Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066012	A. BUILDING: _____ B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR	320 BROUGHTON STREET GASTON, NC 27832

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D 000	Initial Comments The Adult Care Licensure Section and the Northampton Department of Social Services conducted an Annual Survey on November 27, 2018 and November 28, 2018.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 5 of 8 common bathroom sinks. The findings are: Observation in the Special Care Unit (SCU) of resident rooms 146 and 148 shared bathroom on 11/27/18 at 9:30am revealed the water temperature at the sink was 84 degrees Fahrenheit (F) after running the water for approximately 3 minutes. Observation in the SCU of resident rooms 134 and 136 shared bathroom on 11/27/18 at 9:40am revealed the water temperature at the sink was	D 113	It is a policy of Hampton Manor to assure that hot water wil be provided to meet the adequate requirements to all residents according to rule area 10A NCAC 13F .0311(d). 1. The facility will assure that the hot water system will provide the adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. This will be monitored by maintenance, housekeeping, dietary, and/or other mangers and staff assigned. 12-21-18 a. The facility has developed a check off sheet to increase the times and locations that the hot water temperatures are to checked and monitored. This will be monitored by the housekeeping manger, dietary manager and or any staff member that may be assigned to monitor. 12-21-18 b. The facility has turned up each hot water tank to meet the temperature requirements and will continue to monitor and adjust the temperatures daily, this will be monitored by the housekeeping department, kitchen department, housekeeping staff, resident care manager, special care manager and or the administrator. 12-21-18 c. An in-service has been completed on instructions on how to obtain temperatures and the process to be carried out if temperatures need to be adjusted. See attached in-service sign in sheet. 12-21-18 d. Hampton Manor has consulted with a contractor and are looking at the possibility of replacing or repairing 12-21-18	

Reviewed and Acknowledged 01-29-19 Karen M. Polce, RN

the system. –please see attached Est for repair/replacements

1-11-19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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D 113	Continued From page 1 80 degrees F after running the water for approximately 4 minutes. Observation in the SCU of resident rooms 101 and 103 shared bathroom on 11/27/18 at 9:46am revealed the water temperature at the sink was 74 degrees F after running the water for approximately 4 minutes Observation in the SCU of resident rooms 146 and 148 shared bathroom on 11/27/18 at 2:20pm revealed the water temperature at the sink was 80 degrees F after running the water for approximately 3 minutes. Observation in the SCU of resident rooms 151 and 153 shared bathroom on 11/27/18 at 2:20pm revealed the water temperature at the sink was 94 degrees F after running the water for 4 minutes. Confidential interview with a family member revealed: -"The water is always cold here." It had been this way since the resident had moved in, approximately a year and a half. -Her loved one did not want to wash or shower because the water was so cold. -She had not spoken to anyone regarding the water temperature. Interview with the first shift SCU personal care aide (PCA) on 11/28/18 at 10:01am revealed: -The water was sometimes too cold to washor shower the residents. -She would check other showers or sinks onthe floor for warm water when giving bed baths or showers to residents. -She did not report the water temperatures because she thought the management knew this	D 113		

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D 113	Continued From page 2 was a problem. Interview with a resident on 11/28/18 at 9:53am revealed: -She was not able to take a shower due to a recent surgery, so the staff bathed her in the bed. -The staff could not get warm water from her sink. -The staff informed the resident they had to go to other rooms to obtain warm water for the bed bath. Interview with a second resident on 11/28/18 at 1:55pm revealed: -"The water in the shower was frigid." -On scheduled shower evenings, the staff showered residents when the water had been cold. -"I do not like taking showers in cold water; it makes me very cold for the rest of the evening." -Sometimes the water in the shower across the hall was warm and the staff showered residents there. Interview with a third resident on 11/28/18 at 2:04pm revealed: -He refused showers when the water was cold. -He did not want to "catch pneumonia because of the cold water". Interview with the maintenance staff on 11/28/18 at 2:55pm revealed: -This was an old building. The water did not circulate as efficiently as a newer building. -Some of the water heaters have been replaced, but there continued to be a problem in some parts of the building regulating the water temperature. -If there were more residents showering, the	D 113		

