Moore, Veronica M

From:	Dwayne Edwards <edwards1687@gmail.com>
Sent:	Wednesday, May 31, 2017 1:47 PM
To:	DHSR.CON.Comments
Cc:	rhoe-jones, jane e
Subject:	OBJECTION TO CON FOR RIVERBEND/CRAVEN OPCO/CRAVEN PROPCO
Attachments:	Craven opco Owner.html; Craven Propco Owner.html; Affinity Alamance House Patient Died.pdf; Affinity HIV Lawsuit.html; Country Time Inn Survey.pdf; LAFOUNTAIN v. MERIDIAN SENIOR LIVING, LLC Case No. CV 15-03297-RGK (PJWx). Leagle.com.html; Meridian Lawsuit Not paying bills; Meridian Sued Patient Death.html; Meridian Wrongful Death Case.pdf; Who's Running Southeast Louisiana Hospital News Gambit Weekly - New Orleans News and Entertainment.html; Wilmington Nursing Home Fined $2,000 In Death.html; Wood Haven Penalty resident died.html

DEAR MS. JONES:

I strongly object to this CON being approved for this project. These properties are owned by Charles Trefzger (see attached ownership certs) who has been under investigation for poor resident care, fraud and as even had residents die in his homes. His homes have had an enormous amount of fines and penalties over the last few years. Please see the attached list of homes with penalties. He also is not following the budget for other projects your department has approved in the past. Why would we give someone more beds when they cannot comply with the rules and regulations for the homes they have. The last few applications have been denied for using same or improper information and this application should be denied as well. I thank you for your time in this matter. I will be sending Penalty list shortly.

Corporate Names

Legal: Craven Propco, LLC

Limited Liability Company Information

SosId: 1586135
Status: Current-Active
Annual Report Status: Current
Citizenship: Domestic
Date Formed: 4/6/2017
Fiscal Month: January
Registered Agent: Waldrep LLP

Corporate Addresses

Reg Office: 101 S Stratford Rd Ste 210
Winston Salem, NC 27104

Reg Mailing: 101 S Stratford Rd Ste 210
Winston Salem, NC 27104

Principal Office: 328 1st Ave NW
Hickory, NC 28601

Mailing: PO Box 2568
Hickory, NC 28603

Company Officials

All LLCs are managed by their managers pursuant to N.C.G.S. 57D-3-20.

Manager: Charles E Trefzger , Jr
328 1st Ave NW
Hickory NC 28601

Corporate Names

Legal: Craven Opco, LLC

Limited Liability Company Information

SosId: 1586133
Status: Current-Active
Annual Report Status: Current
Citizenship: Domestic
Date Formed: 4/6/2017
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All LLCs are managed by their managers pursuant to N.C.G.S. 57D-3-20.

Manager: Charles E Trefzger , Jr
328 1st Ave NW
Hickory NC 28601

PRINTED: 11/06/2015
FORM APPROVED

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
	HAL001146	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER: ALAMANCE HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 2766 GRAND OAKS BOULEVARD, BURLINGTON, NC 27215

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on October 20, 21, 22 and 23, 2015.	D 000	Responses to cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in this statement of Deficiencies of Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with state law.	
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 A1 VIOLATION Based on observation, record review and interview, the facility failed to assure supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 7 sampled residents who received injuries due to falls (Residents #6, #7). The findings are: 1. Review of Resident #6's FL-2 dated 6/2/15 revealed: -The resident resided in the Special Care Unit (SCU). - Diagnoses included Alzheimer's dementia, hypertension. - The resident was constantly disoriented, was a wanderer, ambulatory, and needed assistance with bathing and dressing. Review of Resident #6's current FL-2 dated 9/04/15 revealed:	D 270	10A NCAC 13F .0901(b) Personal Care and Supervision. (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. 	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beth Mize, Director of Operations
TITLE: Director of Operations
(X6) DATE: 11/25/15

STATE FORM DXVS11 If continuation sheet 1 of 35

11/25/15

Reviewed & Accepted 12/3/15 [signature]

Division of Health Service Regulation

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D 270	Continued From page 1 - Diagnoses included Alzheimer's dementia, s/p ACDF C4-5 (status post, anterior cervical discectomy and fusion surgery in the neck area of the spine), acute, new, and hypertension. - The resident required extensive assistance with ambulation, transfers, toileting, eating, dressing and bathing. Review of Resident #6's Resident Register dated 3/12/15 revealed: - The resident was admitted to the facility on 3/12/15. - The resident had significant memory loss, must be directed, and needed orientation to time and place. - Resident #6 was transferred to a local hospice house on 10/02/15. Review of Resident #6's Initial Resident Assessment Plan dated 3/17/15 revealed: the resident had "no problems with ambulation/locomotion, was "sometimes disoriented", was "forgetful - needed reminders", was "independent" for mobility. Review of Resident #6's Quarterly Review (care plan update) dated 4/08/15 revealed: "no (assessed) changes". Review of Resident #6's Quarterly Review (care plan update) dated 7/08/1515 revealed: "difficulty eating" and "unsteady gait". Review of Resident #6's Care Notes revealed: - On 6/14/15 the resident was complaining of neck pain and was hard to arouse, physician notified and resident was sent to the local hospital's Emergency Department for evaluation, was treated and released and had a follow-up with primary care physician (PCP) within 3 days.	D 270	Every resident will receive a Falls Assessment using the Fall Risk Assessment Tool at move in and after a fall. Any resident identified as a high falls risk by Falls Management Team will be placed on 72 hour monitoring to include increased supervision. ED and Care Manager to determine any immediate interventions required based on circumstances of fall. Documentation for period of 72 hours after fall, vitals initially and every shift x 72 hours or additional as necessary, assessment of possible risk/contribution factors for falls to include lighting, clutter, furniture placement, location, height of toilet seat, FSBS if diabetic, utilization of assisted device, recent medication changes. If resident has 2 falls within 4 week period an order for PT Evaluation or other treatment/interventions to include 72 hour Hot Box Charting for follow up and monitoring. Each morning, Monday thru Friday, ED and/or Care Managers will review shift change report to review notes from previous shift and weekend to address any concerns including falls. ED and/or Care Manager will initial shift change report and review incident reports daily, to ensure compliance and follow up with family, physicians, and compliance with Falls Management Policy.	10/23/15 ongoing 10/23/15 ongoing

Division of Health Service Regulation

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D 270	Continued From page 2 - On 8/22/15 at 8:30 am the resident was found on the floor (location not given) on her right side, refused to have vital signs taken,was transported to the local hospital ER for evaluation and was returned at 11:45 am, PCP and family contacted. - On 8/31/15 (date does not match with Accident/Incident Report of 9/01/15) at 10:20 am the resident was observed on the floor on her left side, sent to the local hospital ER for an unwittnessed fall. PCP and family notified. - On 9/04/15 (no time given) the resident returned from a regional medical center. Review of Accident/Incident Reports for Resident #6 revealed: - On 8/22/15 at 8:00 am, the resident was discovered in room 401 (resident's room) on the floor laying on her right side and was transported to a local hospital by EMS for treatment for bruising; body area(s) bruised not documented. - Power of Attorney (POA) and Primary Care Physician (PCP) physician notified. - On 9/01/15 at 10:05 am, the resident was observed laying on the floor in a bedroom (room not documented) on her left side and was transported to a local hosptal by EMS for treatment of skin tear on forehead and swelling. - The POA and PCP were notified. Review of treatment records from 8/01/15 to 10/21/15 from a local hospital for Resident #6 revealed: - On 8/22/15 at 6:22 am Resident #6 was admitted to the emergency department for a fall injury to right elbow and complaint of all-over pain. - Admission narrative revealed. "Staff states that the pt. was found laying on the floor and that she had been seen earlier in the living room". - The resident was treated, released, and	D 270	To ensure ongoing compliance; Staff will receive formal training on Fall Prevention Awareness at least once per quarter and at hire of new associate. All staff is reminded of fall prevention techniques during monthly staff meetings. The Falls Management Team will review Incident reports at a minimum on monthly basis and will consist of ED, Care Manager, Med Tech/SIC, Aide/Floor Staff and any other discipline as determined by ED. Team will review all resident falls from past month using Incident Reports and charts for trends. All residents that are considered high falls risk have name on yellow paper posted by resident room door to aid staff in knowing who is considered high fall risk.	11/4/15 ongoing 11/5/15 Quarterly thereafter 11/23/15

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D 270	Continued From page 3	D 270		

returned to the facility.
- On 9/01/15 at 10:51 am Resident #6 was admitted to the emergency department for a fall injury of cervical spine.
- EMS report revealed: This was an unwitnessed fall with an unknown cause for the fall, the patient was found on the floor on her left side with staff stating only visible injury was a hematoma to her forehead; staff got the patient off of the floor and placed her on her bed.
- The patient was immobilized and had a hematoma to her left forehead.
- After assessment, the Emergency Department Physician notes revealed the resident needed to be transferred to a medical center for treatment.
- Resident #6 was transferred from the local hospital to the accepting regional medical center by helicopter.

Review of medical records fro Resident #6 from 9/01-04/15 from the regional medical center revealed:
- On 9/01/15 Resident #6 was air-lifted to the medical center from a local hospital and was emergency admitted to the Neurology trauma unit.
- Trauma notes revealed patient found "down" at (the facility), unwitnessed fall, uncertain duration of time "down", unclear LOC (level of conciousness); acute management of significant spine injury.
- Surgical consult for Resident #6 revealed C4-5 concerns with a possible epdiural hematoma behind the fractures, definite cord compression.
-Due to cervical fractures and risk of quadriplegia, and worse prognosis without surgery, family elected to go ahead with surgery to stabilize the spine.
-Strict spine precautions, to surgery tonight (9/01/15) for fusion of cervical vertebrae.

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D 270	Continued From page 4	D 270		

- Resident #6 was discharged on 9/04/15 from the regional medical center to the facility Memory Care Unit with hospice support.

Review of Resident #6's PCP's office notes revealed:
- On 6/02/15 the resident was seen for complaint of neck pain, referred to physical therapy.
- On 6/14/15 the resident was sent to the local hospital per request of family for complaint of resident not steady, leaning, and difficulty to arouse.
- On 6/18/15 the resident was seen for follow-up.
- On 8/22/15 received a call from the facility reporting Resident #6 having a fall and being sent to the hospital.
- On 8/25/15 the resident was seen for follow-up.
- On 8/25/15 facility requested a urinalysis for the resident.
- On 9/01/15 received voicemail from the facility reporting Resident #6 having a fall and being sent to the hospital.
- On 9/06/15 received voicemail from the facility the resident was back at the facility; resident placed with hospice services.
- On 9/08/15 resident complaining of pain, order for Oxycodone 5 mg as needed (prn).
- On 9/10/15 dementia advancing, continue supportive care, Oxycodone changed to 5 mg twice a day (bid); from fall at facility and surgery at (a regional medical center) resident having increasing pain.
- On 9/28/15 received call from hospice reporting resident was not swallowing medications or eating, spitting out Oxycodone, order for liquid morphine 0.25 ml. every 2 hours prn for pain and Ativan 0.5 mg every 4 hours prn for agitation.
- On 10/01/15 visit for Resident #6's declining health, not eating, not taking medications, discontinued oral medications, changed Ativan to

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D 270	Continued From page 5 gel. - On 10/02/15 call from hospice, more decline, moving resident from facility to (a local hospice house). Interview on 10/21/15 at 8:20 am with a SCU Staff revealed: - "Resident #6 fell and broke her neck in a fall last month (September, not sure of date)". - The resident had problems with her neck and head before the fall. - "The resident wandered and was always walking around (the SCU)." - (Resident #6) was found in another resident's room and "it looked like she was seated in a chair, maybe dropped off to sleep, and fell out of the chair". - The time was around 10:00 am and all SCU staff were in a stand-up meeting at the nurse's station. - We heard a weak "thump sound" and ran to look. - The PCA saw the resident lying on the floor in front of a chair. - A nurse was there as she had found the resident on the floor. - EMS was called; "we did not know the extent of Resident #6's injuries until she went to the hospital." - The resident stayed at the hospital about 1 week and returned to (SCU) wearing a neck brace. -Resident #6 was placed with hospice and she died a couple of weeks later. - Her diagnosis was that she had broken her neck. - If a resident was a falls risk, staff were verbally told in stand-up meetings. - The PCA did not know if Resident #6 was considered a fall risk as the PCA was not told she	D 270		

Division of Health Service Regulation

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D 270	Continued From page 6	D 270		

was.
-For falls supervision, staff would watch the residents closely by trying to keep them all together.
- The facility had a fall policy about what to do after a fall, but not sure about one for fall prevention.
- They might use "gripper socks" on the residents.
- All SCU staff were in the meeting at the front desk, so no one was in the hallways when the resident fell.
- There were no changes in supervision after Resident #6's 8/22/15 fall.

Confidential interview with a 2nd SCU Staff revealed:
- Resident #6 liked to walk the halls, sit at the end of the front hall on the couch, or in another resident's room, she was constantly walking around.
- On 9/1/15 the resident wandered into room #405.
- The MA was not sure what happened when Resident #5 fell on 9/1/15, staff was out helping other residents.
- Falls risk residents are checked every hour and toileted every 2 hours.
- After the fall on 8/22/15, Resident #6 had a 3 day, every 30 minutes checks.
- "If (Resident #6 was wandering, she would wander back,"

- Confidential interview with a 3rd SCU staff revealed:
- In August, Resident 6 was having "issues" with her neck.
- The resident walked in and out of other resident's rooms.
- After the 8/22/15 fall she was put on 72 hour checks every 30 minutes, after that residents

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D 270	Continued From page 7	D 270		

would be monitored routinely every 2 hours.
- "Each time a resident had a fall, the same would be done; it was our routine".
- The staff was not sure if the facility had a falls prevention policy.
- When Resident #6 fell on 9/01/15, we were finishing a staff stand-up meeting; meetings were held around 9:45 am to around 10:00 am.
- The meetings were for all SCU staff and were held up front at the nurse's station.
- MAs would conduct the meetings with managers present; the meetings could last 15, 20, or 30 minutes depending on what was going on.
- During the meeting, staff tried to have all residents in the TV/living room area.
- Some residents stayed in their rooms, some walked around.

