [sic] and not a prison."
-Resident #3 had a diagnosis of dementia and was having behaviors because she did not want to be at the facility.
-On 03/02/18 she made the determination for Resident #3 to be placed in the SCU; she did not know what happened or who made the determination for Resident #3 to be placed on the SCU on 05/01/18 and 05/18/18.
-She would have to check some notes to see how long Resident #3 was in the SCU on 03/02/18, 05/01/18 and 05/18/18.

Telephone interview with the Owner on 09/12/18 at 5:52pm revealed:
-Staff were expected to complete a proper assessment and get documentation from the doctor that a resident was appropriate for the

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D914	Continued From page 76 SCU. -"If they (staff) were not doing that, well that's just absurd to me." 3. Review of Resident #8's FL-2 dated 01/02/18 revealed: -Diagnoses included hypertension, schizophrenia, and psychotic disorder. -The resident's level of care was domiciliary. Review of Resident #8's Resident Register revealed his admission date was 01/09/15. Interview with Resident #8 on 09/11/18 at 10:35 a.m. revealed: -Staff had locked him in the special care unit (SCU) at least 2 separate times (he did not remember the dates). -The last time staff locked him in the SCU was about a year ago. -Staff locked him in the SCU to calm him down after he and another resident were in a physical altercation. -Staff locked him in the SCU because he had walked to the store. -The Administrator knew staff had been locking him in the SCU both times. -The Administrator said he should not have been in the road. -He should not have been locked on the SCU by staff. -The last time staff locked him on the SCU it was over night. Interview with Resident #8's family member on 9/11/18 at 3:35pm revealed: -The facility never called her to let her know the resident was placed in the SCU. -Staff did inform her (last year) the resident left the facility and walked down the road to the store,	D914		

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but she never knew anything about him being put in the SCU.
-She expected the staff to call her since she was his guardian.

Interview with Resident #8's family member on 09/17/18 revealed:
-Resident #8 had complained numerous times the resident care coordinator (RCC) slammed her office door in his face.
-Whenever the resident walked up to the office door and if she was on the phone, the RCC would walk over to the door and slam it in his face.
-Whenever the family member was talking to Resident #8 on the resident's telephone, which was near the RCC office, a female in the background yelled at Resident #8 to "get off the phone right now". The family member did not know the name of the female.
-Resident #8 told her the RCC told him his family did not care about him.
- The family member was concerned and did not want the resident mistreated.

Interview with the RCC on 09/20/18 at 2:50pm revealed:
-Resident #8 made multiple telephone calls every day.
-Sometimes when he had the phone off the hook, the RCC told him to hang the phone up.
-Resident #8 walked into the RCC office and has removed items from the office such as a bottle of lotion and asked for candy.
-"I'm not going to let him (Resident #8) walk in my office and take my lotion".
-If the RCC was on the phone and the resident walk in her office, she asked him to leave because residents would "tote" information they overhear.
-The RCC had never shut her office door to keep

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Resident #8 out, but if he was standing in the office doorway, she would close the door.

Interview with the Administrator on 09/11/18 at 10:50am revealed:
-About a year ago Resident #8 got into a fight with another resident and he was placed in the SCU.
-Resident #8 was not in the unit long, maybe 2 hours to calm him down.
-The facility did not have a policy to place residents who live on the assisted living unit on the SCU without orders, but if a resident became violent toward staff or other residents, the resident could be separated from the other resident/staff by placing the resident on the SCU.
-The Administrator was only aware of Resident #8 being placed on the SCU one time.

Interview with the Administrator on 09/24/18 at 11:55am revealed she was not aware of the RCC shutting her office door in Resident #8's face or yelling at the resident to get off the phone.

Interview with the Administrator on 09/11/18 at 3:05pm revealed:
-She was not aware of the resident being placed on the SCU overnight or throughout a shift.
-The resident would try to walk down the street and the staff might put him in the SCU for a little while (1-2 hours) to calm him down.
-The resident never wandered away from the facility and always signed out before leaving.
-The Resident's family and physician were called and informed of the resident leaving the facility, but did not remember if both were informed of the resident being placed on the SCU.
-An order was not obtained to place the resident on the SCU.
-She did not think she needed an order since the

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	HAL046019	A. BUILDING: _____ B. WING _____	09/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEWOOD MANOR	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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
D914	Continued From page 79	D914		

resident was only there temporarily for a short time.

Review of Resident #8's progress notes revealed:
-On 06/17/17 (3-11 shift) Resident #8 left the facility and was walking down the road to his sister's house.
-The medication aide (MA) picked the resident up in the van and brought him back.
-The resident was given an Ativan and placed him on the special care unit until the shift was almost over (10:40pm).

