NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

April 7, 2020

Ms. Fallon Simms, Administrator
Oak Haven Assisted Living, LLC, Licensee
Oak Haven Assisted Living
506 Mattox Road
Greenville, NC 27834

Email: fsimms84@gmail.com

Re: Receipt of Plan of Correction VBGX11
Facility: Oak Haven Assisted Living
Licensure Number: HAL-074-036
County: Pitt

Dear Simms:

Based on our telephone conversation on April 6, 2020 there was an addendum to the Plan of Correction for the Statement of Deficiencies dated January 31, 2020. The pages noting the addendum are provided for your records.

Please do not hesitate to contact us at 910-990-0051, if you have questions or we may be of further assistance.

Sincerely,

Lisa T Clewis RN

Lisa Clewis, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure

cc: Fallon Simms, Executive Director
Leasa Park, Supervisor, Pitt County Department of Social Services
Suzy Morgan, Team 5 Supervisor, Eastern Region Office, Adult Care Licensure Section
Tamara Talbot, Team 6 Supervisor, Eastern Region Office, Adult Care Licensure Section
Raleigh Facility File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074036	A. BUILDING _____ B. WING	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HAVEN ASSISTED LIVING	506 MATTOX ROAD GREENVILLE, NC 27834

(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 and follow up survey from 01/29/20 - 01/31/20.	D 000		
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: Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 1 of 5 sampled residents (#2) including failure to refer for physical therapy and occupational therapy. The findings are: Review of Resident #2's FL-2 dated 08/14/19 revealed diagnoses included diabetes, hypertension, hyperlipidemia, morbid obesity, lumber degenerative disc disease, bilateral arthritis of knees, sleep apnea and depression. Review of Resident #2's Resident Register dated 08/28/19 revealed: -Resident #2 ambulated with a walker and had a limited range of motion in her upper extremities -Resident #2 required extensive assistance with	D 273	Please see Attachment 1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Sims TITLE: Administrator (X6) DATE: 3/27/20

Plan of correction Reviewed and accepted with addendums 04/06/2020 @ 135pm

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showers.
-Resident #2 required limited assistance with dressing, undressing, brushing her teeth and combing her hair.

Review of Resident #2's "Progress Notes" dated 09/29/19 at 9:00pm revealed Resident #2 fell in her room on 09/29/19.

Review of the facilities "Physician's Fax Report of Fall" on 09/29/19 revealed:
-The facility notified Resident #2's Primary Care Provider (PCP) by facsimile that Resident #2 fell on 09/29/19.
-Resident #2 had no apparent injury.

Review of a hospital Discharge Summary dated 10/14/19 revealed:
-Resident #2 was evaluated by physical therapy and occupational therapy while in the hospital.
-The discharge summary recommended the that Assisted Living Facility (ALF) arrange physical therapy and occupational therapy for Resident #2.

Review of PCP note for Resident #2 on 11/19/19 revealed PCP examined Resident #2 for pain at her left shoulder with a decrease in her range of motion.

Review of a PCP physician note on 12/03/19 revealed:
-Resident #2 was examined by PCP.
-Resident #2 complained of pain at her left shoulder and upper arm.
-Resident #2 complained of limited mobility at her left shoulder.

Review of Resident #2's physician orders revealed that the resident was not referred to physical therapy or occupational therapy.

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Interview with Resident #2 on 01/30/20 at 3:20pm revealed:
-She had continued to experience pain at her left shoulder.
-She was required assistance to complete personal tasks which included bathing, brushing her hair and getting dressed.
-She would like to receive physical therapy and occupational therapy to provide her with increased independence.
-She did not understand why she did not receive physical therapy and occupational therapy.

Telephone interview with Resident #2's family member on 01/31/20 at 3:20pm revealed she was not aware that Resident #2 had not received physical therapy or occupational therapy.