Observation on 10/21/15 at 9:50 am of the SCU staff meeting revealed:
- SCU staff were standing around the front of the nurses' station facing the wall behind the desk area, a MA and a manager were conducting the meeting on the other side of the desk facing the staff and behind them, the TV/living room area.
- Most of the residents were seated in the TV/living room area and 2 residents were slowly walking back and forth between tables.

Confidential interview with a 4th and 5th SCU staff revealed:
- After Resident #6's fall in August, she was put on 72 hr. every 30 minute checks; after that she was back on routine every 2 hours checks.
-The same was done for every resident who had a fall.
- For falls prevention, staff was told by the Special Care Coordinator (SCC) to keep a check on residents, but was not told a specific time.
- On 9/01/15, when staff were coming to the

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D 270	Continued From page 8	D 270		

morning meeting, Resident #6 was sitting in her room in a chair.
- The resident was found in another resident's room on her right side on the floor.
- The LHPS (Licensed Health Professional Support) nurse was there to see another resident, heard the resident fall, and went to check on her.
- All SCU staff, at least 1 assisted living staff, and managers attend the morning meetings.
- Staff stands at the nurse's station facing the wall.
- The majority of the residents were in the living room, some wandering around, some in their rooms asleep.
-The managers could see the resident's wandering.
-When Resident #6 fell, the meeting was coming to an end; no one saw her fall.

Confidential interview with a 6th SCU Staff revealed:
-There had been several residents that had fallen in the past 6 months, 2 residents tripped over their feet while walking and had no injuries, a resident fell, had a fractured hip last month, and was in a rehabilitation facility.
- Usually there were 1 staff in the dining room area, and 1 in each hall (2).
- During a staff meeting, all staff are up front at the desk.
- Staff could turn around to check on residents.
- Residents in their rooms would get checked on after the meeting.
- We kept the falls risk residents seated up front (TV/living room area) and they had staff assistance while ambulatory.

Confidential interview with a 7th SCU staff revealed:
- An incident happened while we were in a

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D 270	Continued From page 9 stand-up meeting about 2-3 months ago, not sure of date. - Resident #6, who was no longer at the facility had a fall. -The resident walked into another resident's room that was vacant and sat in the chair. - Five minutes into the meeting we heard a fall and went to check. Resident #6 was lying on the floor on her left side; it looked like she was moving from the chair to the bed. - Resident #6 stated "help me get up off the floor, and complained of neck pain". - She was sent to the hospital and came back with a neck brace, had broken 2 vertebrae; and was placed with Hospice due to having dementia. - Later she was placed with (local hospice house) and passed away. - During the stand-up meetings, all SCU staff stood around the (front) desk, no staff were in the halls. -The meetings lasted up to 30 minutes. - Residents could be in their rooms, no staff checked as the residents were usually asleep. - For falls prevention, residents were checked every 15 or 30 minutes, 1 hour after a fall and hospital visit; staff kept the residents close by and toileted them regularly. Confidential interview with an 8th SCU staff revealed: - Resident #6 fell on 1st shift on 9/01/15 and broke her neck in 2 places and Resident #7 fell the next day and fractured his hip. -Resident #6 always kept her head down, but could raise it. -She fell in the hallway at the end of the hall and was sent to the hospital. -When she came back, she wore a neck brace and a cervical collar. - The resident was ordered pureed food and	D 270		

Division of Health Service Regulation

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D 270	Continued From page 10	D 270		

nectar thickened liquids, but would not eat anything.
- The resident would talk, saying she was not hungry and she would not drink much.
- After 1 week, she was "shutting down", her blood pressure was 90/45 when this staff checked it (did not remember the date or time), she had stopped consuming anything.
- The resident was sent to (a local hospice house) and died 2 days after leaving the facility.
- This staff had not been told Resident #6 was a falls risk.
- This staff was not aware of a facility falls prevention policy, but staff tried to keep residents out of their rooms and together with staff.

Confidential interview with a 9th SCU staff revealed:
- Resident #6 fell on 1st shift on 9/01/15, (could not remember the time) and no one saw her fall.
- She was starting to lose her balance when ambulating, but continued to walk on her own.
-She would wander off down the hallway.
-Staff would try to keep the resident in sight.
- The resident fell in another resident's room, but this staff did not know the details.
- Her health declined after the fall and she stopped eating.
- There was no facility policy for falls prevention, and staff received instructions from the SCC.
- For falls prevention staff would see that shoe laces were tied if the resident walked and try to keep residents in sight.

Interview on 10/23/15 at 11:30 am with the LHPS nurse revealed:
- The nurse started seeing Resident #6 on 4/02/15 and did an initial assessment, no tasks had been ordered at that time.
- On 6/02/15, the nurse was informed physicial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 11	D 270		

therapy (PT) had been ordered and was working with the resident.
- On 9/01/15 there was no visit scheduled with the resident due to no tasks ordered (PT was no longer a task); the nurse was in the facility to see other residents.
- On 9/01/15 the nurse was walking down the 300 hall to see the scheduled resident when she saw Resident #6 lying on her right side on the floor in another resident's room which was the furtherest away from the nurse's station.
- No staff were in the resident rooms or in the hallway.
- The nurse did not know how long the resident had been lying on the floor.
- The resident was making no sounds, but was grimmacing.
- The nurse asked if she was ok and then took the resident's vital signs and yelled for staff to call 911, Resident #6 was on the floor and needed help.
- The resident was in major distress and became agitated.
- The nurse tried to calm the resident while waiting for the staff to arrive.

Interview on 10/22/15 at 10:50 am with Resident #6's POA revealed:
- The resident started leaning her head to the right around Mother's Day (5/10/15).
- Physical therapy was provided and her physician changed some of her medications, but we could not determine the reason for the change.
- Leaning her head caused vision changes, especially when she walked.
- The resident liked to walk around the SCU alot.
- On 8/22/15 the POA was called at 8:15 am by the facility saying the resident had an unwittnessed fall and received bruises; she went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001146	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 12 to the hospital, was seen and released. - The resident had been released by the time the POA got to the hospital. - On 9/01/15, the POA was called (do not remember the time) and was told the resident had fallen on the floor in another resident's room and was sent to a local hospital. - The POA went to the hospital and saw that the resident had a big knot on the left side of her head and wore a cervical collar. - The ER physician told the POA they did not see this type of injury often, the resident had a severe neck injury affecting the C3, C4, C5 and C6 (cervical vertebrae) were almost severed and she needed to be transported to a regional medical center immediately. - Resident #6 was flown by helicopter to a regional medical center and admitted to the emergency trauma area. - The POA was called by the trauma physician and stated "the resident needed to have emergency surgery. - The surgeon told the POA the resident would die if he did not do the emergency surgery, but also could die during the surgery. - The neck surgery was done through the front of the neck instead of the back due to her age and condition, but would be able to stabilize her head and keep her alive. - The POA wanted the resident to be placed in a local hospice house, but placement could only happen if the resident was within 7 days of dying so the resident was sent back to the facility to recover with hospice care. - The head injury looked severe; the bruised spot sunk in after a few days; we were not sure what happened (to her)." - Resident #6 "did not come back from it, she was in a steady decline, which came rapidly." - The fall led to a condition that caused her death;	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 13	D 270		

because of the condition, she could not eat, or eventually, swallow.
- "Family went very often to see the resident and were not sure what staff did to supervise the resident after the previous fall; I often wondered about that."
- Staff never discussed supervision for Resident #6 with the POA.
- After her fall on 8/22/15, the POA did not receive any communication from the facility about supervision for falls prevention or changes in staff supervision.
- "They should have watched her more closely as she was a falls risk."
- The resident was taken to a local hospice house on 10/02/15 and died on 10/04/15.

Interview on 10/23/15 at 12:45 pm with Resident #6's PCP revealed:
- "The resident had advanced dementia and spasms of the neck for a long time and was prone to falls".
- On 6/02/15 the PCP talked with the SCU staff about Resident #6 being "prone to falls, the resident needed to have staff hold hands or have a walker in front of her".
- On 6/18/15 the PCP talked again with staff about the resident being prone to falls.
- Physical therapy was ordered to help with the resident's balance.
- "Resident #6's vision was not good and it was hard for her to see from the side due to her neck condition.
- Staff needed to keep the resident in front of them and always needed someone around watching her.
- If staff was not around, they would not see the resident fall; it was needed to have someone free to keep a check on the residents."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 14 Interview on 10/22/15 at 5:45 pm with the Special Care Coordinator (SCC) revealed: - After Resident #6 fell on 8/22/15 she was supervised by having falls risk monitoring of 30 minute checks if she was not out in the front (TV/living room area), toileting was every 2 hours, and staff made rounds no greater than 1 hour. - After a fall, residents would have staff checks every 30 minutes for 72 hours. After 72 hours, the resident would be evaluated and go back to the falls risk monitoring. - On 9/01/15 Resident #6 was found on the floor at the foot of the bed at 10:15 am in another resident's room. - She walked a lot and often walked into other residents' rooms. - She was found by the LHPS nurse who was going to see another resident. - The staff stand-up meetings happened every day at 9:45 am and lasted 10 to 15 minutes. - All SCU staff attend and stand facing the managers and medication aides. - The majority of the residents were seated in the living area, with maybe 2-3 residents in their rooms at that time. - No staff were on the hallways. - The facility did not have a falls prevention policy, but had a falls program. Interview on 10/22/15 at 7:00 pm with the Special Care Unit Coordinator revealed: - For Resident #6, physical therapy worked with her, we contacted the physician frequently regarding her condition, we did not have a chance to implement alarms. - After Resident #6's fall (on 9/01/15) she was referred to hospice, had fall mat, hospital bed; after discharge from hospital, bed alarm not an option at that point, as we did everything for her, she continued to stay on 30 minute checks.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 15	D 270		

Review of the facility falls prevention policy revealed:
- "Employee Safety Responsibilities" handout which included the following:
- "FALLS: When any individual falls, (resident, employee, or visitor) no one should help him/her get up until a nurse or, in the alternative, an EMT (from a 911 call), has assessed for injuries."
- Attached forms included:
1. Fall Prevention document - 3 steps: observations of the resident, surroundings, and interactions with staff and other residents.
2. Falls Inservice form - steps to take after an unwitnessed fall (no signatures)
3. Falls Among the Elderly form with signatures and dated 7/22/15, factors contributing to falls, gait belt use.
4. Physical Therapy inservice on the use of gait belts, fall prevention, dated 8/5/15; no outline of program content.

Refer to Interview on 10/22/15 at 7:00 pm with the Special Care Unit Cordinator.

Refer to Interview on 10/22/15 at 7:00 pm with the Senior Care Manager.

Refer to Interview on 10/22/15 at 7:00 pm with the Director of Operations.

Refer to Interview on 10/22/15 at 7:00 pm with the Administrator.

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2. Review of Resident #7's current FL-2 dated 6/9/15 revealed:
Review of Resident #7's current FL-2 dated 6/9/15 revealed:
-Resident #7' orientation status was listed as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2706 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 16	D 270		

constantly disoriented.
-Resident #7 needed assistance with bathing, dressing, and was incontinent of bowel and bladder.
-Resident #7's ambulatory status was listed as semi-ambulatory with the use of a walker.
-Diagnoses included Alzheimer's,dementia, weakness, hypokalemia, osteoarthritis, pancreatitis, and depression.

Review of Resident #7's current FL-2 dated 6/9/15 revealed medications included:
-Medications included Tylenol 500mg one by mouth every 12 hours.
-Aspirin 81mg one by mouth daily.
-Paroxetine 40mg one by mouth daily. (Used to treat depression.)
-Neurontin 100mg one by mouth daily. (Used to treat convulsions and nerve pain.)
-Quetiapine 12.5mg one every AM, and one at bedtime. (Used to treat psychosis.)
-Acidophilus capsule one by mouth daily.
-Lisinopril 5mg by mouth at bedtime. (Used to help prevent heart attacks and lower blood pressure.)
-Melatonin 1mg at bedtime. (Used to treat insomnia.)
-Potassium Chloride 10 MEQ by mouth daily.
-Lorazepam 0.5mg daily as need for anxiety.

Review of Resident #7's resident register revealed Resident #7 was admitted on 2/14/13.

Review of the facility's Admit/Discharge Report revealed Resident #7 was discharged from the facility on 10/05/15.

Review of Resident #7's hospital records revealed Resident #7 was discharged to a skilled nursing facilty/rehabilitation center on 10/6/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 17	D 270		

Review of Resident #7's care plan dated 6/4/15 revealed:
-Resident #7's mental health and social history was documented as a wanderer.
-Resident #7's ambulation status was documented as ambulatory with and aids or device, limited range of motion, and limited strength.
-Resident #7's bowel and bladder status was documented as incontinent.
-Resident #7's orientation status was documented as forgetful and constantly disoriented.
-Resident #7's vision and hearing status was documented as adequate for daily activities.
-Resident #7's activity of daily living status was documented as requiring extensive assistance (3 personal care aides) with bathing, dressing, and hygiene after toileting.
-Resident #7's mobility status was documented as needing limited assistance.
-"The resident ambulates throughout facility with walker or wheelchair and has a very unsteady gait."
-"The resident is able to propel himself through the facility while in his wheelchair."
-"The resident is able to transfer to and from chairs with assistance from staff for safety."