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D 113	Continued From page 3 Water temperature would drop. -If the temperature of the water heater was raised, the water in some areas of the building became too hot. -The corporate office had subcontracted the maintenance projects, and the maintenance supervisor frequents the building 2 or 3 times a week. -He had been informed regarding the problem since October 2018. -This had been an ongoing problem. Review of the facility hot water temperature logs for November revealed: -Weekly water temperature checks were completed by the maintenance supervisor. -Three random rooms in each hallway were checked every week. -On 11/05/18, the temperature in the resident bathroom sinks ranged from 107-109 degrees F. The bathroom sink in room 101 tested at 108 degrees F. -On 11/12/18, the temperature in the resident bathroom sinks ranged from 107-110 degrees F. The bathroom sink in rooms 134 and 151 tested at 107 degrees F. -On 11/21/18 the temperature in the resident bathroom sinks ranged from 107-110 degrees F. The bathroom sink in rooms 103 and 151 tested at 108 degrees F, and the bathroom sink in room 134 tested at 110 degrees F. -On 11/26/18 the temperature in the resident bathroom sinks ranged from 107-109 degrees F. The bathroom sink in room 136 tested at 108 degrees F, and the bathroom sink in room 146 tested at 109 degrees F. Interview with the Administrator on 11/28/18 at 3:15pm revealed: -She had not been informed of any problem with	D 113		

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D 113	Continued From page 4 the water temperatures recently. -When she had been informed in the past, the housekeeper raised the temperature on the water heater and it was resolved. -She had informed her corporate office that some "recent inspections" have had concern over the water temperatures. -She thought the maintenance supervisor was getting "quotes" on possible solutions to the problem.	D 113		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 2 of 3 sampled residents with a history of falls (Resident #1 and Resident #6). The findings are: Review of the facility's "Fall Intervention Program" revealed:	D 270	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law. It is a policy of Hampton Manor to assure that staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms according to rule area 10A NCAC 13F .0901 (b).	

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D 270	Continued From page 5 -A fall risk assessment tool was to be completed for all residents admitted to determine factors that may contribute to possible falls. -Staff were to complete an incident report for any fall. -Staff were responsible for completing a 72 hour follow-up on resident falls to investigate possible circumstances contributing to the fall and document observations for the period of 72 hours after the fall. -If a resident had two falls within a four week period, the physician would be contacted requesting an order for physical therapy (PT) evaluation or other treatment/interventions. -For any fall, the resident was placed on the "hotbox and alert charting" for 72 hours for follow-up and monitoring. -The healthcare team would review incident reports on a monthly basis. -Possible interventions included: no-slip rugs, shoes tied/not too big, fall mat, bed/chair alarm, medication review, possible room changes, clutter free room, physical therapy referral, care plan meetings, walker/wheelchair. 1. Review of Resident #6's current FL-2 dated 01/30/18 revealed: -Diagnoses included Alzheimer's disease. -The resident was documented as being semi-ambulatory. Review of Resident #6's Care Plan dated 01/23/18 revealed: -The resident required limited assistance with ambulation and was able to propel her own wheelchair. -The resident required limited assistance with transfers. -The resident required extensive assistance with toileting.	D 270	1. The facility will assure that each resident is provided appropriate supervision in reference to the residents assessed needs and care plan and current symptoms. a. A 24 hour communication Log has been developed and placed in the Special Care Unit and the Assisted Living Unit. This Log will be reviewed daily by the SIC/MT and then reviewed by the RCM and SCM daily. b. SIC/MT will communicate every shift any incidents or concerns identified with the residents. Any needs identified will be reported to the PCP for further direction c. Training for all MT/SIC for completion of the 24 hour Communication Log was completed 12-18-18. d. Any identified increased supervision needs will be implemented by the Care managers and or Executive Director according to the individual needs. e. Changes will be communicated verbally and documented in the 24 Hr. Communication Log. f. All Safety Alarms are identified on the residents MAR and are checked and monitored each shift by MT/SIC. g. The 24 Hr. Communication Log also identifies any resident that has a safety alarm in place. This is also communicated verbally shift to shift. h. Batteries are located on each med Cart. If batteries need to be	12-18-1 12-18-1 12-18-1 12-18-1 12-18-18 12-18-18 12-18-18 12-18-18

			replaced it is the responsibility of the SIC/MT. Care Managers will assure med cart is stocked with appropriate batteries needed. i. Alarms that are broken were replaced. Med tech's and Care manager are to ensure that the alarms are audible and in working condition. Any concerns will be reported to the Executive Director for assistance. This will be tracked thru the 24 Hr. Communication Log during review daily by Care Managers. j. All staff were in-serviced on Personal care and Supervision by the Executive Director.	12-18- 12-18-1 12-18-1 12-20-1