Interview with Resident Care Coordinator (RCC) on 01/31/20 at 2:00pm revealed:
-Resident #2 had not received physical therapy or occupational therapy.
-It was an "oversight" that was unintentional.
-The RCC would speak with Resident #2's PCP today to request an order for physical therapy and occupation therapy.
-Resident #2 should have been referred to physical therapy and occupational therapy.

Telephone interview with Resident #2's PCP on 01/31/20 at 3:00pm revealed:
-Resident #2 had not been referred to physical therapy or occupational therapy.
-It was a mistake and "we dropped the ball" referring to she and the facility.
-She would compete an order for physical therapy and occupational therapy.
-Resident #2 would benefit from physical therapy and occupational therapy.

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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

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 and interviews the facility failed to assure 2 of 5 residents sampled were treated with respect and dignity as evidenced by performing toileting and perineal hygiene in front of another resident (#4) and wearing a garbage bag wrapped around the bottom of a urinary leg bag (#3).

Please see Attachment 2

The findings are:

1. Review of Resident #4's current FL-2 dated 10/22/19 revealed:
-Diagnoses included vascular dementia, ischemic stroke, depression, and seizure disorder.
-The resident was intermittently disoriented, required assistance with bathing and dressing, and was incontinent of bowel and bladder.
-The resident was semi-ambulatory and dependent upon a wheelchair.

Observations from 4:15pm - 4:20pm on 01/30/20 revealed:
-Resident #4 was sitting in his wheelchair by his bed.
-The resident's roommate was in a recliner located approximately four feet to the left of Resident #4's bed watching television.
- At 4:15pm, a personal care aide (PCA) rolled Resident #4's wheelchair to the foot of his bed.
-The PCA locked the wheelchair and instructed Resident #4 to stand and hold onto the bed.

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-Resident #4 leaned forward, grabbed hold of the foot of the bed, and his buttocks were elevated out of the wheelchair.
-At 4:18pm, the PCA pulled down Resident #4's pants and incontinent brief exposing the resident's buttocks.
-The PCA wiped Resident #4's buttocks with a disposable wipe.
-The PCA told Resident #4 his incontinent brief was wet.
-The PCA pulled up Resident #4's incontinent brief and pants.
-The PCA was prompted regarding resident privacy.
-The PCA instructed Resident #4 to sit down in the wheelchair.
-The PCA pushed Resident #4 in his wheelchair towards the bathroom located in the resident's room.
-The PCA did not proceed to the bathroom with Resident #4.
-The PCA turned from the bathroom and pushed Resident #4 to his bed.
-The PCA assisted Resident #4 to the bed.
-The PCA removed Resident #4's pants.
-The PCA placed a clean incontinent brief on Resident #4 and pulled the brief up to the residents' thighs.
-The PCA removed the saturated incontinent brief from Resident #4.
-The PCA tossed the saturated incontinent brief on the floor towards the foot of Resident #4's bed.
-The PCA wiped Resident #4's groin and perineal area with a disposable wipe.
-The PCA pulled up Resident #4's clean incontinent brief and dressed the resident with pants.

Interview with the PCA on 01/20/20 at 4:20pm revealed:

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-She had performed toileting and perineal hygiene for Resident #4 in front of his roommate many times.
-Resident #4 did not mind being exposed in front of his roommate because the resident had never said anything.
-Resident #4's roommate did not mind the resident being exposed in front of him because the resident had never said anything.
-The PCA had never asked either resident about their privacy preference.

Interview with the Special Care Unit Coordinator (SCUC) on 01/30/20 at 4:45pm revealed:
-Resident #4 could stand, pivot, and sit on the toilet.
-She expected Resident #4 to have been taken to the bathroom for toileting and perineal hygiene to respect the resident's and the roommate's privacy.

Interview with the Owner on 01/31/20 at 7:40am revealed she expected residents to have privacy when performing toileting and perineal hygiene.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

2. Review of Resident #3's current FL-2 dated 01/14/20 revealed diagnoses included vascular dementia, blindness, developmental disability, urostomy, recurrent urinary tract infections (UTI) and diabetes mellitus.