Review of Resident #7's care notes revealed:
-There were no care notes provided for the month of July.
-There were 6 documented falls from 8/6/15 through 9/29/15.
-8/6/15 (no time documented) "Resident #7 fell in the bathroom, range of motion was done, vital signs were taken."
-8/26/15 at 9AM "Resident #7 was observed losing his balance in common area falling to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 18	D 270		

floor landing on his bottom. No injuries present at this time. No other reports at this time. Will continue to monitor."
-8/26/15 at 6:55PM "Resident #7 became very aggressive towards staff, hitting, scratching, punching, and kicking staff members. Requested UA& culture check. Resident was also given PRN Ativan."
-8/28/15 (no time documented) "Resident #7 was complaining of pain in both knees, and not being able to walk.Waiting on order for x-ray and UA/culture."
-8/28/15 (no time documented) "Resident #7 had no complaint of pain or discomfort. Got the UA/culture sent off and sending a clarification on X-rays."
-8/31/15 "The urine specimen that was sent off was unlabeled so the lab could not use it. Staff was trying to collect another one."
-9/3/15(no time listed) "Upon arrival was told by 3rd shift supervisor in charge that resident must have scooted on his bottom from bathroom to bed."
-9/4/15 "Resident #7 was returned from hospital at 6:50AM. No new orders."
-9/4/15 10:20AM "Resident #7 was observed on the floor on right side. He was sent out via EMS to hospital."

Review of Resident #7's accident and incident reports revealed;
-There were only 3 reports provided (9/4/15, 9/22/15, and 9/29/15.)
-On 9/4/15 at 1:40AM Resident #7 was found on the floor of his bedroom on his left side.
-Resident #7 presented with a laceration to his left temple and pressure was applied to stop bleeding.
-On 9/4/15 at 1:50AM Resident #7 was sent out of facility to the local emergency room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2756 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 19	D 270		

-Resident #7 was alert before he was taken out of facility.
-Resident #7 was not seen by the primary care physician.
-The facility staff spoke directly with Resident #7's primary care physician at 2AM.
-The POA was notified at 2:05AM.

Review of facility's documentation of emergency room records dated 9/4/15 revealed:
-3AM Resident #7 was seen after "patient fell out of bed and hit head."
-7:30AM discharge instructions included a diagnosis of a closed head injury, trauma, and a skin tear.
-"Follow up with your primary care physician as soon as possible."

Review of Resident #7's hospital radiology report signed and dated 3:58 AM 9/4/15 revealed:
-The reason for the head CAT scan was a fall out of bed and head trauma.
-No evidence of acute intracranial abnormality.

Review of facility's documentation of emergency room records dated 9/4/15 revealed:
-9:20AM Resident #7 was seen after he "tripped".
-"Lacerations from an earlier fall were noted above left eye."
-3:40PM discharge instructions include a diagnosis of 2nd fall today.

Review of Resident #7's hospital radiology report signed and dated 10:07AM 9/4/15 revealed:
-The reason for the 2 view chest x-ray was hypoxia (deprivation of oxygen) and falling.
-There were bilateral degenerative changes with chronic rotator cuff tears.

Further review of Resident #7's care notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER: ALAMANCE HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 2766 GRAND OAKS BOULEVARD, BURLINGTON, NC 27215

(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 270	Continued From page 20	D 270		

revealed:
-9/11/15 (2nd) "Resident #7 was observed sitting on dining room floor. Resident has no new bruises or skin tears."
-9/22/15 7:40AM "Resident #7 is being sent to hospital via EMS. He was found sitting in the floor in front of his bed."
-9/22/15 (3rd) "Resident #7 was sent to ER at (about 2:10AM) because he was observed sitting in his room on the floor."

Review of Resident #7's incident and accident report dated 9/22/15 revealed:
-On 9/22/15 at 7:30AM Resident #7 was found to be lying on his back on floor in front of bed.
-On 9/22/15 at 7:40AM Resident #7 was sent out of facility to the local emergency room.
-Resident #7 was alert and no apparent injuries were noted before he was taken out of facility.
-Resident #7 was not seen by the primary care physician.
-A message was left on the primary care physician's office answering machine at 7:50AM.
-The POA was notified at 7:45AM.

Review of Resident #7's emergency room physician record dated 9/22/15 revealed at 8:38AM Resident #7 was seen because of a fall while getting into bed resulting in a right shoulder injury and a rib fracture.
Review of Resident #7's hospital radiology report at 9:09AM on 9/22/15 revealed:
-The reason for the exam was post fall and pain with passive range of motion.
-"There was severe arthritis of the right shoulder with evidence consistent with chronic complete rotator cuff tear. There is osteopenia. There is suggestion of joint effusion. There is a displaced fracture of the right 9th rib which may be acute. There is an old healed fracture of the right 4th rib.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 21	D 270		

Continued From page 21

The impression was a possible fracture of the right 9th rib. There were severe arthritic changes of the right shoulder."
Review of Resident #7's hospital radiology report at 9:52AM on 9/22/15 revealed:
-The reason for additional views was a rib fracture was seen on the shoulder x-ray.
-There was a fracture of the right 9th rib. There was an old fracture of the left 5th rib.

Further review of Resident #7's care notes revealed:
-9/23/2015) 2nd (no time given) "Resident #7 continues to be monitored. He continues to stand and walk. When trying to assist him he becomes aggressive and combative. 30 minute checks still being implemented."

Review of Resident #7's emergency room physician report dated 9/23/15 revealed:
-2:26AM Resident #7 was seen after resident was found on the floor of his facility.
-Around 6AM Resident #7 was discharged with a diagnosis of a contusion of the occipital scalp (Head injury) and instructions to follow up with his primary care physician in 2-3 days.

Review of Resident #7's hospital CAT scan report signed and dated 4:26AM on 9/23/15 revealed no acute intracranial injury.

Further review of Resident #7's care notes revealed:
-9/26/15 "Resident #7 up today combative and in some pain. PRN Tylenol given at 9AM."
-9/28/15 2:30PM "Resident #7 has been in his room in bed with complaints of pain. Has eaten meals in room. And transfers with assistance."
-9/29/15 3:55PM "Resident #7 sent to ER. Found on floor lying on back. Resident complaint of back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 22	D 270		

pain. Was sent to ER."
-9/30/15 "Resident has been out at hospital with right hip fracture."
-10/2/15 was the last entry in the care notes "out of facility in hospital."

Review of Resident #7's local Emergency room physician report dated 9/29/15 revealed:
-"The patient was unable to ambulate. The staff at facility reported to EMS they don't have enough staff to watch patient so they left him in a wheelchair. Unwitnessed fall. Found on ground. EMS called."
-"X-ray showed closed right femoral neck fracture, plan to operate tomorrow. Admit to the hospital."

Review of Resident #7's CAT scan of the abdomen and pelvis dated 9/29/15 revealed:
-There was an acute impacted right femoral neck fracture. The right hip remained located.

Review of Resident #7's orthopedic consultation report signed and dated 9/30/15 at 1:23PM revealed:
-"The patient is an 88-year old patient who slipped out of a wheelchair apparently. He is unable to give a history and is quite confused. He had an obvious deformity to the leg and was brought to the ER where he was found to have a displaced femoral neck fracture."
-"He cannot cooperate with the exam and cannot answer questions."
-"A recommendation for a right hip hemiarthroplasty later today."

Review of Resident #7's primary care physician's discharge summary signed and dated 10/5/15 revealed:
-The diagnoses at the time of discharge included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 23	D 270		

hypertension, dementia, anxiety and agitation, anemia secondary to blood loss, and a fall with impacted right hip fracture, status post right hip hemiarthroplasty.
-During the hospital stay Resident #7 had episodes of anxiety and agitation and needed intravenous anti-psychotics. He was also seen by palliative care. The patient also received physical therapy. The patient overall appeared stable at the time of discharge. He was discharged in stable condition and advised to undergo further physical therapy and was sent to rehab.
-An addendum revealed Resident #7 was held over the weekend because of a fever.

Confidential staff interview revealed:
-Resident #7's room was the last room on the left on the opposite end from the front desk in the unit.
-Most of the falls were on 2nd and 3rd shift.
-Resident #7 would fall sometimes in the bathroom after tripping on his own feet.
-It took at least 2 staff and sometimes 3-4 staff to take care of Resident #7.
-"Resident #7 used to not want to get out of bed because he was sore, we would use the walker to get him up into his wheelchair."
-"We have bed/chair alarms; he might have had one, but not for very long, right before he was discharged."
-Staff member could not recall exactly how many times Resident #7 had fallen in the past 2-3 months.

A 2nd confidential staff interview revealed:
-"He stop letting me help him and got really combative around mid-July early August." (cannot recall exact date)
-"We would be trying to change him and he would kick staff during incontinent care."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2756 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 24	D 270		

-"It took at least 3 staff to toilet him."
-"Resident #7 used to walk with a limp but he could walk on his own."
-Resident #7 started using a walker and holding onto the side rails in the halls.
-Sometimes Resident #7 would not remember where his glasses were and they would be in his room.
-Resident #7's room was all the way on the end of the hallway.
-Staff had not seen a mat on the floor by his bed or known of bed/chair alarms being used.
-Anytime a resident fell and came back from the hospital they were put on 30 minute checks x 3 days.
-"It had always been that way and we would document the falls and behaviors."
-Staff member could not recall exactly how many times Resident #7 had fallen in the past 2-3 months.
-Most falls occurred as a result of Resident #7 trying to get to the bathroom on his own.

A 3rd confidential staff interview revealed:
-"I started noticing Resident #7 declining (physically/mentally) in July after a fall. He was very stubborn and independent. He fell so many times I can't recall the exact number."
-"We would check on him and 5 minutes later he would fall."
-"He became so combative even with the physical therapist that they signed off on him."
-Resident #7 was taken off Gabapentin and he had Lorazepam ordered for anxiety as needed.
-"By August after falls Resident #7 seemed to decline and it seemed like he decided he was not going to walk anymore."
-Staff had not seen a bed/chair alarm or mat used for Resident #7.
-"All of us suggested Resident #7 be moved

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER: ALAMANCE HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 2766 GRAND OAKS BOULEVARD, BURLINGTON, NC 27215

(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 270	Continued From page 25	D 270		

closer to the front desk of the unit. We were told by the Special Care Unit Coordinator (SCC) there was no room available. If Resident #7 had been moved closer to the front desk in the unit I believe it would have kept him ambulatory longer. I don't think it would have helped after August."
-Staff could not recall exactly but estimated Resident #7 fell 5 times since July 2015.
-"We were told Resident #7 fractured his right hip after this last fall and they would have to replace the ball in his right hip and he would have to go to rehab."
-It was standard procedure to do 30 minute checks x 3 days after a fall.
-Staff could not recall the details of 9/22/15 but knew Resident #7 fell 2 times within a 24 hour period.

A 4th confidential staff interview revealed:
-Resident #7 was very aggressive with staff and other residents.
-"Mid-August Resident #7's behaviors and health really started declining all at once."
-"Resident #7 wanted to be independent and was always asking to be taken to the bathroom. Then he would have episodes of trying to do everything for himself. We had a hard time with him."
-There were no alarms or mats for Resident #7.
-It took on average 2-3 staff to assist Resident #7 with activities of daily living.
-"There were at least 4 falls since July 2015 and I'm sure there were more. We do 30 minute checks after a fall x 3 days."
-"I think if Resident#7 had been moved closer to the front desk in the unit he wouldn't have fallen so much. We could have kept a closer eye on him. We could have done more than 30 minute checks just because staff would have been walking past his room."
-"Several of us staff suggested to the Special

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

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D 270	Continued From page 26	D 270		

Care Unit Coordinator (SCC) for Resident #7 to be moved closer to the unit's front desk about a month before Resident #7 left the facility. We were told they would try to see what could happen."
-"Resident #7 had just been put to bed the night he fell and broke his hip. Several staff had just put his night clothes on and other staff were trying to get him medicine for anxiety. We think he tried to get up to the bathroom. After an unwitnessed fall we call EMS. 2 days after this fall we were told he broke his hip."
-"Alarms, mat, and gripper socks would have helped. Sitters were never mentioned. I think Resident #7 would have benefited from a higher level of care."

3rd shift staff interview unsucessful.

Interview with the Special Care Unit Coordinator (SCC) on 10/22/15 at 6PM revealed:
-Resident #7 had Lorazepam as needed for anxiety.
-"Resident #7 had started declining physically and mentally by the end of August. He was very challenging because he could be very physically combative with staff but not residents. When he was admitted to the facility he could still walk. Then he started having to use a walker or wheelchair. He could pivot out of his wheelchair to toilet to get to another chair."
-"He came in with a hunched over back and limited range of motion in his right arm."
-The SCC believed there were 3-5 falls during August-September 2015. The family refused a bed alarm, and mat in September 2015.
-A sitter had not been addressed through the facility or with the family.
-The SCC was aware that even though a family refuses to pay out of pocket for devices that the

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
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ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 27 responsibility ultimately fell on the facility. -Staff were looking into moving Resident #7 closer to the front desk of the unit per other staff's requests but the SCC had not considered the fact that moving Resident #7 might have enabled staff to check on Resident #7 more often than every 30 minutes as she felt like her staff were already doing that. -The facility staffed 10:1 ratio of residents to staff on 1st shift and 8:1 on 2nd and 3rd shift. On average there were 4 staff on 3rd shift. She was aware that sometimes it took 3 staff to assist Resident #7 with his activities of daily living. -The SCC believed Resident #7's Primary Care Physician (PCP) was aware of all falls. The staff from the facility would fax requests for orders as necessary. -"I think we were able to meet Resident #7's needs. It was never discussed with the Administrator or doctor about the need for a higher level of care." Family Interview on 10/22/15 at 10:51 revealed: -"I noticed a decline physically and mentally in Resident #7 in late July-early August. I did not say anything about it at the time, but I did share my concerns with the staff (cannot recall exact names) at facility about him not being able to use the walker anymore" -"Late July-early August he began to fall a lot; he was taken to the ER 4 times. These times were at night. I believe he couldn't understand that he had incontinent briefs on and he was still trying to get up to use the bathroom." -Resident #7 had chronic shoulder issues. He could feed himself but if you tried to do passive range of motion it was painful for him. -"Somewhere around September 10th or 11th I met with the Special Care Unit Manager (SCC) and I told her I was concerned about Resident #7	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 26	D 270		

being so far from the front desk in the unit. The SCC said she had just been discussing that issue and was working on getting Resident #7 a room closer to the front desk, but the other family member would have to agree to change rooms first."