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D 270	Continued From page 6 Review of Resident #6's incident reports and staff notes revealed: -On 05/15/18 at 8:30pm, the resident was found sitting on the floor in her bathroom; she had a swollen area on the back of head, and was sent to the Emergency Department (ED) and diagnosed with a mild closed head injury. -On 06/13/18 at 2:30am, the resident was found lying on the floor on her right side, she had an abrasion to her right elbow, and was sent out to the ED and diagnosed with a neck injury and contusion of the right shoulder. -On 07/06/18 at 1:10am, the resident was found sitting on the floor on her buttocks with no apparent injury. -On 08/06/18 at 9:15pm, the resident was found lying on her back on the floor with no apparent injury. -On 10/27/18 at 8:00pm, the resident was found lying on the floor in her bathroom with her head against the wall, was sent out to the ED and diagnosed with a contusion of the scalp. -On 11/20/18 at 4:50am, the resident was found on the floor of her bedroom with her head bleeding, was sent out to the ED and diagnosed with a contusion and laceration of the scalp requiring staples to her head. -Resident #6 had six falls from 05/15/18 to 11/20/18, four of which resulted in admission to the ED and no documentation of interventions. Interview on 11/28/18 at 4:05pm with an evening shift Special Care Unit (SCU) personal care aide (PCA) revealed: -If a resident was at risk for falling, it would be communicated to the staff during shift change meetings. -Resident #6 was a "fall risk." -She checked on "fall risk" residents every five	D 270		

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D 270	Continued From page 7 minutes. Interview on 11/28/18 at 4:28pm with a second evening shift SCU PCA revealed: -She tried to "keep her eyes on all the residents." -She had not been provided with specific instructions on how often she should check on the residents. -She had never been told to increase the level of supervision for Resident #6. Interview on 11/28/18 at 4:30pm with the SCU medication aide (MA) revealed: -If a resident was a "fall risk," they tried to keep them at the nurse's station for the first 72 hours after a fall to "keep an eye on them." -After the first 72 hours following a fall, the resident would not be supervised anymore frequently than other residents. Interview on 11/28/18 at 5:20pm with a third evening shift SCU PCA revealed: -She knew Resident #6 had fallen in the past. -She had not been instructed on how often to check on Resident #6. "We just try to keep an eye on her." Interview on 11/28/18 at 4:50pm with the Special Care Manager (SCM) revealed: -She had been employed with this facility for seven years. -She was aware of Resident #6's falls. -Resident #6's falls often occurred at night when she would attempt to get out of bed and walk to the bathroom. -Resident #6 did not understand to use the call bell system when she needed assistance. -Resident #6's Primary Care Provider (PCP) had ordered a bed alarm for her sometime last year (she was unable to remember the exact date or	D 270		

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D 270	Continued From page 8 locate the order) and the resident had been using the bed alarm ever since then. -PCAs were supposed to check on all residents every two hours both day and night to offer toileting. -PCAs were supposed to check on all residents every thirty minutes both day and night to check for safety and other needs. -Staff did not document anywhere when they checked on the residents. -Supervision had not been increased for Resident #6 since she began having frequent falls. She was not checked on any more often than the other residents. Observation on 11/28/18 at 5:10pm revealed there was no bed alarm on Resident #6's bed, and the SCM was unable to locate one anywhere in the resident's room. Interview on 11/28/18 at 5:13pm with three SCU PCAs revealed: -"I have worked here for three months, and I've never seen a bed alarm on her (Resident #6) bed." -"She (Resident #6) doesn't have a bed alarm." -"I've never seen one for her (Resident #6). Interview on 11/28/18 at 5:14pm with the SCM revealed: -She had located a bed alarm with Resident #6's name on it in a drawer at the nurse's station. -There were no batteries in the alarm. -She did not know who removed the bed alarm from Resident #6's bed or how long it had been off her bed. Telephone interview on 11/28/18 at 5:19pm with Resident #6's responsible party revealed: -She visited the facility one to two times weekly.	D 270		

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D 270	Continued From page 9 -She was aware of Resident #6's falls. -During her most recent fall, Resident #6 had hit her head on her nightstand and required sutures. -Resident #6's falls usually occurred in her room at night when she was trying to get to the bathroom. -Resident #6 was to the point where she could no longer understand to use the call bell system to call for assistance. -Resident #6 would tell her that she would yell out for help, but staff would not come in to assist her. -It was becoming increasingly difficult for Resident #6 to walk without assistance. -She had purchased a bed alarm for Resident #6 approximately eighteen months ago to help alert staff if she attempted to get out of bed at night. -The staff would place the bed alarm on Resident #6's bed at night and then place it on her wheelchair when she sat in it during the day. -The bed alarm was used for about thirty days and then "disappeared." She "had no idea where it was." -When she asked the staff where the alarm was, no one could tell her. -She was not aware of any increase in supervision for Resident #6 since her falls. -The facility had not communicated to her regarding how they would prevent Resident #6 from falling in the future. Interview on 11/28/18 at 5:41pm with the Administrator revealed: -She was not familiar with Resident #6, but was aware she had fallen several times. -She expected staff to check on all residents every one to two hours at night. -She did not know if supervision had been increased for Resident #6 since her falls. -It was "all staff's responsibility" to assure if a resident had a bed alarm, it was on the bed each	D 270		