4. Review of Resident #1's FL-2 dated 01/23/18 revealed:
-Diagnoses included diabetes, chest pain, dyspnea, congested heart failure, atrial fibrillation, cardiomyopathy, depression, Parkinson's disease, and dementia/delusions.
-A diet order for no added salt (NAS).

Interview with Resident #1 on 09/7/18 at 10:40am revealed:
-The staff talked to him like [expletive]; they talked rough to the resident.
-The Administrator told me I was on a diet to lose weight and limit my food and fluid intake.
-When the resident was in the dining room eating meals, the staff talked to him like a child, including the Administrator and the resident care coordinator (RCC).
-The resident was not allowed to drink coffee, even after he talked to the physician a few months ago and the physician informed him he could drink coffee.
-The staff limited the resident's intake of water and at meals, he only received a small glass of tea (about 6 ounces) and no water.
- He was given a small amount of milk at breakfast to put in cereal at breakfast and a half

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D914	Continued From page 80	D914		

cup of beverage with snacks.
-Sometimes the resident became so thirsty. He would "sneak" and drink water from the water cooler in the facility. The staff talked "dirty" to the resident if they caught him.
-Staff, including the Administrator, talked to him like he was a child and had took food off of his plate at times and on some occasions would not allow him to eat meals.
-About 3 or 4 days ago, during lunch, there was not enough food to serve everyone and Resident #1 was served 2 bologna sandwiches. A medication aide (MA) asked him "what are you doing with 2 sandwiches" and snatched one of the sandwiches off his plate.
-If staff observed Resident #1 purchasing a snack from the vending machine in the facility or if the resident's family brought him food between meals, the resident was not allowed to eat the next meal.
-The staff often went in the resident's bedroom and searched his closet and drawers. They threw away his personal items including his snacks.
-The resident was careful about who he talked to about his concerns because the Administrator and the RCC had threatened to discharge him recently for talking to the "state".
-He was afraid the Administrator would call him in her office and tell him she was going to get rid of him if she became aware he was complaining.

Observation of Resident #1 on 09/07/18 at 10:40am revealed the resident was crying during the interview.

Review of record revealed no physician orders for fluid restrictions.

Interview with Resident #1's primary physician on 09/13/18 at revealed:

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D914	Continued From page 81 -The resident was ordered fluid restriction in 2017 (1500cc) and the fluid restriction was increased to 2000cc a few weeks later. -The fluid restriction was discontinued earlier this year (did not remember date). -The resident's only diet restriction was no added salt, but there were no orders to withhold meals. -The facility had not reported the resident's meals were being withheld and the physician expected the facility to follow the resident's ordered diet. Confidential staff interview revealed: - A medication aide (MA), the RCC and the Administrator were verbal abusive to Resident #1. -The staff took food from him at meal time if he had eaten anything between meals. Interview with the Administrator on 09/07/18 at 12:05pm revealed: -If Resident #1 went outside of the facility with his family to eat, the resident was not allowed to eat the next meal, because he did not have an order for double portions. -Resident #1 ate "a lot" and wanted food piled up on his plate at meal time. -The resident bought food from the snack machine and kept food in his room which caused roaches. -Staff went in his room and looked for food in his dresser drawers and bedside table and removed the food to prevent roaches. -The facility had the right to look through resident drawers without their permission. -She did not believe the staff was verbally abusive to the resident. -The resident was argumentative with staff. -She did not threaten to discharge the resident at any time but the resident had the right to leave if he did not want to stay at the facility.	D914		

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D914	Continued From page 82 5. Review of Resident #9's FL-2 dated 08/06/18 revealed: -Diagnoses included insulin dependent diabetes mellitus, Parkinson's disease, tardive dyskinesia, schizophrenia and hypertension. -There was a diet order for no added salt. Interview with Resident #9 on 09/07/18 at 11:15am revealed: -The staff snatched food from him if they caught him eating food he was not allowed to eat between meals. -He was not allowed to eat the next meal if he ate in between meals (such as fast foods). -If they knew he had eaten food before a meal and was served a plate, they would take the plate away. -The staff got angry with him if he did something wrong such as kept food in his room. -They would search his room, take his food and fuss at him about causing roaches in the room. -He had never talked to the Administrator or the resident care coordinator (RCC) about this because he thought they knew the staff was taking food from the residents. Confidential interview revealed the staff, including the Administrator was verbally abusive to Resident #9 and took food from him. Interview with the Administrator on 09/07/18 at 12:05pm revealed: -If Resident #9 ate food from a restaurant or if family brought in food for him between meals, he was not allowed to eat the next meal because he did not have an order for double portions. -Staff removed food from his room to prevent roaches in his room and it was ok for staff to look in his dresser drawers, closets and other places for food.	D914		