-"Sometime in early September Resident #7's primary care physician made referral for a psych evaluation. The SCC was going on vacation and I told her to hold off on that appointment until she got back from vacation. It was my impression she had already scheduled the appointment. Resident #7 fell and was discharged from the facility before he got that appointment."

-"There was another incident (cannot recall exact date) where Resident #7 was trying to sit in the dining room chair, he just missed the chair. Then he fell on the 23rd of September. I think the facility called our family every time."

-"I don't recall any conversations about bringing in a sitter or adding more staff. I think that would have helped at night. I can't recall how many staff the facility has at night. The only thing I recall regarding early September is one of the staff (couldn't recall name) asked if I were leaving after my visit to the facility and would I bring Resident #7 down to the living room because they didn't want to leave him alone in his room."

-"The SCC did mention bed/chair alarms and a mat to go on the floor by Resident #7' s bed. I refused the alarms because of the cost. I refused the mat because I was afraid he would slip in his sock feet."

-"At some point I inquired about using bedrails to the SCC but was told they were not used at facility."

-"Our family received 8-10 calls from the facility at the end of July-early August. He always fell at night and was found on the floor when staff were making rounds."

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D 270	Continued From page 29	D 270		

-"I do not recall ever being told that Resident #7 had broken rib. Another call from the facility said Resident #7 had hit his head and I did see some old bruising."
-"I was informed Resident #7 had fallen on 9/29/15 at 10PM and was in the ER. A surgeon called me on 9/30/15 and told me Resident #7 would require surgery."
-"Resident #7 can't move his arms above his head. If you explain things you are going to do to him first; he will come around. The physical therapist at the facility had signed off on him due to his cognition. After his last fall and surgery he had to go to a skilled nursing facility. They are really monitoring him there."
-"I do feel like the facility let the family know when Resident #7 fell. I knew it was just a matter of time before he really got hurt. He was just an accident waiting to happen. He was no longer safe to use the walker. I think he would have benefited from being moved closer to the front desk in the unit. He probably could have benefited from a sitter at night. They still used the walker when trying to transfer him to the wheelchair. The SCC said she had seen him coming down the hall before with the walker."

Interview with Resident #7's Primary Care Physician (PCP) on 10/22/15 at 4:55PM revealed:
-He had been Resident #7's primary care physician x 2 years.
-The PCP had noted in his chart on 9/2/15 "An improvement in behaviors, very unsteady on his feet, high risk for falls, currently on Paxil and Seroquel."
-He had ordered a psychiatric evaluation to help manage antipsychotic medications for Resident #7 on 9/9/15.
-The PCP was not aware that Resident #7 had sustained a laceration to his head, had a broken

(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 270	Continued From page 30	D 270		

rib or got a CAT scan.
-The only fall he was aware of for Resident #7 was his last fall at the facility and the call was generated from the orthopedic surgeon late September 2015 from the local hospital.
-Resident #7's medications had been adjusted in the hospital after the fall because Resident #7 couldn't sleep.
-Resident #7 was discharged to a skilled nursing facility for rehabilitation after his surgery.
-"I think a bed alarm and mat would have helped."
-The PCP was not aware Resident #7's room was located all the way down the hall opposite from the unit's front desk. The PCP believed Resident #7 could have benefited from being closer to the front desk of the unit.
-"It sounds to me like they need better supervision at the facility."

Interview with the Administrator on 10/22/15 at 7:30 pm revealed:
"The majority of Resident #7's falls happened within a months' time."
-"We did not have an opportunity to go through the above mentioned processes with Resident #7 before he fell and broke his hip. He was hospitalized, had surgery, and discharged from the hospital to a rehabilitation facility."

Refer to Interview on 10/22/15 at 7:00 pm with the Special Care Unit Cordinator.

Refer to Interview on 10/22/15 at 7:00 pm with the Senior Care Manager.

Refer to Interview on 10/22/15 at 7:00 pm with the Director of Operations.

Refer to Interview on 10/22/15 at 7:00 pm with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2755 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 31	D 270		

Continued From page 31

the Administrator,

____

Interview with facility management (Director of Operations, Senior Care Manager, Administrator, and Special Care Unit Coordinator) were concurrently conducted on 10/22/15 at 7:00PM.
Interview on 10/22/15 at 7:00 pm with the Special Care Unit Cordinator
The current monitoring system for residents who are are a fall include: Stand-up meetings with all staff to discuss current and newly identified residents who were fall risks.
-A roster of residents were kept on the medication cart with additional notes.(shift to shift report).
30 minute checks on the residents, engaging residents in activities, and keeping them in the common room areas so staff could watch the residents.
-Standard procedure after a fall was 30 minute checks x 3 days.
-"The assessments come from me(Special Care Unit Coordinator), quarterly reviews, direct visualization of the residents, PT/OT recommendations and from the doctors."
-"After a fall we go by our protocols, contact the doctor, contact the family, take vital signs, and implement 30 minute checks."
-An unwitnessed fall was always a send out to the ER. When a resident came back from the ER, 30 minute checks were implemented x 3 days, vital signs were taken x 3 days on all shifts, and if the resident had not returned to baseline, the doctor was notified.

Interview on 10/22/15 at 7:00 pm with the Senior Care Manager revealed:
-"The facility keeps doing the same thing if a resident keeps falling."
-The staff had conversations with the Power of

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	HAL001148	A. BUILDING: ______ B. WING ______	R 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 270	Continued From page 32	D 270		

Attorney, and doctor to address a higher level of care.
-"If we can not meet their (the residents') needs, we try to have conversations with the family; sometimes families resist discharge."

Interview on 10/22/15 at 7:00 pm with the Director of Operations revealed:
-The facility implemented 30 minute checks after each fall.
-The facility could use bed and chair alarms for falls risk residents and daily visualizations of residents, physical therapy, occupational therapy, and recommendations from resident's physicians.
-"We offered bed alarms and a mat which the family refused as they would have to pay for it out of pocket."
- "We will pay for alarms and mats and all kinds of things families cannot pay for out of pocket."
-"If we have a resident who we feel we can not meet their needs; we start to have a conversation with the family about a possible discharge."

Interview on 10/22/15 at 7:00 pm with the Administrator revealed;
-The monitoring system for resident's at risk for falls are: discussion at stand -up meetings, a roster of falls risks residents are kept on the medication carts, 30 minute checks on the residents, engaging residents in activities, and keeping them in the common room areas so staff can watch the residents.
-The facility could use bed and chair alarms for falls risk residents and daily visualizations of residents, physical therapy, occupational therapy, and recommendations from resident's physicians.
-After a resident had an unwitnessed fall, was sent to the hospital, and returns, 30 minute checks went done for 72 hours on all shifts which included checking vital signs.

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D 270	Continued From page 33 -For residents who continue to fall, "If they keep falling, we do the same thing". -"If we can not meet their (the residents') needs, we try to have conversations with the family; sometimes families resist discharge." ____________________ The Director of Operations provided a Plan of Protection for residents effective 10/23/15. "Effective immediately, any resident identified a high fall risk by the falls management team will be immediately placed on a 72 hour monitoring until alternative interventions can be implemented. Senior care managers will review/train new falls management plan with care manager and ED on 10/23/15. Senior care manager will train Med/Techs on 1st and 2nd shift on 10/23/15. Care managers will train all med techs on Falls Management Plan on 3rd shift on 10/23/15. This will continue daily until all med techs are trained. New Falls Management Plan will be implemented and monitored by management to include review of fall incidents. Fall Risk worksheet will be completed on all residents, 72 hour follow up after fall, monthly fall management team meetings to include review recommendations and follow through. Communication log will be reviewed by care manager and or ED, initialed with follow up on any concerns noted." CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2015.	D 270		
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	D912		

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
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ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

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D912	Continued From page 34 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for 2 of 7 sampled residents who received injuries due to falls (Residents #6, #7). [Refer to Tag D 0270, 10A NCAC 13F .0901(b), (Type A1 Violation)].	D912	G.S. 131D-21 (2) 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. Resident Rights training with a focus on resident right to receive the proper care based on needs and care plan was completed with all staff on 11/4. Ombudsman has been contacted to set date for Resident Rights Training.	11/4/15 ongoing quarterly therefter

Voluntary Resolution Agreement

Between the

S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS

and

WILLIAMSTON HOUSE

Transaction Number: 12-140805

TABLE OF CONTENTS

I. Introduction

A. Parties to the Agreement;

B. Jurisdiction

C. Purpose of the Agreement

II. Definitions

A. Resident/Client

B. Facility Staff

C. Having HIV/AIDS

D. Qualified Individual with a Disability

E. Section 504 Coordinator

F. Section 504 Grievance Procedure

III. General Provisions

A. Facilities Covered by Agreement

B. Suspension of Administrative Actions

C. Effective Date and Term of Agreement

D. Failure to Comply with the Terms of Agreement

E. Effect on Other Compliance Matters

E. Effect on Other Compliance Matters

F. Prohibition against Retaliation and Intimidation

G. OCR's Review of Compliance with the Agreement

H. Non-Waiver Provision

I. Entire Agreement

J. Modification of Agreement

K. Publication or Release of Agreement

L. Third Party Rights

M. Technical Assistance

N. Miscellaneous

O. Authority of Signer

P. Severability

Q. Successor in Interest

IV. Obligations

A. Non-Discrimination Policy

B. Notice of Non-Discrimination Policy

C. Training

D. Designation of Section 504 Coordinator

E. Section 504 Grievance Policies and Procedures

V. Reporting Requirements

VI. Signatures

Appendix A: Sample Non-Discrimination Policy

Appendix B: Sample Section 504 Grievance Procedure

I. Introduction

I. Introduction

This Voluntary Resolution Agreement (the "Agreement") resolves the U.S. Department of Health and Human Services ("HHS") Office for Civil Rights ("OCR") Complaint Number 12-140805, a complaint filed on behalf of an individual with HIV (the "Affected Party"). The Complainant alleges that on March 21, 2012, WP-Williamston Health Holdings, LLC, d/b/a Williamston House[i] ("the Facility"), an assisted living facility, denied admission to the Affected Party because he has HIV and thereby allegedly discriminated against him on the basis of his disability, in violation of Section 504 of the Rehabilitation Act of 1973. OCR concluded that as a result of this failure, the Facility may not be following appropriate non-discrimination policieor procedures regarding the admittance of individuals with HIV/AIDS.

A. <u>Parties to the Agreement:</u>

1. United States Department of Health and Human Services ("HHS"), Office for Civil Rights ("OCR"); and

2. WP-Williamston Health Holdings, House, LLC d/b/a Williamston House

B. <u>Jurisdiction</u>: The Facility participates in the Medicaid program and is subject to Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and its implementing regulation at 45 C.F.R. Part 84 ("Section 504"). Section 504 prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. Part 84 prohibits such discrimination in programs and activities receiving Federal financial assistance from HHS.

C. <u>Purpose of the Agreement</u>: To resolve these matters without further burden or the expense of additional review or enforcement proceedings, the Facility affirms, to the best of its knowledge, that it has complied and will continue to comply with all provisions of Section 504. The Facility agrees to the terms stipulated in this Agreement. The Facility's willingness to enter into this Agreement with OCR in no way constitutes an admission of liability for the events that allegedly occurred in March 2012. The promises, obligations or other terms and conditions set forth in this Agreement constitute the exchange of valuable consideration between the Facility and OCR. The actions described in this Agreement fully address the issues described in the OCR complaint Number 12-140805. This Agreement shall not be construed as an admission or as evidence of any violation of any law or regulation or of any liability or wrongdoing on the part of the Facility.

Back to top

II. Definitions

For purposes of this Agreement, the terms listed below shall have the following meaning:

A. **<u>Resident/Client</u>** means any individual who is seeking or receiving health care, support, or other services from the Facility or its employees and/or contractors under its supervision and control.

B. **Facility Staff** means employees and/or contractors under the Facility's supervision or control, including

services from the Facility or its employees and/or contractors under its supervision and control.

B. **Facility Staff** means employees and/or contractors under the Facility's supervision or control, including but not limited to, its Executive Director, Business Office Manager, Resident Care Manager, Memory Care Manager, Medical Technicians, Nurses, Personal Care Aides, Medication Aides, Geriatric Aides, other health care personnel, administrative personnel, and all volunteers who have or are likely to have direct contact with residents, clients and their companions as defined herein.

C. **Having HIV/AIDS** means: (1) having tested positive for antibodies to the Human Immunodeficiency Virus (HIV); (2) being infected with HIV; (3) having Acquired Immune Deficiency Syndrome (AIDS); or (4) having AIDS-related opportunistic infections. For purposes of this Agreement, having HIV/AIDS also means having a record of being in one of the four categories listed above, or being perceived or regarded as being in one of the four categories listed above.

D. **Qualified Individual with a Disability** means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, meets the essential eligibility requirements for the receipt of services or participation in programs or activities provided by a recipient of Federal financial assistance.

E. **Section 504 Coordinator** means the individual designated by the Facility to coordinate and oversee its efforts to comply with and carry out the Facility's Section 504 responsibilities.

F. **Section 504 Grievance Procedure** means the Facility's process for addressing complaints of disability discrimination from employees, applicants, residents, clients, companions, and other interested parties that incorporate appropriate due process standards and provide for the prompt and equitable resolution of grievances.

Back to top

III. General Provisions

A. **Facilities Covered by Agreement**: The Agreement includes all programs and services the Facility administers or provides directly or through sub-recipients or contractors throughout the Term of this Agreement.

B. **Suspension of Administrative Actions**: Subject to the continued performance by the Facility of the stated obligations and required actions contained in this Agreement and in conformity with Section III-D, Failure to Comply with the Terms of Agreement, OCR shall suspend administrative action on OCR Complaint No. 12-140805.