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D 270	Continued From page 10 night. -She did not know why Resident #6's bed alarm would have been in a drawer in the nurse's station instead of on her bed. -If the bed alarm required new batteries, the staff should have immediately put new batteries in it and put it back on the resident's bed. Attempted telephone interview with Resident #6's PCP on 11/28/18 at 5:00pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. 2. Review of Resident #1's current FL-2 dated 05/30/18 revealed: -Diagnoses included traumatic ischemia of muscle, muscle weakness, other malaise. -The resident was documented as being ambulatory. Review of Resident #1's record revealed: -There was an ordered for PT on 05/30/18, upon admission, for five times per week. -There were PT notes documented by the physical therapist. -Resident #1 received PT and was discharged on 07/31/18, there was no other evaluation or treatment ordered. Review of Resident #1's Resident Register revealed she was admitted to the facilityon 05/16/18. Review of Resident #1's Care Plan dated 06/04/18 revealed: -Resident #1 required limited assistance with ambulation with use of walker.	D 270		

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D 270	Continued From page 11 -Resident #1 required limited assistance with transfers. -Resident #1 required assistance with all transfers because she was a "high fall risk". Review of visit notes from Resident #1's primary care provider (PCP) on 10/01/18 revealed Resident #1 had a diagnoses of dementia. Review of the facility's incident reports and charting notes revealed Resident #1 had five falls from 07/11/18 to 11/22/18 as follows: -On 07/10/18 at 7:00pm, the resident fell to her knees, she was sent to the Emergency Department (ED) and diagnosed with a closed sacral fracture. -On 08/04/18 at 7:30am, the resident fell on her bottom getting out of bed, she was not sent out to the ED after consulting power of attorney (POA) due to not hitting her head and only complaints of minor discomfort. A mobile x-ray was completed, and no fractures were indicated. -On 08/12/18, the resident was complaining of left side pain, she was sent to the ED, and diagnosed with low back strain, muscle spasm, and a contusion of left hip. -On 11/18/18 at 11:50pm, the resident was found on the floor with a "slim red mark down the center of her back", she was sent to the ED and was diagnosed with contusion of abdominal wall. -On 11/21/18 at 1:45pm, the resident was found slipping out of her chair to the floor with no apparent injury. -On 11/22/18 at 9:53pm, the resident was found sitting on the floor beside her roommates' recliner, she was sent to the ED and diagnosed with an acute head injury without loss of consciousness, and sub-acute T12 compression fracture. -From 07/10/18 through 11/22/18, Resident #1	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
D 270	Continued From page 12 had 5 falls, there were no documented interventions and 4 falls resulted in significant injury. Observation on 11/27/18 at 9:39am of Resident #1 revealed: -The resident was in her bedroom sitting in her chair next to her bed. -The resident had a walker present to assist with ambulation. -There were incontinence supplies in the bags on the floor surrounding the resident's chair. -The call bell was hanging from the dresser behind Resident #1's chair touching the floor. Interview on 11/28/18 at 7:45am with a personal care aide/medication aide (PCA/MA) revealed: -Resident #1 had falls frequently. -Resident #1 was the only resident who had falls frequently on the assisted living side. -She was instructed by the Resident Care Manager (RCM) to assist Resident #1 more with activities of daily living (ADLs). -She told other PCAs and MAs when changing shifts to try to check on Resident #1 every thirty minutes because of her frequent falls. -She did not know if other PCAs or MAs were instructed to increase supervision for Resident #1. -She did not know of any specific instructions to increase supervision for Resident #1. -Resident #1's room had been uncluttered by staff but the family continued to bring more items into her room. -The staff on the assisted living side could not provide one-on-one care. -The RCM instructed her to "keep eyes on her" -The RCM discussed memory care with the family, but they were against the plan.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066012	A. BUILDING: _____ B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR	320 BROUGHTON STREET GASTON, NC 27832

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D 270	Continued From page 13 Interview on 11/28/18 at 10:17am with the Resident Care Manager (RCM) revealed: -She knew Resident #1 was at risk for falls. -Resident #1 was admitted to the facility with a history of falling. -PCAs were supposed to check on all residents every two hours for 72 hours after a fall. -PCAs were supposed to check on all residents throughout the day for safety. -One-on-one care was not provided to residents who resided in assisted living. -Staff did not document anywhere when they checked on the residents. -They tried interventions for Resident #1 such as removing clutter from her room, changing room to be closer to nurse station, PT was ordered when she first was admitted. A second interview on 11/28/18 at 4:00pm with the RCM revealed: -She had not increased supervision for Resident #1's due to limited staff. -"We will see if we can do a little bit more, I will check with our protocol nurse". -She had been concerned since Resident #1 has had three falls in a row, "in the past week". -There was concern about falls in July and August 2018, but after discussing with family, they said that "falls were going to happen" due to her history. -"We are going to try to put some other interventions in place". -She had another care plan meeting with Resident #1's power of attorney (POA) on 11/28/18 and the family agreed to get a bed alarm. -Resident #1 received PT in June and July 2018 and was discharged and there was no other evaluation or treatment ordered. -"I have also discussed with family the possible	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066012	A. BUILDING: _____ B. WING _____	11/28/2018