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D914	Continued From page 83 The failure of the facility to assure residents were free of physical and verbal abuse and neglect resulted in residents being fearful of and abused by staff, the Resident Care Coordinator and the Administrator, Resident #3 feeling imprisoned after placement on the Special Care Unit (SCU) on three separate occasions; Resident #8 feeling punished after being placed in the SCU for signing out of the facility to visit a family member; and Resident #1 and Resident #9 experiencing suffering and humiliation after staff withheld food and further took food away from residents. These failures by the facility represent serious abuse and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/07/18 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 24, 2018.	D914		
D921	G.S. 131D-21(11) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 11. To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation. This Rule is not met as evidenced by: TYPE B VIOLATION	D921		

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D921	Continued From page 84 Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled residents (Residents' #1 and #3) were free to voice concerns and complaints about care and services at the facility without retaliation as evidenced by a discharge notice given Resident #3 on 08/13/18 following a dispute with family members on 08/10/18 and threats to discharge Resident #1 if he complained or talked to the "state". The findings are: Confidential interview with a staff revealed residents were threatened with being discharged from the facility by the Administrator and staff if the residents complained about anything. 1. Review of Resident #3's current FL-2 dated 05/29/18 revealed diagnoses included Alzheimer's dementia with behavioral disturbances, schizophrenia, osteoarthritis, type 2 diabetes mellitus and hypertension. Review of a progress note dated 08/10/18 (no time) for Resident #3 revealed: -The Special Care Coordinator (SCC) documented Resident #3's family came to speak with the SCC; the resident's guardian initiated the conversation regarding misunderstanding with how transportation worked. -The Resident Care Coordinator (RCC) entered the room and advised the family that they could take Resident #3 home if they were not satisfied with the services. -The RCC asked the family to remove themselves from the facility and suggested they come back on Monday and speak with the Administrator. -The family chose to leave Resident #3 at the	D921		

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D921	Continued From page 85 facility. Review of progress notes dated 08/10/18 through 09/07/18 for Resident #3 revealed there was no documentation of a meeting with Resident #3's guardian and/or family members. Review of a Notice of Transfer/Discharge for Resident #3 revealed: -There was a hand written notation next to the safety of other individuals in this facility is endangered, which read "due to family behavior." -The reason for discharge was documented as "Needs cannot be met by the facility/Family is very unhappy by her being here." -There was no documentation of a physical address Resident #3 was going to be discharged to. -The notice was signed by the Administrator and dated 08/13/18. Interview with Resident #3's guardian on 09/10/18 at 10:20am revealed: -The facility had given Resident #3 a discharge notice because of an incident where other family members were upset because no one had explained the new rules for the SCU. -The notice had been dismissed because the facility did not fill out the correct form so Resident #3 no longer had to leave by 09/11/18. -She did not know of any other facilities Resident #3 could have been transferred to because family members had already tried to get Resident #3 into another facility and the resident wasn't accepted. Review of a Notice of Dismissal for Resident #3 dated 08/20/18 revealed the notice of discharge dated 08/13/18 was dismissed because "the form used was obsolete and no longer accepted."	D921		

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D921	Continued From page 86 Interview with the Administrator on 09/11/18 at 10:24am revealed: -She was out of town when the incident occurred between Resident #3's family member and staff at the facility. -Staff had told the Administrator Resident #3's family was in the facility being disrespectful and threatening staff. -There was so much going on at that time with Resident #3 making her own appointments and arranging her own ride that it created a lot of confusion. -She issued a discharge notice for Resident #3 because of the family members' behavior. -The discharge notice was "basically to keep the other family members in line," to stop their complaints and arguments with staff. -Resident #3's guardian "played the fence" between the facility and the other family members. -None of the family members wanted to take Resident #3 home and Resident #3 did not want to go another facility because she did not want to be in any facility. -The discharge notice she gave to Resident #3 dated 08/13/18 was completed on the wrong form, but she did plan to complete a new discharge form for Resident #3. -She felt that "with everything going on with the family and (name of Resident #3), we cannot meet her (Resident #3) needs." -She was unable to say what needs Resident #3 had that the facility was not able to meet. -She had not spoken with Resident #3's doctor yet, but she and the Resident Care Coordinator (RCC) had met with Resident #3's guardian about the plan to discharge Resident #3. -She had kept documentation of everything that had been done so far with Resident #3 and the	D921		

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D921	Continued From page 87 family members. Review of progress notes for Resident #3 revealed there was no documentation of meeting with Resident #3's guardian regarding resolving complaints and concerns or about discharging Resident #3. Telephone interview with the Administrator on 09/24/18 at 11:58am revealed: -She had issued a discharge notice to Resident #3 because she felt the facility was not able to meet the needs of the resident. -She did not like the way Resident #3's family was disrespectful to the staff and other residents. -She did not provide a specific response to how Resident #3's family was disrespectful to the staff and other residents. -She called Resident #3's guardian on the Tuesday after the discharge notice was given (08/14/18) to discuss the family's concerns. -Resident #3's family members said they were coming to the facility that Monday (08/13/18), but did not. -Resident #3's family was upset about the ambulance service transportation and upset with the Administrator. -She did not provide specific reasons Resident #3's family was upset with her. -Resident #3's family members were looking to move the resident to another facility and gave a verbal 14 day notice; Resident #3's family members did not provide a written 14 day notice. -Resident #3's family members knew the resident did not want to be at the facility and she thought issuing the discharge notice was "the best thing to do, (name of Resident #3) was not happy and the family (members) were not happy." Refer to interview with the Administrator on	D921		