Observation's on 01/30/20 at 4:30pm revealed:
-Resident #3 was standing in his bathroom with his pants down.
-Resident #3 had a supra-pubic urinary catheter (a tube inserted directly in the bladder) with a leg

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bag strapped to his left thigh above the knee.
-There was a clear plastic trash bag tucked behind the bottom of Resident #3's urinary catheter leg bag and behind the leg straps.
-A personal care aide (PCA) was emptying Resident #3's urinary catheter leg bag.
-The PCA performed perineal hygiene on Resident #3.
-The PCA readjusted the clear plastic garbage bag around the bottom of Resident #3's urinary catheter leg bag.
-The PCA pulled up Resident #3's pants.

Interview with the PCA on 01/30/20 at 4:30pm revealed she did not remove the plastic bag because she did not know why the plastic trash bag was wrapped around the bottom of Resident #3's urinary catheter leg bag.

Interview with Resident #3's guardian on 01/30/20 at 4:35pm revealed she did not know the resident had a garbage bag wrapped around the bottom of the urinary catheter leg bag.

Interview with the Special Care Unit Coordinator (SCUC) on 01/30/20 at 4:45pm revealed:
-A PCA told her this morning (01/30/20) Resident #3's urinary catheter leg bag may have been leaking because his pant leg was wet where the urinary catheter leg bag was positioned.
-She had told the PCA this morning (01/30/20) to hold a plastic garbage bag under the urinary catheter leg bag drainage spout to see if urine dripped from the drainage spout.
-She did not tell the PCA to leave the plastic garbage bag around Resident #3's urinary catheter drainage bag.
-She had called the home health (HH) provider today (01/30/20) and left a message Resident #3's urinary catheter leg bag was leaking.

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Interview with the Executive Director on 01/31/20 at 8:00am revealed she did not expect Resident #3 to have had a garbage bag wrapped around the urinary catheter drainage bag.

A second interview with the SCUC on 01/31/20 at 2:24pm revealed she had changed Resident #3's urinary catheter leg bag on 01/30/20 and the urinary catheter leg bag was no longer leaking.

Based on observations, interviews, and record review it was determined Resident #3 was not interviewable.

D 371 10A NCAC 13F .1004(n) Medication Administration

D 371

Please see Attachment 3

10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure medication was administered in accordance with infection control measures as evidenced by 1 of 5 sampled residents (#5) receiving antibiotic ointment applied directly to a wound with a gloved hand without hand hygiene or changing gloves after application of the ointment to the wound.

The findings are:

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Review of Resident #5's current FL-2 dated 05/07/19 revealed:
-Diagnoses included vascular dementia, diabetes mellitus, and diabetic polyneuropathy.
-The resident was constantly disoriented.

Review of Resident #5's physician's order dated 01/28/20 revealed:
-The resident had an infected right index finger with redness and swelling.
-There was an order for triple antibiotic ointment to the resident's right index finger daily, cover with a non-stick dressing, secure with tape.

Observation of Resident #5's right index finger on 01/30/20 at 8:15am revealed:
-The finger was streaked pinkish red and swollen.
-The finger had several scattered open wounds to the top, sides and back of the finger.

Observation of a medication aide (MA) on 01/30/20 at 8:15am revealed
-The MA washed her hands and applied gloves.
-The MA removed a dry gauze dressing from Resident #5's right index finger.
-The MA cleaned the wounds to Resident #5's right index finger with soap, water, and a clean gauze pad.
-The MA rinsed the wounds to Resident #5's right index finger with water and a gauze pad.
-The MA did not remove or change gloves.
-The MA removed keys from her right pocket and unlocked the medication cart without removing or changing gloves.
-The MA opened the bottom left drawer of the medication cart without removing or changing gloves.
-The MA discarded her gloves in the trash after opening the bottom left drawer of the medication