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D 270	Continued From page 14 need for memory care." Observation of Resident #1 on 11/28/18 between 4:00pm-4:46pm revealed: -Resident #1 was pacing from the common area of the facility near the front door to her bedroom. -PCAs attempted to redirect Resident #1 from the front door and found her a seat at the nursing station. -Resident #1 refused to sit at the nursing station and was observed continuously pacing in the front lobby with the use of her walker. Telephone interview on 11/27/18 at 4:25pm with Resident #1's POA revealed: -He knew of Resident #1's falls. -He felt Resident #1's room was small and there was not much room for her to maneuver. -He had observed the call bell was not always within reach. -He had been present in the room and Resident #1 had not been assisted by staff with ADLs. -He had observed Resident #1 in the bathroom on occasions not receiving assistance. -He had not participated in any care plan meetings about increasing Resident #1's falls or increased supervision. -"Yesterday [11/26/18] was the first discussion about the clutter in her the room". -The RCM notified him of falls; each fall had been in the bedroom. -The facility had not communicated howthey would prevent Resident #1 from falling in the future. Interview on 11/28/18 at 5:39pm with the Administrator revealed: -She knew Resident #1 had a history of falls prior to being admitted. -She knew Resident #1 had falls since she was	D 270		

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D 270	Continued From page 15 admitted. -They followed their fall program intervention strategies to help prevent falls. -Resident #1's room had been changed to be closer to the nurse's station. -A fall risk assessment had been completed and a 72 hour follow-up form was completed. -She expected staff to check on Resident #1 every hour. -She was not sure if staff were checking on Resident #1 every hour. -There was no documentation tool used to record increased supervision. -She expected the RCM to have a care plan meeting with families to discuss falls and interventions. -The RCM had some care plan meetings with Resident #1's POA regarding falls. -Staff were notified during stand-up meetings and shift change regarding the care and supervision each resident needed. -There was no documentation of increased supervision for Resident #1. -She notified Resident #1's POA when she was admitted that assisted living did not provided one-on-one care. -Assisted living was supposed to be a trial to see "if it would work out". Attempted telephone interview on 11/28/18 at 5:00pm with Resident #1's PCP was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. _____ The facility failed to assure staff provided supervision for 2 of 3 residents including Resident	D 270		

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D 270	Continued From page 16 #6 who resided in the SCU and had 6 falls from 05/15/18-11/20/18 which resulted in injuries and Resident #1 who had 5 falls from 07/11/18-11/22/18 which resulted in injuries. This failure was detrimental to the health and safety of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 12/19/18. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 12, 2019 .	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure medications	D 358	It is a policy of Hampton Manor to assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with orders by licensed prescribing practitioner which are maintained in the resident's record and in the facility according to rule area 10A NCAC 13F .1004 (a) 1. The facility will assure that each resident receives the correct medication thru implementation of the Bucket System. 12-20-18 2. The facility will assure that all orders if not utilized will be discontinued and medication returned to the pharmacy. 12-20-18 3. The facility implemented a Bucket System consisting of folders to assure all medication orders are processed according as described 12-18-18	

below:

a. Folder #1 Yellow – For new physician orders.
b. Folder # 2 – Orange - For new orders in Quick MAR and then any orders waiting for medications arrive from Omnicare.
c. Folder #3- Red – For meds not delivered to include other task: incomplete orders that requires physician clarification, etc.
d. Folder #4- Blue – For orders that may include labs, diets, DMR, oxygen, therapy & Follow up for any other miscellaneous orders.
e. Folder #5- Green - For all completed and ready to file. This folder assures that orders are complete and have been processed and medications received or physician orders have been implemented.