C. **Effective Date and Term of Agreement**: This Agreement shall become effective on the date it is signed by both parties (the "Effective Date") and will remain in effect for twelve (12) months after the Effective Date, at which point if OCR determines that the Facility has substantially complied with this Agreement, then OCR's review and monitoring of this Agreement shall terminate. Notwithstanding the

signed by both parties (the "Effective Date") and will remain in effect for twelve (12) months after the Effective Date, at which point if OCR determines that the Facility has substantially complied with this Agreement, then OCR's review and monitoring of this Agreement shall terminate. Notwithstanding the Term of this Agreement, the Facility acknowledges that it will comply with Section 504 and other applicable Federal nondiscrimination statutes and their implementing regulations for as long as the Facility continues to receive Federal financial assistance.

D. **Failure to Comply with the Terms of Agreement**: If OCR determines that the Facility has failed to comply with any provision of this Agreement, the parties will confer and attempt to reach agreement as to what steps may be necessary to resolve the compliance issues to both parties' satisfaction. If an agreement is not reached, OCR may terminate this Agreement with thirty (30) calendar days' notice and take appropriate measures to effectuate the Facility's compliance with Section 504. Such measures may include OCR reopening its investigation of the Facility's compliance with Section 504. OCR may incorporate into its reopened investigation any relevant evidence of noncompliance with the Agreement and any relevant evidence obtained by OCR prior to the signing of the Agreement. OCR also may exercise all rights available under Section 504, including, but not limited to issuing noncompliance findings and initiating necessary enforcement proceedings.

E. **Effect on Other Compliance Matters**: The terms of this Agreement do not apply to any other issues, reviews, investigations, or complaints of discrimination that are unrelated to the subject matter of this Agreement and that may be pending before OCR or any other Federal agency. Any unrelated compliance matter arising from subsequent reviews or investigations shall be addressed and resolved separately. Nothing in this Agreement shall be construed to limit or restrict OCR's statutory and regulatory authority to conduct future complaint investigations and compliance reviews related to the Facility and the subject matter of this Agreement. This Agreement does not address or resolve issues involved in any other investigation, compliance review, or civil, criminal, or administrative action under Federal laws by other Federal Agencies, including any action or investigation under Section 504.

F. **Prohibition Against Retaliation and Intimidation**: The Facility shall not retaliate, intimidate, threaten, coerce, or discriminate against any person who has filed a complaint or who has assisted or participated in the investigation of any matter addressed in this Agreement.

G. **OCR's Review of Compliance with the Agreement**: OCR may review the Facility's compliance with this Agreement. As part of such review, OCR may require written reports, access to witnesses, copies of documents, and/or inspection of the Facility. Throughout the duration of this Agreement, the Facility agrees to retain the records required by OCR to assess its compliance.

H. **Non-Waiver Provision**: Failure by OCR to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision shall not be construed as a waiver of OCR's right to enforce other deadlines or any provisions of this Agreement.

I. **Entire Agreement**: This Agreement constitutes the entire understanding between the Facility and OCR

I. **Entire Agreement**: This Agreement constitutes the entire understanding between the Facility and OCR in resolution of OCR Complaint No. 12-140805. Any statement, promise, or agreement not contained herein shall not be enforceable through this Agreement.

J. **Modification of Agreement**: This Agreement may be modified by mutual agreement of the parties in writing.

K. **Publication or Release of Agreement**: OCR places no restrictions on the publication of this Agreement or its terms. In addition, OCR may be required to release this Agreement and all related materials to any person upon request, consistent with the requirements of the Freedom of Information Act, 5 U.S.C. § 522, and its implementing regulation at 45 C.F.R. Part 5.

L. **Third Party Rights**: This Agreement can be enforced only by the parties specified in this Agreement, their legal representatives, and assigns. This Agreement shall be unenforceable by third parties and shall not be construed to create third party beneficiary rights.

M. **Technical Assistance**: OCR will provide appropriate technical assistance to the Facility regarding compliance with this Agreement, as requested and as reasonably necessary.

N. **Miscellaneous:** When OCR verifies that the Facility has completed all actions contained in this Agreement, OCR shall consider all matters related to this investigation resolved and shall so notify the Facility in writing

O. **Authority of Signer**. The individual who signs this Agreement on behalf of the Facility represent that he or she is authorized to bind the Facility to the Agreement.

P. **Severability.** In the event that a court of competent jurisdiction determines that any provision of this Agreement is unenforceable, such provision shall be severed from the Agreement and all other provisions shall remain valid and enforceable; provided, however, that if the severance of any such provision materially alters the rights or obligation of the Parties, they shall, through reasonable, good faith negotiations, agree upon such other amendments hereto as may be necessary to restore the Parties as closely as possible to the relative rights and obligation initially intended to them hereunder.

Q. **Successor in Interest.** This Agreement is binding on the Parties, and their successors in interest, and the Facility shall have a duty to so notify all such successors in interest of the existence and terms of this Agreement.

Back to top

IV. Obligations

A. **Non-Discrimination Policy**: The Facility shall not discriminate against any individual on the basis of disability, including but not limited to HIV/AIDS. The Facility shall not refuse to admit or serve any

A. **Non-Discrimination Policy**: The Facility shall not discriminate against any individual on the basis of disability, including but not limited to HIV/AIDS. The Facility shall not refuse to admit or serve any resident/client on the grounds that he or she poses a direct threat to the health or safety of others due to a disability, without first conducting an individualized assessment of that individual. The individualized assessment must be based on current medical knowledge or on the best available objective evidence to ascertain the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and, whether reasonable modifications of policies, practices, or procedures will mitigate the risk.

Within thirty (30) calendar days of the Effective Date of this Agreement, the Facility shall ensure that it adopts the Non-Discrimination Policy set forth in Appendix A. The Facility shall ensure that its staff complies with the Non-Discrimination Policy and Section 504.

B. **Notice of Non-Discrimination Policy**: Within thirty (30) calendar days of the Effective Date of this Agreement, the Facility shall ensure that it prominently displays the Non-Discrimination Policy, attached as Appendix A, in the Facility's waiting area and/or lobby. The Facility shall ensure that it reaffirms its obligations to comply with the requirements of Section 504 and reaffirms its adherence to the Non-Discrimination Policy set forth in Appendix A. Such evidence may include documentation that the Facility provided training or held meetings regarding its obligation to provide notice of the Non-Discrimination Policy prior to the Effective Date.

Within ninety (90) calendar days of the Effective Date of this Agreement, the Facility shall publish the Non-Discrimination Policy on its website and in each of the Facility's pamphlets, brochures, website and/or other existing promotional materials, and in all future promotional materials, including journal, periodical or newspaper advertising purchased during the term of this Agreement.[ii]

C. **Training**:

1. Training of the Section 504 Coordinator: Within thirty (30) calendar days of the Effective Date of this Agreement, the Facility shall provide evidence that the Section 504 Coordinator receives training on their responsibilities under this Agreement and the requirements of Section 504. This training shall include, but is not limited to Section 504's prohibition on retaliation; the obligation to provide reasonable accommodations and program modifications; requirements regarding the Facility's obligation to not deny services or other opportunities to any individual because of a disability, including, but not limited to HIV/AIDS; and, the proper handling of Section 504 grievances. Evidence of such training may include documentation that the Facility provided such training prior to the Effective Date. In the event a new Section 504 Coordinator is identified, the Facility shall provide this training within thirty (30) days of the designation.

2. Training of Facility Staff: The Facility shall submit a copy of the staff training materials to OCR for review within ninety (90) calendar days of the Effective Date of this Agreement. If OCR has any concerns regarding the proposed staff training materials, OCR shall so notify the Facility no later than

review within ninety (90) calendar days of the Effective Date of this Agreement. If OCR has any concerns regarding the proposed staff training materials, OCR shall so notify the Facility no later than fifteen (15) calendar days after OCR's receipt of the proposed training materials. Within one hundred twenty (120) calendar days of the Effective Date of this Agreement, the Facility shall ensure that staff receive comprehensive training on the Non-Discrimination Policy, specifically the Facility's responsibility to provide disabled individuals, including, but not limited to, those with HIV/AIDS, with full and equal enjoyment of the services, privileges, facilities, accommodations, and benefits of the Facility. The Facility shall provide comprehensive training for any staff member who was unable to attend the comprehensive training program due to illness or other exigent circumstances within thirty (30) calendar days of the training, or for employees who were hired subsequent to the date that the initial comprehensive training was held, within thirty (30) calendar days of hire.[iii]

D. Designation of Section 504 Coordinator: Within fifteen (15) calendar days of the Effective Date of this Agreement, the Facility shall ensure that one individual is designated to be responsible for coordination of its efforts to comply with Section 504. The Facility shall publish, in an appropriate forum, the name, title, function, physical address, and telephone number of the Section 504 Coordinator. The Section 504 Coordinator shall be available to answer questions and provide appropriate assistance to the Facility's staff and the public, regarding its obligation to provide equal services, accommodations, or other opportunities to any individual with a disability. Additionally, the Section 504 Coordinator will be responsible for processing any Section 504 complaints received at the Facility.

E. Section 504 Grievance Policies and Procedures: Within fifteen (15) calendar days of the Effective Date of this Agreement, the Facility shall implement the Section 504 Grievance Procedure for addressing complaints of disability discrimination found in Appendix B. The Facility shall take steps to notify each of its staff, residents, clients, and interested persons of the information contained in the Section 504 Grievance Procedure. This information shall be communicated as follows:

1. 1. The Facility shall post copies of the Section 504 Grievance Procedure of conspicuous size and print in visible locations throughout the Facility. This document shall include the title and contact information for the Facility's Section 504 Coordinator.

2. The Facility shall publish the Section 504 Grievance Procedure in its Admissions Kits and on its website. This document shall direct individuals to contact the covered Facility's Section 504 Coordinator at a specified telephone number, physical address, or unique email address or, alternatively, to contact the Facility's administrator.

3. The Facility's Section 504 Coordinator shall be responsible for maintaining and providing copies of the Section 504 Grievance Procedure, in alternate formats if necessary, to interested persons when required.

Back to top

Back to top

V. Reporting Requirements

The Facility shall provide OCR with the following:

A. No later than forty-five (45) calendar days after the Effective Date of this Agreement, written confirmation that the Non-Discrimination Policy and the Section 504 Grievance Procedure have been printed and displayed in the waiting area and/or lobby of the Facility, as described in Section IV.B. and E.

B. No later than one hundred fifty (150) calendar days after the Effective Date of this Agreement, copies of:

1. the Non-Discrimination Policy and Section 504 Grievance Procedure, as published in the Facility's pamphlets, brochures, website and/or other existing promotional materials, including journals, periodicals, or newspaper advertising; and

2. a list of individuals, by name and title, who have attended the training program.

C. At twelve (12) months after the Effective Date of this Agreement, letters describing:

1. the number and type of grievances filed by, or on behalf of, individuals with HIV/AIDS against the Facility or any staff member of the Facility, including the status and/or outcome of each such grievance/complaint; and

2. the number of individuals with HIV/AIDS who were referred for admission and were accepted, and the number of individuals with HIV/AIDS who were denied admission and the reasons for the denial.

VI. Signatures

The individuals signing represent that they are authorized to execute this Agreement and legally bind the parties to this Agreement.

_______/s/__________________________________ 8/8/2014___________

Charles E. Trefzger, Jr. Date

Administrator

WP-Williamston Health Holdings, LLC

d/b/a Williamston House

_______/s/__________________________________ __8/11/2014_____________

Timothy Noonan Date

________ ____________________________________ __ ______________

Timothy Noonan Date

Regional Manager, Region IV

U.S. Department of Health & Human Services

Office for Civil Rights

Back to top

Appendix A: Sample Non-Discrimination Policy

____________________, does not discriminate against any person on the basis of race, color, national origin, age, or disability (including but not limited to HIV/AIDS), in admission, treatment, or participation in its programs, services and activities, or on the basis of sex in its health programs and activities or in employment.

_____________________, does not deny admission to its facility, continued residence in its facility or medically appropriate treatment (as determined by the current state of medical knowledge) on the basis of an applicant's or resident's HIV/AIDS status. If _____________ staff have a question of whether admission, continued residence, or a medical procedure would benefit an applicant or resident with HIV/AIDS, and if the admission, continued residence, or medical procedure would be indicated in the absence of such condition, ____________ staff shall consult with an infectious disease specialist or other appropriate specialist as time and circumstances permit before making a final decision regarding or recommendation to the applicant or resident.

_____________________________ shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability (including but not limited to HIV/AIDS) unless ________________ can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity or would result in undue financial and administrative burdens.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at 45 C.F.R. Parts 80, 84, and 91, and Section 1557 of the Patient Protection and Affordable Care Act of 2010.

If you believe that you have been discriminated against on the basis of race, color, national origin, age, sex, or disability (including but not limited to HIV/AIDS), you may file a grievance against ________________ and/or a member of its staff with the:

sex, or disability (including but not limited to HIV/AIDS), you may file a grievance against ________________ and/or a member of its staff with the:

Section 504 Coordinator

____

____

___-___-____ (voice)

___-___-____ (fax)

___-___-____ (TDD)

______________@___ (email)

Filing a grievance with _______ will not prevent you from filing a discrimination complaint with the:

Office for Civil Rights

U.S. Department of Health & Human Services

200 Independence Ave., S.W.

Room 509F HHS Bldg.

Washington, D.C. 20201

800-368-1019 (voice)

202-619-3818 (fax)

800-537-7697 (TDD)

OCRComplaint@hhs.gov (email)

Back to top

Appendix B: Sample Section 504 Grievance Procedure

It is the policy of ____________________ not to discriminate on the basis of disability. _________________ has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) of the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 prohibits discrimination on the basis of disability in any program or activity receiving Federal

resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) of the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. The Law and Regulations may be examined in the office of (insert name, title, tel. no. of Section 504Coordinator), who has been designated to coordinate the efforts of ____________________ to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (insert name of facility/agency) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 504 Coordinator within (insert timeframe) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (insert name of facility/agency) relating to such grievances.
- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 504 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

__________________ will make appropriate arrangements to ensure that disabled persons are provided other accommodations, if needed, to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

[i] Williamston House, managed by Meridian Senior Living, LLC: (1) is licensed as an "Adult Care Home/Home for the Aged" by the North Carolina Department of Health and Human Services; and (2) participates in the Medicaid program, Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 et seq.
[ii] For pamphlets, brochures, and purchased advertising where space is limited, the Facility may use the following short-form Non-Discrimination Policy:

____________________ does not discriminate against any person on the basis of race, color, national origin, age, or disability (including but not limited to HIV/AIDS), in admission, treatment, or participation in its programs, services and activities, or on the basis of sex in its health programs and activities or in employment. For further information about this policy, contact the Section 504 Coordinator at ___-___-____ (voice), ___-___-____ (fax), ___-___-____ (TDD), or ______________@___ (email).