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cart.
-The MA removed a tube of antibiotic ointment and gauze pad from the medication cart drawer.
-The MA applied gloves, removed the cap and squeezed the antibiotic ointment onto her gloved right index finger.
-The MA spread the ointment from her gloved right index finger onto the wounds on Resident #5's right index finger.
-The MA did not change gloves.
-The MA opened the gauze pad and applied the dry gauze to Resident #5's right index finger.
-Without changing gloves, the MA recapped the antibiotic ointment tube and placed it in her right lower shirt pocket.
-The MA removed the keys from her pocket while wearing the soiled gloves.
-The MA unlocked the medication cart wearing the same gloves.
-The MA opened the bottom left drawer of the medication cart wearing the same soiled gloves.
-The MA opened a plastic bag of shared resident wound care supplies and fumbled through the bag wearing the same soiled gloves.
-The MA searched through the bottom left drawer of the medication cart containing supplies and medications for other residents wearing the same soiled gloves.
-The MA closed the bottom left drawer of the medication cart.
-The MA locked the medication cart.
-The MA removed her gloves.
-The MA pushed the medication cart to the medication room/SCUC office.

Interview with the MA on 01/30/20 at 8:30am revealed:
-Infection control classes were taught yearly by the owner.
-Her last infection control class was the middle of

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2019.
-She was taught to wash her hands, wear gloves perform wound care, remove gloves, and wash hands after wound care.
-She had never been taught to apply ointment to a gauze pad, cotton tipped swab, or tongue depressor for wound application.
-She had been taught it was acceptable to use a gloved finger to apply ointments to wounds.
-She did not realize she was contaminating other items with her gloves after touching a dirty dressing and wounds.

Interview with the Special Care Unit Coordinator (SCUC) on 01/30/20 at 8:45am revealed:
-She expected the MA to have applied the antibiotic ointment to the residents wound by squeezing the ointment on the wound from the container.
-She expected the MA to have used a gauze pad to spread the ointment over the wound.
-She expected the MA to have changed gloves after performing wound care.
-She did not expect the MA to have touched the tube of ointment, medication cart keys, medication cart, or supplies in the medication cart with soiled gloved hands because of contaminating those items with germs.

Interview with the Executive Director (ED) on 01/30/20 at 9:00am revealed:
-Infection control training was performed yearly by the LHPS nurse.
-Antibiotic ointment should be applied with a gloved finger.
-The ointment should be applied to a wound by using the gloved finger to spread the ointment over the wound.
-A dressing should be applied to the wound after the ointment was spread over the wound with the

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gloved finger.
-Gloves should be removed and hand washing performed after the clean dressing was applied.
-After the ED was prompted, she acknowledged the gloves should have been changed after the ointment was applied to Resident #5's wound because of cross contamination to the ointment tube, medication cart keys, medication cart, and supplies in the medication cart.

Interview with the owner on 01/30/20 at 9:50am revealed:
-All infection control training was performed yearly.
-She had checked off the MA on infection control in 2019.
-She expected gloves to have been changed after removing Resident #5's dirty dressing.
-She expected gloves to have been changed after cleaning Resident #5's finger wound.
-She expected the MA to have discarded her gloves after applying a clean dressing to Resident #5's finger wound.
-She expected the antibiotic ointment to have been applied to a dressing and the dressing applied to Resident #5's wound.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 01/31/20 at 10:45am revealed:
-The resident had a chronic infection of his right index finger.
-The resident would bite his finger causing recurrent wounds and infections.
-The resident was being treated with oral antibiotics, an antibiotic ointment, and dry dressing changes.
-She did not expect the antibiotic ointment to have been applied to the resident's finger with a gloved hand.

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-Cross contamination placed residents at risk for infection.
-She would contact home health to teach staff how to apply the dressing to the resident's finger.