4. All orders will be reviewed by the Care managers for accuracy as well as for returns on a weekly basis. Ed Randomly completes audits for compliance. 12-21-18

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	HAL066012	A. BUILDING: _____ B. WING _____	11/28/2018

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D 358	Continued From page 17 were administered as ordered for 1 of 5 sampled residents (Resident #3) related to an ipratropium-albuterol nebulizer treatment, used to control the symptoms of lung disease and prevent the worsening of chronic obstructive pulmonary disease (COPD). The findings are: Review of Resident #3's FL2 dated 04/24/18 revealed: -Diagnoses included multi infarct dementia, COPD, hypertension and acute renal failure. -Medications included ipratropium-albuterol, 0.5-3mg/3ml ampule via nebulizer treatment, every 6 hours for COPD. Review of a subsequent physician's order dated 11/02/18 revealed an order for ipratropium-albuterol, 1 vial, every 6 hours as needed (PRN)for dyspnea or wheezing. Review of Resident #3's August 2018 electronic medication administration record (eMAR) revealed: -There was an entry for ipratropium-albuterol via nebulizer, every 6 hours, administered at 12:00am, 6:00am, 12:00pm and 6:00pm. -There was documentation from 08/01/18 to 08/30/18, ipratropium-albuterol was administered at the scheduled times, with the exception of one dose at 12:00pm on 08/06/18. -A total of 123 vials of ipratropium albuterol were documented as administered to Resident #3. Review of Resident #3's September 2018 eMAR revealed: -There was an entry for ipratropium-albuterol via nebulizer, every 6 hours, administered at 12:00am, 6:00am, 12:00pm and 6:00pm.	D 358		

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D 358	Continued From page 18 -There was documentation from 09/01/18 to 09/30/18, ipratropium-albuterol was administered at the scheduled times, with the exception of one dose each on 09/04 and 09/10. Resident #3 was out of the facility at 12:00pm on both days. -A total of 118 vials of ipratropium-albuterol were documented as administered to Resident #3. Review of Resident #3's October 2018 eMAR revealed: -There was an entry for ipratropium-albuterol via nebulizer, every 6 hours, administered at 12:00am, 6:00am, 12:00pm and 6:00pm. -There was documentation from 10/01/18 to 10/31/18, ipratropium-albuterol was administered at the scheduled times. -A total of 124 vials of ipratropium-albuterol were documented as administered to Resident #3. Review of Resident #3's November 2018 eMAR revealed: -There was an entry for ipratropium-albuterol via nebulizer, every 6 hours, administered at 12:00am, 6:00am, 12:00pm and 6:00pm. -There was documentation from 11/01/18 to 11/27/18, ipratropium-albuterol was administered at the scheduled times. -There was an entry for ipratropium-albuterol 3mg/3ml vial, inhale every 6 hours prn dyspnea or wheezing. -There was documentation on 11/17/18 at 7:38pm, ipratropium-albuterol was administered for shortness of breath. -A total of 108 vials of ipratropium-albuterol were documented as administered to Resident #3. Interview with the pharmacist at the facility's contracted pharmacy on 11/28/18 at 4:30pm revealed: -There was an order for ipratropium-albuterol via	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 19 nebulizer treatment every 6 hours for COPD dated 04/24/18. -There was an order for ipratropium-albuterol via nebulizer treatment PRN for wheezing and shortness of breath, not to exceed 4 times a day, dated 11/02/18. -The medication was filled and delivered upon the request of the facility staff. It was not sent routinely. -The fill history for the ipratropium-albuterol medication was as follows: August 2018 there was no request for the medication and none was sent; September 7, 2018 a 30 day supply ofthe medication was sent to the facility for the scheduled dose; October 4, 2018 a 7.5 day supply (30 vials)of the medication was sent to the facility for the scheduled dose; November 3, 2018 a 7.5 day supply of the medication was sent to the facility for the prn order. -A total of 135 vials of ipratropium-albuterol were sent to the facility between August 2018 and November 28, 2018. Observation of medications on hand in the Special Care unit (SCU) medication cart revealed the prn box of 30 vials of ipratroprium-albuterol, fill date 11/03/18, were on the medication cart with 7 vials remaining. Interview with the first shift medication aide (MA) on 11/15/18 at 11:35am revealed: -Resident #3 waited at the medication cart and requested his ipratropium-albuterol every 6 hours. -The MAs dispensed the vial of medication to Resident #3 who proceeded to his room and completed the nebulizer treatment independently. -The nebulizer equipment was beside his bed on	D 358		