[iii] For the Facility's health professionals, including but not limited to doctors, nurses, physicians' assistants, and pharmacists, this training may be provided by the AIDS Education and Training Centers (AETC) Program, funded by HHS's Health Resources and Services Administration (HRSA). A directory of the AIDS Education and Training Centers is located at www.aidsetc.org/aidsetc?page=ab-00-00

Back to top

PRINTED: 04/07/2016
FORM APPROVED

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
	HAL036018	A. BUILDING: 01 B. WING ______	03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TIME INN	602 BREVARD ROAD KINGS MOUNTAIN, NC 28086

(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
C 000	Initial Comments Report of a Biennial Construction Survey by Frank Strickland 03/23/2016: Information obtained from the DHSR database indicates that this facility was licensed on 04/01/1982 as a HA. An addition for 33 beds was licensed in 10/24/1994 and the faciliuty is currently licensed for 59 Beds with a 26 Bed Special Care Unit. Therefore, this facility was surveyed for conformance with the applicable portions of the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds, and applicable portions of the 1978 (Revision 4) and the 1991 (1994 Revision) Edition, of the North Carolina Building Code(s), Institutional Occupancy, and the 1977 and 1994 Minimum Standards and Regulations for Homes for the Aged in effect at time of initial licensure. Deficiencies have been cited and a Plan of Correction is required.	C 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of truth of the facts alleged or conclusion set forth in the statement of deficiencies or corrective action, report, the Plan of Correction prepared solely as a matter of compliance with State Laws. It is the policy of Country Time Inn to assure the rights of all residents guaranteed under 10A NCAC 13F. 0306(a)(1)(2)(3)(e) are maintained and may be exercised without hindrance.	
C 164	Housekeeping and Furnishings-Clean, Repaired SECTION .0300 - PHYSICAL PLANT 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; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1-Based on observation, this facility failed to provide an environment in accordance with this Rule by not providing ventilation where odors are	C 164	10A NCAC 13F. 0306(a)(1)(2)(3) (e) Housekeeping and Furnishings	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Hagans
TITLE: Executive Director
(X6) DATE: 05/02/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036018	A. BUILDING: 01 B. WING _______	03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TIME INN	602 BREVARD ROAD KINGS MOUNTAIN, NC 28086

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C 164	Continued From page 1 generated. This could affect residents and staff by subjecting them to house-keeping odors. Findings on 03/23/2016: The mechanical exhaust fans are not exhausting interior air in the following rooms: (a) Guest Men's/Women's Bathrooms (b) Lower Shower Room 2-Based on observations, this facility has failed to maintain the finishes of the interior doors. Findings on 03/23/2016: The following interior doors are scratched and have unsuitable finishes: (a) Admininstrator's Office (b) Doctor's Office (c) Living Room (d) 200 Hall Resident Room doors 3-Based on observation, the facility has not maintained and serviced the HVAC supply and return air grilles. Findings on 03/23/2016: The return-air grilles have excessive grease build-up in Kitchen. 4-Based on observation, the facility has not maintained the ceramic tile in the roll-in showers areas throught the facility. Findings on 03/16/2016: The ceramic tile is moldy where the surrounding shower tile walls meet the shower floor in the Spa Rooms.	C 164	1. Executive Director entered a work order to repair the Mechanical exhaust fans (a) the guest Men's/Women's bathroom (b) Lower shower room 2. Executive Director entered a work order into BMS to refinish the interior facility doors (a)administrator's office (b) Doctor's office (c) Living room (d) 200 hall resident room doors 3. The return kitchen air grill has been cleaned by BMS on 3/29/2016 and will be monitored/cleaned monthly.	
C 189	Building Equipment Maintained Safe, Operating	C 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036018	A. BUILDING: 01 B. WING ______	03/23/2016

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C 189	Continued From page 2 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1-Based on observation, this facility has not been maintained in a safe and operating condition of the exit doors. This could affect all residents and staff in the event of a fire to exit the facility. Findings on 03/23/2016. The following exit doors have a deficiency that prevents it's safe operation to exit the facility: (a) Exit Door #4 drags on the concrete landing and restricts it's operation to open fully. (b) Exit Door #11 has had the panic bar removed prevent the door from opening. (c) The courtyard exit gate in the SCU drags and restdricts it's operation to open fully. 2-Based on observations, this facility fire protection equipment incorporated in the HVAC system was not maintained in a safe manner. This could effect all residents and staff by not providing full detection of smoke in the facility. Findings on 03/23/2016: The sampling tubes and the interior ductwork has excessive particulate build-up for AHU #2. 3-Based on observations, this facility has not provide fire detection in all the required spaces to	C 189	4. Ceramic tile in the shower/spa rooms has been clean and disinfected removing all mold. This will be cleaned daily by housekeeping. It is the policy of Country Time Inn to assure the rights of all residents guaranteed under 10A NCAC 13F. 0311 Other requirements are maintained and may be exercised without hindrance. 10A NCAC 13F.0311 Other Requirements 1. (a) Exit Door #4 has been repaired by BMS and is no longer dragging on the concrete. (b) Exit Door #11 panic bar has been re-mounted.	

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
	HAL036018	A. BUILDING: 01 B. WING ______	03/23/2016

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C 189	Continued From page 3 keep the facility safe. This condition would affect all residents and staff by not detecting fire and not activating the fire alarm system to notify all of the emergency and not releasing door locks for evacuation. Findings on 03/23/2016: There is not any fire detection in the SCU/Dining Hall closet.	C 189	(c) The courtyard exit gate has been repaired and no longer drags. 2. The AHU #2 has been cleaned by BMS on 03/29/2016 and will be cleaned and monitored monthly by BMS. 3. A fire detection monitor has been installed in the SCU/Dining Hall closet.	

LAFOUNTAIN v. MERIDIAN SENIOR LIVING, LLC

Email | Print | Comments (0)
Case No. CV 15-03297-RGK (PJWx).

SHAWN LAFOUNTAIN v. MERIDIAN SENIOR LIVING, LLC

United States District Court, C.D. California.

June 29, 2015.

- View Case
- Cited Cases
- Citing Case

Attorney(s) appearing for the Case

Shawn Lafountain, individually, and on behalf of other members of the general public similarly situated and on behalf of other aggrieved employees pursuant to the California Private Attorneys General Act, Plaintiff, represented by Edwin Aiwazian, Lawyers for Justice PC & Jill Jessica Parker, Lawyers for Justice PC.

Meridian Senior Living, LLC, an unknown business entity, Defendant, represented by Leonora M Schloss, Jackson Lewis LLP & Danny Yadidsion, Jackson Lewis LLP.

Meridian Senior Living, LLC, an unknown business entity, Defendant, represented by Leonora M Schloss, Jackson Lewis LLP & Danny Yadidsion, Jackson Lewis LLP.

CIVIL MINUTES — GENERAL

R. GARY KLAUSNER, *District Judge*.

Proceedings: (IN CHAMBERS) Order re Motion to Remand (DE 10) and Motion to Strike (DE 7)

I. FACTUAL BACKGROUND

On March 16, 2015, Shawn Lafountain ("Plaintiff"), a former hourly-paid, non-exempt employee of Meridian Senior Living, LLC ("Defendant"), filed a Complaint in Santa Barbara Superior Court bringing a putative class action on behalf of all of Defendant's current and former hourly-paid or non-exempt employees. Plaintiff alleges eleven causes of action against Defendant for various violations of the California Labor Code.[1]

On May 1, 2015, Defendant removed the action to this Court pursuant to the Class Action Fairness Act ("CAFA"). On May 26, Plaintiff filed the current Motion to Strike Portions of Defendant's Answer. May 27, 2015, Plaintiff filed the current Motion to Remand. For the following reasons, the Court GRANTS Plaintiff's Motion to Remand, and DENIES as moot Plaintiff's Motion to Strike.

II. JUDICIAL STANDARD

A defendant may remove a case from state court when the federal court would have had original jurisdiction. 28 U.S.C. § 1441(a). "If at any time before final judgment it appears that the district court lacks subject-matter jurisdiction, the case shall be remanded." 28 U.S.C. § 1447(c); *see also ARCO Envtl. Remediation v. Dep't of Health & Envtl. Quality,* 213 F.3d 1108, 1113 (9th Cir. 2000) ("If a case is improperly removed, the federal court must remand the action because it has no subject-matter jurisdiction to decide the case.").

A defendant seeking to remove a case must file in the district court a notice of removal "containing a short and plain statement of the grounds for removal." 28 U.S.C. § 1446(a). In a CAFA case, "the proper burden of proof imposed upon a [removing] defendant to establish the amount in controversy is the preponderance of the evidence standard." *Rodriguez v. AT & T Mobility Servs., LLC.,* 728 F.3d 975, 977 (9th Cir. 2013). "[A] defendant's notice of removal need include only a plausible allegation that the amount in controversy exceeds the jurisdictional threshold . . . [and] need not contain evidentiary submissions." *Dart Cherokee Basin Operating Co., LLC v. Owens,* 135 S.Ct. 547, 549 (2014). However, if a plaintiff contests the allegations set forth in the notice of removal, "both sides submit proof and the court decides, by a preponderance of the evidence, whether the amount in controversy requirement has been satisfied." *Id.* at 553.

III. DISCUSSION

CAFA grants federal courts original jurisdiction over class action cases that meet the following requirements: (1) the proposed class contains more than 100 members; (2) minimal diversity exists between the parties; and (3) the amount in controversy exceeds $5,000,000. 28 U.S.C. § 1332(d); *Kuxhausen v. BMW Fin. Servs. NA LLC,* 707 F.3d 1136, 1139 (9th Cir. 2013). Minimal diversity exists when any member of a plaintiff class is diverse from any defendant. 28 U.S.C. § 1332(d)(2)(a).

between the parties; and (3) the amount in controversy exceeds $5,000,000. 28 U.S.C. § 1332(d); *Kuxhausen v. BMW Fin. Servs. NA LLC,* 707 F.3d 1136, 1139 (9th Cir. 2013). Minimal diversity exists when any member of a plaintiff class is diverse from any defendant. 28 U.S.C. § 1332(d)(2)(c). Defendant contends that the Court has subject matter jurisdiction over this case, as all three requirements have been met. The Court disagrees with respect to the amount in controversy.

A. Size of Proposed Class

According to Plaintiff, Defendant improperly asserts, without documentation or a declaration, that there are 811 class members. However, in its Opposition, Defendant proffers the declaration of Scott Pechaitis, Esq. ("Pechaitis") who conducted data analysis for this case. Analyzing Defendant's records during the period from June 1, 2013 to February 15, 2015, Pechaitis identified approximately 811 putative class members. (Pechaitis Decl. ¶ 6.) Thus, the Court finds that Defendant sufficiently satisfied its burden of showing a putative class exceeding 100 members.

B. Minimal Diversity of the Parties

The citizenship of an LLC for purposes of diversity jurisdiction is the citizenship of its members. *Johnson v. Columbia Properties Anchorage, LP,* 437 F.3d 894, 899 (9th Cir. 2000). If any member of a limited liability company ("LLC") is itself a partnership or association (or another LLC), the federal court needs to know the citizenship of each submember as well. *Id.* Defendant has submitted a declaration from Robert A. Sweet ("Sweet"), Defendant's Chief Investment Officer and Vice President. In his declaration, Sweet confirms that Defendant is an LLC consisting of three members: (1) Kacy Kang, a citizen of North Carolina; (2) Kevin Carlin, a citizen of Washington; and (3) White Point Holdings, LP. (Sweet Decl. ¶ 3.) The citizenship of White Point Holdings, LP is determined by identifying the citizenship of its members. In his declaration, Sweet establishes that White Point Holdings, LP has three partners: (1) Charles E. Trefzger, a citizen of North Carolina; (2) himself, a citizen of Maryland; and (3) Timothy P. O'Brien, a citizen of Maryland. (Sweet Decl. ¶ 3.) Therefore, for purposes of diversity jurisdiction, Defendant is a citizen of North Carolina, Washington and Maryland. As Plaintiff is a citizen of California, there is minimal diversity between the parties.[2]

C. Amount in Controversy

In a CAFA case where a plaintiff's state court complaint does not specify a particular amount of damages, the removing defendant bears the burden of establishing, by a preponderance of the evidence, that the amount in controversy exceeds $5,000,000. *Rodriguez,* 728 F.3d at 977. If a defendant's assertion of the amount in controversy is challenged, "both sides submit proof and the court decides, by a preponderance of the evidence, whether the amount-in-controversy requirement has been satisfied." *Dart Cherokee Basin Operating Co., LLC,* 135 S. Ct. at 554 (citing 28 U.S.C. § 1446(c)(2)(B)). To satisfy the burden to demonstrate the amount in controversy, defendants may rely upon facts presented in the removal petition as well as any "summary-judgment-type evidence relevant to the amount in controversy at the time of removal." *Singer v. State Farm Mut. Auto. Ins. Co.,* 116 F.3d 373, 377 (9th Cir. 1997) "Under this system, CAFA's requirements are to be tested by consideration of real evidence and the reality of what is at stake in the litigation, using reasonable assumptions underlying the defendant's theory of damages exposure." *Ibarra v. Manheim Invs., Inc.,* 775 F.3d 1193, 1198 (9th Cir. 2015). Nevertheless, a court "cannot base [a finding of] jurisdiction on [a] [d]efendant's speculation and conjecture." *Lowdermilk v. U.S. Bank Nat'l Ass'n,* 479 F.3d. 994, 1002 (9th Cir. 2007).

jurisdiction on [a] [d]efendant's speculation and conjecture." *Lowdermilk v. U.S. Bank Nat'l Ass'n,* 479 F.3d. 994, 1002 (9th Cir. 2007).