Review of the MA's training records revealed:
-The MA had received training on medication administration and wound care by the Licensed Health Professional Support (LHPS) nurse on 09/07/18.
-The MA had received training on infection control on 07/26/19.

Attempted telephone interview with Resident #5's Power of Attorney on 01/31/20 at 10:30am was unsuccessful.

Based on observations, interviews, and record review it was determined Resident #5 was not interviewable.

Attachment 1

10ANCac 13F .0902(b) Health Care

It is Oak Haven Assisted Living's Policy to comply with all state rules and regulations regarding health care. An audit of all charts will be completed by the RCC and Executive Director (03/2020). Random chart audits will continue monthly by RCC and Quarterly by the Executive Director. Contact with physicians / providers will be noted on shift reports and Progress notes. Progress notes are to be charted in the residents file. Executive director will get the shift report daily from the RCC and administrator weekly. Appointments will be kept in a calendar and weekly appointments will be included with shift reports.

Telephone call with Fallen Simms, Administrator
04/06/2020

(1) Completion date 03/31/2020
(2) Chart audits to ensure referral and Health care orders are all captured and Not Overlooked / missed.

LE 04/06/2020 135pm

Attachment 2

10A NCAC 13F .0909 Resident Rights

It is Oak Haven Assisted Living's Policy to comply with all state rules and regulations regarding Resident's Rights. A Resident Rights In -Service was conducted by the Regional Long Term Care Ombudsman on 2/27/2020. All staff were required to attend and a roster of the attendees is being maintained in the facility, as well as the content of the material.

On going Residents Rights training will Occur Periodically during the year. The next in service will be conducted by the Administrator in June 2020. A roster will be kept of all attendees, as well as, the content of the material delivered.

All staff members have been given a copy of the North Carolina Resident's Rights to review. They are required to sign an acknowledgement stating that they understand and are aware of the rights of the residents and failure to comply will result in immediate corrective actions and may lead to termination.

New employees will be givien training on resident rights taught by their supervisor and acknowledgement will be signed before they are released to perform duties on the floor. A log will be kept by Executive director in the Acknowledgement.

Concerns noted by residents will be followed up on immediately by medication staff / RCC. Documentation of these concerns will be noted on a progress note and shift report. The RCC / Executive Director will review shift notes daily to ensure all concerns / needs of the resident are met in a timely manner. Administrator will follow up weekly to make sure the matters have been solved or a plan is in place to solve the issue.

Employee was immediately terminated. (resident 4)

An in-service was taught by home health RN to educate staff on catheter care (resident 3). Any addition problems are to be reported to RCC immediately to ensure prompt correction of equipment. 03/04/2020

Telephne call with Fallon Simms. Administrator 04/06/2020

Completion date 03/04/2020
to 04/06/2020 13Fm

Attachment 3

10A NCAC 13F .1004(a) Medication Administration

It is Oak Haven Assisted Living's Policy to comply with all state rules and regulations regarding medication administration. All Medication Aides were In- Serviced on Oak Haven's Policy on Medication Administration (02/15/2020) by a RN that included our protocol for wound care to ensure correct infection control procedures. Implementation of a new wound care check off form will ensure on-going compliance of these regulations and documentation. This system is to ensure all new and current Medication aides are checked off and understand the policy. Executive director will actively keep a log of the check off and Administrator will check quarterly. Before a new medication aide is released from training pass medications alone and released from training, executive director is responsible to make sure the form has been completed and employee understands policy. All medication aides are required to have infection control yearly and new medication aides are required to have this before they complete their training. Executive Director will file the Completion certificate on going and administrator will check each Quarter.

Completion date: 03/15/2020

Telephone call with Falen Simms, Administrator 04/06/2020

Medication pass observations performed randomly and all medication aides observed on medication pass quarterly by the Resident Care Coordinator (RCC)

A log for medication pass observations documented by the RCC and submitted to the Executive Director weekly and to the Administrator weekly.

K 04/06/2020 1:35pm