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D 358	Continued From page 20 the nightstand. -He informed the staff if he needed new tubing or any other assistance. -He also had a PRN order for ipratropium-albuterol for periods of shortness of breath in between his scheduled treatments. -He was a heavy smoker and had COPD. Interview with the Special Care Manager (SCM) on 11/28/18 at 5:05pm -Resident #3 had been putting the medication in his nebulizer since he had been at the facility. -He waited at the medication cart 4 times a day and requested his nebulizer medication. -The MA gave him the ipratropium-albuterol vial and he returned to his room to administer the treatment. -The MA "looked in on him" to make sure he was administering the treatment. -He was a heavy smoker and requested his medication when he was short of breath. -She did not know why the primary care physician (PCP) added a PRN order for the nebulizer treatment. -The order did not discontinue the scheduled dose of ipratropium-albuterol. -She did not know the pharmacy had sent 135 vials of ipratropium-albuterol from August 2018 to present and there was documentation the medication had been administered 472 times. Interview with the Administrator on 11/28/18 at 5:15pm revealed: -The SCM reviewed the orders and administration of medications in the SCU. -She did not oversee the clinical aspects of the facility. -The MAs observed the residents closely with their medications. -She knew the MAs watched Resident #3 prepare	D 358		

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D 358	Continued From page 21 and start his nebulizer treatment andchecked him during the treatment. -Resident #3 is a high functioning resident in the SCU. -She would review the records and determine why there was a discrepancy between the fill history of the ipratropium-albuterol and the documentation of administration. Interview with Resident #3 on 11/28/18 at 5:40pm revealed: -He requested the nebulizer medication when he was feeling short of breath. -He kept the nebulizer equipment in his room and went to the medication cart to get the ipratropium-albuterol when needed. -He prepared and administered the treatment himself. -The PCP recently changed his scheduled order to a PRN order. -Now he only requested the medication when he felt short of breath. -He went out several times to smoke during the day and night and sometimes needed the nebulizer treatment. Attempted telephone interview with the primary care physician on 11/28/18 at 3:45pm was unsuccessful.	D 358		
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.	D912	It is a policy of Hampton Manor to assure that the all resident will receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws, rules and regulations according to G.S. 131D-21 (2)	

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D912	Continued From page 22 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 2 of 3 sampled residents with a history of falls (Resident #1 and Resident #6).	D912	1. All staff were in serviced on Resident Rights 12-18-18 by the Executive Director. 2. Resident Rights training was held on 12-20-18 by Ombudsman, Tye Whitaker. Training content and sign in sheet can be located in the QA Binder.	12-18-20 12-20-20

12-22-18

Water Temp in-service

Held by Jeanette Toney

Standard Plumbing Sewer and Drain, Inc.
123 Justin Ave.
Hertford, NC 27944

standardplumbing@yahoo.com

Phone #	Fax #	
(252) 264-3696	(252) 264-1017	NC LIC #22359 VA LIC #2705073908

Estimate

Date	Estimate #
12/21/2018	018479

Name / Address
Hampton Manor C/O Affinity Living Group PO Box 2565 Hiclory, NC 28603

Rep	Quote is good for 30 days. Prices are subject to change due to supply house increase.	Total Fixtures	Project/P.O.
DD			

Description	Cost	Total
Estimate for the following work to be completed at Hampton Manor: Install two recirculator lines and electrical for two pumps for each hallway as needed to maintain hot water for all bathrooms. Halls with two recirculator pumps each and main center hall with 1 recirculator electrical pump and checks. All return lines to be insulated with R6.5 insulation as needed to maintain water temperature. Total of nine pumps. Electrical - $3,823.75 Parts - $4,568.14 Labor -$10,500.00 Permit - $450.00 Total - $19,341.89, plus tax.	19,341.89	19,341.89

Thank you for the opportunity to earn your business.

Total **$19,341.89**

EXTRA COST WILL BE INCURRED IF PROPERTY IS LOCATED IN FLOOD ZONE. THIS COVERS FLOOD LEVEL BRACING AND INSULATION.

Note: Any deviations from specified work listed above will result in extra cost over this quoted price. Interest will accure at 3% per month on any unpaid balance after 30 days and 3% every month thereafter. Customer agrees to pay all attorney fees should this become necessary in the collection of any unpaid balance.

We are not responsible for venting gas fixtures.

Estimates must be signed, dated and returned to Standard Plumbing Sewer and Drain, Inc. before work can begin.

X_____
Signature of Authorized Agent

X_____ **Date**

Weekly Water Temperature Checks

Facility Name: _____

Month/Year: _____

Completed By: _____

Notes: Check at least 3 rooms per hallway.