The Court finds that Defendant failed to meet its burden of proving that the amount in controversy exceeds $5,000,000, as Defendant makes assumptions that are unsupported by the allegations in the Complaint or by the evidence. Defendant's calculations assume one hour of unpaid minimum wages per week, one hour of unpaid overtime wages per week, and either one or five missed meal and rest periods per week for each putative class member. Moreover, Defendant assumes that all members of the putative class suffered every violation, at all times without providing evidence to substantiate its theory. Courts have rejected this kind of assumption. *See Martinez v. Morgan Stanley & Co., Inc.,* No. 09-CV-2937-L(JMA), 2010 WL 3123175, at *6 (S.D. Cal. Aug. 9, 2010) (rejecting defendant's calculation of overtime hours, meal and rest period violations, waiting time penalties, and wage statement penalties because the variables were not clearly suggested by the complaint or supported by evidence); *Roth v. Comercia Bank,* 799 F.Supp.2d 1107, 1118-1126 (C.D. Cal. 2010) (finding that defendants' calculations improperly presumed that there was a violation as to each class member even though the complaint contained "[s]tatements suggesting that overtime violations, missed meal periods, untimely payment of wages, and/or provision of inaccurate wage statements occurred regularly and/or consistently or even often") (internal quotations omitted).

As Defendant has not evidentiarily supported the variables used in its amount in controversy calculations, the Court finds its valuation is too speculative. *See Ibarra,* 775 F.3d at 1199 ("[A] damages assessment may require a chain of reasoning that includes assumptions . . . [but] those assumptions cannot be pulled from thin air [and] need some reasonable ground underlying them."). Defendant's improper speculations pervade all eleven claims. Consequently, the Court has no adequate basis to determine that the amount in controversy exceeds $5,000,000. Thus, Defendant has failed to satisfy its burden of proving that the amount in controversy requirement is satisfied and, as a result, has failed to establish that the Court has subject matter jurisdiction.

IV. CONCLUSION

In light of the foregoing, the Court GRANTS Plaintiff's Motion to Remand. Based on this ruling, the Court DENIES as moot Plaintiff's Motion to Strike.

IT IS SO ORDERED.

FootNotes

1. These causes of action include claims for unpaid overtime, unpaid meal period premiums, unpaid rest period premiums, unpaid minimum wages, final wages not timely paid, wages not timely paid during employment, non-compliant wage statements, failure to keep requisite payroll records, unreimbursed business expenses, violation of California Business & Professions Code §§ 17200, *et seq,* and violation of California Labor Code Private Attorneys General Act of 2004, or "PAGA."

2. The Court notes that the 4th Circuit determines the citizenship of an LLC for purposes of CAFA like a corporation, by assessing its place of incorporation and principal place of business. *See Ferrell v. Express Check Advance of S.C. LLC,* 591 F.3d 698, 705 (4th Cir. 2010). Some California district courts have similarly applied this method of analysis. *See Marroquin v. Wells Fargo, LLC,* No. 11-CV-163-L-BLM, 2011 WL 476540 (S.D. Cal. Feb 3, 2011) (holding that an LLC is considered an

v. Express Check Advance of S.C. LLC, 591 F.3d 698, 705 (4th Cir. 2010). Some California district courts have similarly applied this method of analysis. *See Marroquin v. Wells Fargo, LLC,* No. 11-CV-163-L-BLM, 2011 WL 476540 (S.D. Cal. Feb 3, 2011) (holding that an LLC is considered an "unincorporated association" in a CAFA case). Sweet's declaration confirms that at all relevant times, Defendant's principal place of business and corporate headquarters were in North Carolina. (Sweet Decl. ¶ 4.) As stated above, Plaintiff is a citizen of California. Thus, even determining Defendant's citizenship using this method of analysis, there is minimal diversity between the parties.

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- 213 F.3d 1108
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- 707 F.3d 1136
- 437 F.3d 894
- 116 F.3d 373
- 775 F.3d 1193
- 591 F.3d 698

From S.Ct., Reporter Series

- 135 S.Ct. 547

From F.Supp.2d, Reporter Series

- 799 F.Supp.2d 1107

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Case Number: 14CVS2474	Plaintiff: Doctors Making Housecalls, LLC	Status: Closed
Opened:	Defendant: Meridian Senior Living, LLC	County: Durham
4/8/2014	Type Case: Mandatory Complex Business	Judge: James L. Gale

Show Parties

Filings	
Court Filed: 8/19/2015	Close Case Filed by: Court
Plaintiff Filed: 8/19/2015	Dismiss [Voluntary] Filed by: Doctors Making Housecalls, LLC
Court Filed: 6/16/2015	Notice of Telephone Status Conference Filed by: Court
Court Filed: 6/1/2015	Order Filed by: Court
Court Filed: 2/23/2015	Order Granting Joint Motion to Stay Proceedings Pending Settlement Negotiations Filed by: Court
Defendants Filed: 2/20/2015	Joint Motion to Stay Proceedings Pending Settlement Negotiations Filed by: Meridian Entities, Charles E. Trefz
Defendants Filed: 2/20/2015	Joint Motion to Stay Proceedings Pending Settlement Negotiations Filed by: Meridian Entities, Charles E. Trefz
Court Filed: 12/29/2014	Administrative Order Filed by: Court
Defendants	Rule 12 Motion in Lieu of Answer Filed by: Bowen Primary & Urgent Care, P.A. e

Filed: 11/20/2014	
Defendants Filed: 11/19/2014	Reply Memorandum in Support of Motion to Dismiss Amended Complaint Pursuant to Rule 12 (b)(6) Filed by: Meridian Entities, Charles E. Trefz
Court Filed: 11/4/2014	Order Granting Consent Motion for Extension of Time to File Reply Brief Filed by: Court
Court Filed: 11/4/2014	Order Granting Consent Motion for Extension of Time to File Reply Brief Filed by: Court
Defendants Filed: 11/3/2014	Consent Motion for Extension of Time to File Reply Brief Filed by: Bowen Primary & Urgent Care, P.A. e
Defendants Filed: 10/31/2014	Consent Motion for Extension of Time to File Reply Brief Filed by: Meridian Entities, Charles E. Trefz
Plaintiff Filed: 10/23/2014	Response Brief in Opposition to Defendants' Motion to Dismiss Amended Complaint Filed by: Doctors Making Housecalls, LLC
Court Filed: 10/16/2014	Order Filed by: Court
Plaintiff Filed: 10/16/2014	Motion to Enlarge Word Limit for Plaintiff's Response Brief Filed by: Doctors Making Housecalls, LLC
Plaintiff Filed: 10/7/2014	Amended Case Management Report Filed by: Doctors Making Housecalls, LLC
Defendants Filed: 10/1/2014	2014.10.01 Memorandum in Support of Motion to Dismiss Amended Complaint Pursuant to Rule 12 (b)(6) Filed by: Meridian Entities, Charles E. Trefz
Defendants	2014.10.01 Motion to Dismiss Amended Complaint Pursuant to Rule 12(b)(6) Filed by: Meridian Entities, Charles E. Trefz

Filed: 10/1/2014	
Defendants Filed: 9/30/2014	Rule 12 Motion in Lieu of Answer Filed by: Bowen Primary & Urgent Care, P.A. e
Plaintiff Filed: 8/29/2014	Amended Complaint and Request for Preliminary and Permanent Injunction Filed by: Doctors Making Housecalls, LLC
Court Filed: 8/18/2014	Notice of Hearing and Case Management Conference Filed by: Court
Plaintiff Filed: 7/28/2014	Case Management Report Filed by: Doctors Making Housecalls, LLC
Plaintiff Filed: 7/25/2014	Case Management Report Filed by: Doctors Making Housecalls, LLC
Court Filed: 7/21/2014	Order Granting Motion for Extension of Case Management Deadlines Filed by: Court
Plaintiff Filed: 7/19/2014	Motion to Extend Case Management Deadlines Filed by: Doctors Making Housecalls, LLC
Defendants Filed: 7/15/2014	Reply in Support of Motion to Dismiss Pursuant to Rule 12(b)(6) Filed by: Bowen Primary & Urgent Care, P.A. e
Defendants Filed: 7/15/2014	Reply Memorandum in Support of Motion to Dismiss Complaint Pursuant to Rule 12(b)(6) Filed by: Meridian Entities, Charles E. Trefz
Court Filed: 7/10/2014	Stipulated Consent Protective Order Filed by: Court
Plaintiff Filed: 7/3/2014	Response in Opposition to Defendants' Motions to Dismiss Filed by: Doctors Making Housecalls, LLC
Court Filed: 6/24/2014	Order Granting Joint Motion for Extension of Time Filed by: Court
Plaintiff	Joint Motion for Extension of Time Filed by: Doctors Making Housecalls, LLC

Filed: 6/23/2014	
Plaintiff Filed: 6/18/2014	Joint Motion for Entry of Stipulated Consent Protective Order Filed by: Doctors Making Housecalls, LLC
Defendants Filed: 5/30/2014	Memorandum in Support of Motion to Dismiss Pursuant to Rule 12(b)(6) Filed by: Meridian Entities, Charles E. Trefz
Defendants Filed: 5/30/2014	Motion to Dismiss Complaint Pursuant to Rule 12 (b)(6) Filed by: Meridian Entities, Charles E. Trefz
Defendants Filed: 5/29/2014	Rule 12 Motion in Lieu of Answer Filed by: Bowen Primary & Urgent Care, P.A. e
Court Filed: 5/12/2014	Notice of Telephonic Status Conference Filed by: Court
Court Filed: 4/29/2014	Order Granting Motion for Extension of Time to File Answer or Other Responsive Pleadings Filed by: Court
Defendants Filed: 4/28/2014	Motion for Extension of Time to File Answer or Other Responsive Pleadings Filed by: Meridian Senior Living, LLC, et al.
Court Filed: 4/8/2014	Assignment Order Filed by: Court
Court Filed: 4/8/2014	Designation Order Filed by: Court
Defendant Filed: 4/7/2014	Notice of Designation Filed by: Meridian Senior Living, LLC, et al.
Defendants Filed: 4/2/2014	Notice of Appearance Filed by: Bowen Primary & Urgent Care, P.A. et. al.
Court Filed: 3/28/2014	Motion for a Temporary Restraining Order and Preliminary Injunction Filed by: Court
Court Filed: 3/28/2014	Complaint Filed by: Court

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Hear 911 call: Family sues assisted-living facility after woman dies of hypothermia

911 call from Kathryn Brackett's death

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on January 12, 2017 at 1:40 PM, updated January 12, 2017 at 2:03 PM

comments

KENT COUNTY, MI - The family of an 85-year-old woman who was found dead outside an assisted-living facility has filed a lawsuit against Crystal Springs.

Kathryn Brackett died of hypothermia outside the facility at 1175 68th St. SE on Oct. 27.

She left the home around 12:30 a.m. and wasn't found until 5 a.m. It was cold, in the mid-30s, and raining overnight, the lawsuit said.

Crystal Springs, part of Meridian Senior Living LLC., told the victim's family it provided a safe, secure and monitored facility for residents who had a tendency to wander, the family said.

Brackett would wander from the home she shared with her husband until she started living at Crystal Springs.

"The night of Brackett's death, staff responsible for overseeing Brackett's care admitted visual checks of Brackett's whereabouts were not personally performed, instead assuming other team members had done them," according to the statement by the Sam Bernstein Law Firm.

"Kathryn Brackett's family entrusted her care and safety to this facility, and Crystal Springs failed her in the worst possible way," Mark Berstein said.

The law firm released the 911 call that a staff member from the facility made to dispatchers after finding the victim.

Bernstein said the state Department of Licensing and Regulatory Affairs determined that the facility failed to follow policy.

Bernstein said the state Department of Licensing and Regulatory Affairs determined that the facility failed to follow policy.

The lawsuit was filed Thursday, Jan. 12, in Kent County Circuit Court.

Crystal Springs declined to comment.

The woman, with early onset dementia, had tried to leave the facility in the past, the lawsuit said.

The lawsuit accused the facility of negligence and carelessness for failing to perform routine checks despite Brackett's tendency to wander. It said the facility should have been equipped with proper security and alarms to detect doors opening.

The woman's husband, Michael Brackett, filed the lawsuit.

Kent County sheriff's deputies reported that the woman was found about 40 feet from her room in a fenced courtyard. She was face-down, partially on the sidewalk and partially on the ground.

There was a blanket, shoes and stuffed animals on the victim's walker.

Police said that the door handle to the exit door did not appear to be locked. The handle was very loose. The alarm on the door appeared to be working.

The victim's body temperature was 71.6 degrees, according to police reports contained in the lawsuit.

An unpublished opinion of the North Carolina Court of Appeals does not constitute controlling legal authority. Citation is disfavored, but may be permitted in accordance with the provisions of Rule 30(e)(3) of the North Carolina Rules of Appellate Procedure.

NO. COA10-594
NORTH CAROLINA COURT OF APPEALS

Filed: 3 May 2011

SARAH WILLIAMSON,
ADMINISTRATRIX OF THE ESTATE OF
JAMES WARD CARVER,
Plaintiff,

v.

Bertie County
No. 09 CVS 314

WINDSOR HOUSE ONE, LLC, THIRD STREET MANAGEMENT, LLC, and CHARLES E. TREFZGER, JR.,
Defendants.

Appeal by Defendants from Order entered 15 March 2010 by Judge Cy A. Grant in Bertie County Superior Court. Heard in the Court of Appeals 17 November 2010.

Gugenheim Law Offices, P.C., by Stephen J. Gugenheim and Jonathan R. Harris, for plaintiff-appellee.

Bell, Davis & Pitt, P.A., by Michael D. Phillips, for defendant-appellants.

HUNTER, JR., Robert N., Judge.

Windsor House One, LLC, Third Street Management, LLC, and Charles E. Trefzger, Jr. ("Defendants") appeal the trial court's

Order denying Defendants' Motion to Dismiss or, in the Alternative, to Compel Arbitration. We affirm the Order.