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D921	Continued From page 88 09/24/18 at 11:58am. 2. Review of Resident #1's FL-2 dated 01/23/18 revealed: -Diagnoses included diabetes, chest pain, dyspnea, congested heart failure, atrial fibrillation, cardiomyopathy, depression, Parkinson's disease, and dementia/delusions. Interview with Resident #1 on 09/07/18 at 10:40am revealed: -The resident was careful about who he talked to about his concerns because the Administrator and the RCC had threatened to discharge him recently for talking to the "state". -He was afraid the Administrator would call him in her office and tell him she was going to get rid of him if she became aware he was complaining. Interview with the Administrator on 09/07/18 at 12:05pm revealed: -The resident was argumentative with staff and complained about his care. -She did not threaten to discharge the resident at any time, but the resident had the right to leave if he did not want to stay at the facility. Refer to interview with the Administrator on 09/24/18 at 11:58am. _____ Telephone interview with the Administrator on 09/24/18 at 11:58am revealed: -She did not threaten residents with discharge for making complaints or talking about complaints against the facility, "Why would I want to discharge them?" -She has told residents if they were not happy at the facility and they wanted to find somewhere else, she was more than happy to find them somewhere to go.	D921		

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D921	Continued From page 89 The failure of the facility to assure Resident #1 and Resident #3 were not threatened with discharge from the facility for making complaints about the care and services which was detrimental to Resident #1's and Resident #3's health, safety and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/07/18 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2018.	D921		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' right which resulted in significant noncompliance with state rules and	D980		

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D980	Continued From page 90 regulations related to health care and residents' rights. The findings are: Confidential interview with a staff revealed: -It was "difficult to report anything to anyone" regarding concerns about care and services at the facility and staff performance. -"No one seemed to care." -Anytime something was reported, staff and the Administrator had an attitude. Interview with the Administrator on 09/07/18 at 12:04pm revealed: -She was responsible for the overall operation of the facility. -She was in the facility "almost 24/7 to make sure staff was doing what I expect them to." -She observed staff frequently to make sure staff were not being disrespectful to residents. Telephone interview with the Owner on 09/12/18 at 5:52pm revealed: -He had never witnessed any staff grabbing, pulling or dragging residents. -It was news to him that staff in general, including the Administrator, were mean, rude, disrespectful, withheld meals and took residents' personal items. -He expected a proper assessment, documentation from the physician that a resident was appropriate for the special care unit (SCU) and a completed admission packet prior to a resident being admitted to the SCU. -Residents being placed on the SCU without staff following the proper admission process was "absurd". -He was concerned about the allegations against staff and the Administrator.	D980		

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D980	Continued From page 91 -He would be at the facility on 09/13/18 to address these issues. 1. Based on observations, interviews and record reviews, the facility failed to assure all residents were free of verbal and physical abuse by three direct care staff, a housekeeper, the Resident Care Coordinator and the Administrator; for 4 of 9 sampled residents (#1, #3, #8 and #9) by being placed on the special care unit in lieu of supervision (#3 and #8), staff taking and withholding food and drink (#1 and #9) and staff taking a resident's personal cellular phone (#3). [Refer to Tag 914 G.S. 131D-21(4) Residents' Rights (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up for 1of 5 sampled residents (#2) including referral to urgent care services for uncontrolled arthritic knee pain. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to allow Resident #3 to exercise the right to chose her transportation to and from medical appointments because she was in the special care unit. [Refer to Tag 911 G.S. 131D-21(1) Residents' Rights (Type B Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled residents (Residents' #1 and #3) were free to voice concerns and complaints about care and services at the facility without retaliation as evidenced by a discharge notice given Resident #3 on 08/13/18 following a dispute with family members on 08/10/18 and threats to discharge Resident #1 if he complained or talked to the	D980		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEWOOD MANOR	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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
D980	Continued From page 92 "state". [Refer to Tag 911 G.S. 131D-21(11) Residents' Rights (Type B Violation)]. The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing supervision, health care, and residents' rights. The Administrator's failure to assure responsibility resulted in all residents being fearful of staff, fear of placement in the special care unit, and fear of retaliation. The Administrator's failure to assure responsibility for implementation of rules and regulations governing assisted living facilities resulted in serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/18 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 24, 2018.	D980		