Ensure temperatures is not below 100 F and not above 115 F

Report any temperatures out of range to the Administrator

Dates							
Location	Temp	Location	Temp	Location	Temp	Location	Temp

Comments: _____

IN – SERVICE

12-18-18 AND 12-19-18

TRAINING ON HOW TO COMPLETE 24 HOUR COMMUNICATION LOG/STAND UP AND INCREASED SUPERVISION

Syranda Whitaker, Regional Long Term Care Ombudsman

Barbara Long
Shaunte Crowell
Cora Gordon
Ameshia Jones
Odell Coffield
Glenda Maguire
Shaunte Crowell
Connie Kennedy
Krystal Bro
Victoria Harry
Curtis Sch
Kelly

Allison Braswell
Gracie Clements
Crystal Mead
Glenda Maguire RCM
Elizabeth Sledge
Ethel Webb
Megan Jarratt
Rolonda Keene
Wanda
Linda A Squire
Shaunte Crowell
Barbara Long
Katie Griffies
Madison Ferrell
Daneshia Gray
Patricia Smith

IN – SERVICE

12-18-18 AND 12-19-18

TRAINING ON HOW TO COMPLETE 24 HOUR COMMUNICATION LOG/STAND UP AND INCREASED SUPERVISION

Debbie Coffin, MT(SIC)

Glenda Mayfield RCM

Amesha Jones RCM

Heather Johnson, MT(SIC)

Katie Griffies

Lisa Penn

Amesha Jones

Ashley Bowen

Jami Sapp

Meg Garrett

Jodi Hale

Shelly Ramsey

IN-SERVICE 12/20/2018

RESIDENTS RIGHTS

TAUGHT BY TYE WHITIKER

Cyrenda Whitaker, RLTCO

Katie Jeffries CNA

Shaunte Crowell

Victoria Garner

Jodi Hale

[illegible]

[illegible]

[illegible]

[illegible] Sillman

Krystal B[illegible]

Odyle Coppedge

[illegible]

Gracie Clements

[illegible]

Elizabeth Sl[illegible]

Tamara L. Rudd

Connie [illegible]

Linda Squire

Allison Braswell

IN-SERVICE 12/20/2018

RESIDENTS RIGHTS

TAUGHT BY TYE WHITIKER

Teresa Baggett
Bryanna Carroll
Daneshia Gray
Patricia Smith
Ashley Bolton

HAMPTON MANOR 24 HOUR COMMUNICATION LOG AND SHIFT CHANGE REPORT

DATE:_____ TIME:_____

HELD BY:_____ STAFF PRESENT:_____

_____

CALL OUTS:_____

ACCIDENTS/INCIDENTS-CHANGE OF CONDITION AND BEHAVIORS:_____

_____

W/C BED ALARMS (ENSURE THAT BATTERIES ARE IN AND WORKING PROPERLY:_____

_____

RESIDENT SENT TO HOSPITAL:_____

RESIDENT NOT PRESENT OUT TL-HOSP:_____

FALLS:_____NEW MEDICATION ORDERS:_____

MANAGERS/RCM/SCM/ADM/MOD MUST REVIEW AND INITIAL DAILY:_____

HAMPTON MANOR 24 HOUR COMMUNICATION LOG AND SHIFT CHANGE REPORT

DATE:_____ TIME:_____

HELD BY:_____ STAFF PRESENT:_____

_____

CALL OUTS:_____

ACCIDENTS/INCIDENTS-CHANGE OF CONDITION AND BEHAVIORS:_____

_____

W/C BED ALARMS (ENSURE THAT BATTERIES ARE IN AND WORKING PROPERLY:_____

_____

RESIDENT SENT TO HOSPITAL:_____

RESIDENT NOT PRESENT OUT TL-HOSP:_____

FALLS:_____NEW MEDICATION ORDERS:_____

MANAGERS/RCM/SCM/ADM/MOD MUST REVIEW AND INITIAL DAILY:_____

(Community Name) AL 24 Hour Report

Date:	Shifts		
Initials of Med-Tech			
Room/Resident	3rd Shift (11p-7a)	1st Shift (7a-3p)	2nd Shift (3p-11p)

BUCKET #1- Yellow
NEW PHYSICIAN ORDERS:

Task: Faxed new order(s) to MedTech Pharmacy and waiting for order(s) to show-up in QuickMAR.

BUCKET #2 - Orange
NEW ORDERS IN QuickMAR

Task: New order(s) showed up in QuickMAR. Waiting for medication to arrive from MedTech Pharmacy.

BUCKET #3 - Red
MEDS NOT DELIVERED

Task: Order is incomplete and requires physician clarification; needs a hard copy (i.e. controlled med); requires prior authorization by doctor.

BUCKET #4 - Blue
LAB / DIET / DME / Oxygen Therapy / Hospital follow-up / MISC. ORDERS

Task: These orders require follow-up by our community with another clinical/support service group.

BUCKET #5- Green
READY TO FILE

Task: These orders have been processed and medications received or physician orders have been implemented. These should be filed in the appropriate section of the chart with the most current date on top.

The Med-Aids should be able to be taught to handle buck #1 through #3.

The RCM would oversee the bucket system and should fli through bucket #1 on twice daily basis and the buckets #2 on a once daily basis.

The night shift med-aid could be specifically trained on hc to file the items that reach Bucket #5.