I. Factual & Procedural Background

On 21 February 2008, Sarah Williamson ("Williamson") contacted the Pasquotank County Department of Social Services ("DSS") to report that her father, James Ward Carver, was no longer able to care for himself. Mr. Carver refused to eat, bathe, groom himself, or take his medications. Williamson also reported that her father was suffering from dementia, tended to wander from his home, and refused to accept the assistance of his family members.

DSS responded by sending Paulette McCoy, a social worker, to Mr. Carver's home on the same day. After interviewing Mr. Carver and following an emergency examination by a physician, DSS determined that Mr. Carver was in need of protective services. On 22 February 2008, DSS filed a Petition for Order Authorizing Emergency Services. That day, Magistrate Stephen R. Masters granted an Order Authorizing Emergency Services. The Order provided that DSS "is hereby authorized to furnish and provide such services as are reasonably necessary for James Carver pursuant to the provisions of N.C. Gen. Stat. § 108A-106, including the removal of James Carver from his residence in the

discretion of the Petitioner." DSS immediately placed Mr. Carver in an adult care home in Elizabeth City, North Carolina.

On 28 February 2008, Chief District Court Judge C. Christopher Bean signed an Order extending the 22 February 2008 Emergency Order, appointing a Guardian ad Litem for Mr. Carver, and ordering DSS to provide emergency services for Mr. Carver as defined under N.C. Gen. Stat. § 108A-106.

On 7 March 2008, District Court Judge Eula E. Reid entered an Order Authorizing Protective Services permitting DSS to provide Mr. Carver with protective services pursuant to N.C. Gen. Stat. § 108A-105. Judge Reid subsequently amended the Order on 21 April 2008, to include the provision that the court recommended Mr. Carver be maintained in an extended care facility near Elizabeth City in order that his family could visit him on a regular basis.

On 11 March 2008, DSS Director, Melissa C. Stokely ("Director Stokely" or "Stokely"), executed a Delegation of Authority ("DOA") authorizing several members of her staff, including DSS Supervisor Carolyn Thomas ("Thomas"), to act as Stokely's representative pursuant to N.C. Gen. Stat. § 108A-14(b). By the terms of the DOA, Director Stokely delegated to Thomas the authority to

> act on [her] behalf in signing written release of information forms related to any minor or adult of whom [she is] legal

> custodian or legal guardian, to sign any forms giving [her] consent for the administration of medication or treatment (to include surgery) for any minor or adult of whom [she is] legal custodian or legal guardian. This includes the authority to give verbal or telephone consent for the release of information, the administration of medication and/or treatment, including surgery, for any minor or adult of whom [she is] the legal custodian or legal guardian. The above-cited delegation of authority is valid to the extent that orders of the Courts delegate such authority to [her] in [her] position as Director of Pasquotank County Department of Social Services.

During February and March 2008, Mr. Carver was admitted to three different adult care homes, a nursing home, and the hospital as his needs fluctuated. On 28 March 2008, Thomas placed Mr. Carver at Windsor House, in Windsor, North Carolina. At the time of admission, Windsor House presented Thomas with a set of documents, which Thomas signed in her capacity as the representative of Director Stokely. These documents included a dispute resolution agreement, which provided Mr. Carver, his estate, successors, assigns, heirs, personal representatives, executors, and administrators agreed to submit all legal claims against Windsor House, or its officers, directors, managers, employees, or agents to binding arbitration and to waive his constitutional right to a trial by jury. Mr. Carver did not sign the Dispute Resolution Agreement.

Mr. Carver was declared incompetent on 1 May 2008 by the district court, Plaintiff was appointed as Mr. Carver's General Guardian, and DSS closed its case on Mr. Carver. On 27 May 2008, Mr. Carver fell in the shower and hit his head on the floor. He was taken to the hospital, found to have suffered a fracture to his vertebrae, diagnosed with quadriplegia, and died on 3 June 2008.

Plaintiff, as administratrix of her father's estate, filed this suit in Bertie County Superior Court on 30 July 2009 alleging negligence, medical negligence, and wrongful death against Windsor House One, LLC, which owns Windsor House; Charles E. Trefzger, Jr., an officer of Windsor House One; and Third Street Management, LLC, which provides management services to Windsor House. Prior to filing an answer, Defendants filed a Motion to Dismiss or, in the Alternative, to Compel Arbitration and Stay Litigation based on the Dispute Resolution Agreement signed by Thomas and Windsor House. Plaintiff opposed Defendants' Motion alleging neither Director Stokely nor Thomas had actual or apparent authority to bind Mr. Carver to an arbitration agreement.

On 15 March 2010, the Superior Court entered an Order dismissing Defendant's Motion. The trial court found the arbitration agreement was void as a matter of law. The trial court concluded that Director Stokely did not authorize Thomas

to sign arbitration agreements on her behalf, and that neither DSS nor Thomas had the legal authority to sign the Dispute Resolution Agreement. From this Order, Defendants appeal.

II. Jurisdiction and Standard of Review

While the trial court's dismissal of Defendants' motion to compel arbitration is an interlocutory order, "[t]he right to arbitrate a claim is a substantial right which may be lost if review is delayed, and an order denying arbitration is therefore immediately appealable." *United States Trust Co., N.A. v. Stanford Group Co.*, 199 N.C. App. 287, 289-90, 681 S.E.2d 512, 514 (2009) (citations and quotation marks omitted). Therefore, this appeal is properly before this Court. We review the trial court's order *de novo*. *See Bass v. Pinnacle Custom Homes, Inc.*, 163 N.C. App. 171, 175, 592 S.E.2d 606, 609 ("The trial court's conclusion regarding a motion to compel arbitration is reviewable *de novo*."), *disc. review denied*, 358 N.C. 542, 598 S.E.2d 381 (2004).

III. Analysis

Defendants argue the trial court erred in concluding Director Stokely did not authorize Thomas to act on her behalf to sign arbitration agreements for Mr. Carver. Defendants argue the trial court "narrowly construed" Director Stokely's Delegation of Authority in a manner that is not supported by the evidence. We disagree.

In support of their argument, Defendants point to Director Stokely's sworn Affidavit, in which she states, in part, she authorized Thomas "to admit Carver to Windsor House and to sign on my behalf all documents required for Carver's admission to Windsor House, including . . . [the] Dispute Resolution Agreement." Director Stokely further averred, "Thomas was acting within the scope of her authority . . . when she signed the documents necessary for Carver's admission to Windsor House." Defendants maintain this affidavit leaves "no doubt" that Thomas had actual and apparent authority to execute all contracts necessary for Carver's admission to Windsor House.

Whether Director Stokely delegated to Thomas the authority to sign the arbitration agreement, however, is a conclusion of law to be determined by a court of law, not by Director Stokely. *See Lemon v. Combs*, 164 N.C. App. 615, 622, 596 S.E.2d 344, 349 (2004) ("'Statements in affidavits as to opinion, belief, or conclusions of law are of no effect.'" (citations omitted)).

Actual authority may be either express or implied. *Munn v. Haymount Rehab. & Nursing Ctr., Inc.*, __ N.C. App. __, __, 704 S.E.2d 290, 295 (2010). If a principal has delegated authority to her agent by words authorizing certain acts, then such authority is express authority. 3 Am. Jur. 2d *Agency* § 70 (2002). Furthermore, express authority is "conferred upon the agent or employee in express terms, and *it extends only to such*

powers as the principal gives the agent in direct terms, with the express provisions controlling." *Id.* (internal citations omitted) (emphasis added).

The express provisions of the DOA make clear that Director Stokely did not delegate such authority to Thomas. Stokely begins the DOA by quoting section 108A-14(b) of our General Statutes: "The director may delegate to one or more members of his staff the authority to act as his representative. The director *may limit the delegated authority of his representative to specific tasks* or areas of expertise." N.C. Gen. Stat. § 108A-14(b) (2009) (emphasis added.) Stokely then explicitly limited Thomas' authority stating, Thomas could "sign[] written release of information forms," could "sign any forms giving [her] consent for the administration of medication or treatment (to include surgery)," and could "give verbal or telephone consent" for the same. Nowhere in the DOA does she give Thomas the authority to sign arbitration agreements. Accordingly, Stokely did not delegate to Thomas actual authority to sign the Dispute Resolution Agreement.

Nor did Thomas have apparent authority to sign arbitration agreements on behalf of Directory Stokely. "Apparent authority is that authority which the principal has held the agent out as possessing or which he has permitted the agent to represent that he possesses." *Munn*, __ N.C. App. at __, 704 S.E.2d at 295

(citation and quotation marks omitted). A third party may not establish that a transaction between the agent and the third party was authorized by the principal absent actual reliance by the third party on the principal's assertions of the agent's authority at the time of the transaction. *Knight Pub. Co., Inc. v. Chase Manhattan Bank, N.A.*, 125 N.C. App. 1, 15, 479 S.E.2d 478, 487 (1997). Furthermore, reliance by the third party must result from the third party's exercise of reasonable care in determining what authority the principal conferred upon her agent. *Munn*, __ N.C. App. at __, 704 S.E.2d at 295. Representations made by Thomas, if any, as to her authority to sign the arbitration agreement are irrelevant. *Id.* at __, 704 S.E.2d at 296 ("The scope of an agent's apparent authority is determined not by the agent's own representations but by the manifestations of authority which the principal accords to him." (citation and quotation marks omitted)).

Defendants acknowledge Thomas presented the DOA to Windsor House at the time of Mr. Carver's admission. As the text of the DOA expressly limits Thomas' authority to consent to "release of information" forms and "administration of medications and treatment (including surgery)," we conclude any reliance by Windsor House on the DOA for believing Thomas had authority to sign the Dispute Resolution Agreement was not the result of reasonable care. Consequently, we conclude Thomas did not have

apparent authority to sign the Dispute Resolution Agreement and Defendants' arguments are dismissed.

IV. Conclusion

Because we have determined that Carolyn Thomas did not have actual or apparent authority to enter into the Dispute Resolution Agreement at the time of Mr. Carver's admission to Windsor House, we do not reach the issue of whether Director Stokely had such authority to delegate. The trial court's order is

Affirmed.

Judges STEELMAN and STEPHENS concur.

Report per Rule 30(e).

Who's Running Southeast Louisiana Hospital?

Charles Maldonado on the company selected by the state of Louisiana to operate the region's largest public mental health facility

By Charles Maldonado @ChMaldonado
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- Meridian Behavioral Health Systems seems on track to take over Southeast Louisiana Hospital.

When the Louisiana Department of Health and Hospitals (DHH), along with St. Tammany Parish government, announced earlier this month that they had found a company to keep 58 patient beds — 42 juvenile and 16 adult acute — at Southeast Louisiana Hospital (SELH) open and operating, it was a relief to those who feared the Mandeville facility would shut down its mental health services entirely.

But few took a close look at Meridian Behavioral Health Systems, the Florida-based company chosen to operate SELH. Media reports at first had it confused with Meridian Behavioral Healthcare, a 16-year-old Gainesville, Fla.-based nonprofit organization. Meridian Behavioral Health Systems (http://meridianbhealth.com) is a for-profit private company formed less than a year ago.

Running SELH is a major undertaking. Even though the state plans to lay off more than 300 employees as part of the hospital's privatization, Meridian CEO Wes Mason told WWL-TV last week that he plans to employ about 150 on the campus.

Formed earlier this year, Meridian has never handled a facility the size of SELH, as Mason admitted during a Dec. 3 news conference. Moreover, in its application to the state, the nascent company listed no facilities — not one — it had ever run.

In September, DHH issued an open-ended request for information (RFI) seeking contractors to provide services for patients either on the SELH campus or elsewhere in the metro New Orleans area.

"We happened to see that Southeast was closing, and people were looking to keep the hospital open," Mason said. "We approached the state, as well as some providers, about how we might be able to help solve the problem with Southeast closing."

Asked why DHH picked a new company to run the hospital, departmental spokesman Ken Pastorick said no other responding company was interested in running such a large operation. Two other companies — MMO Behavioral and River Oaks Hospital — offered to open beds in other locations. Another, City Medical Management, didn't offer to run any juvenile beds on the SELH campus.

other companies — MMO Behavioral and River Oaks Hospital — offered to open beds in other locations. Another, City Medical Management, didn't offer to run any juvenile beds on the SELH campus.

"The state reviewed Meridian's RFI and Meridian was the only company that met all of DHH's requirements and expectations regarding operations on the campus of Southeast and was also the only provider interested in working with the adolescent population and keeping the Developmental Neuropsych Unit open," DHH spokesman Ken Pastorick wrote in an email to *Gambit*.

The state's first instruction in the RFI was that applicants should "demonstrate comprehensive experience in working with adult, adolescent and child/youth patients with serious mental illness... ."

Meridian's response to the RFI did not indicate what, if any, facilities the company has run. Its website shows locations in seven states, but it doesn't name them or provide addresses.

"This is the only agreement DHH has with Meridian," Pastorick wrote in response to *Gambit's* query about the company's relevant experience. "DHH believes Meridian would have more detailed information regarding its own facilities and therefore we would suggest this question is better answered by Meridian. DHH recommends Meridian be contacted directly for this detailed information."

Mason said Meridian is opening a residential treatment facility called Kenbridge Youth Academy in Virginia next year and has handled another property in South Carolina, which he declined to name, citing a confidentiality agreement. The company also is working with the University of Kentucky on a proposed facility in Lexington, he said. Other locations listed on the website indicate either administrative offices or individual staff members working in facilities run by Meridian Senior Living, an affiliated company.

"But I will add our [individual] experience as operators," Mason said. "I have over 12 years experience at the executive level. As a company, we have combined experience of over 100 years running facilities much, much larger than this."

Prior to founding Meridian, Mason worked for a number of for-profit behavioral health management companies, including the country's largest, Universal Health Services. According to his bio, Mason's relevant experience includes "opening a 20-bed inpatient psychiatric unit for adults in Winston-Salem, N.C., in a private/public partnership."

His bio does not identify the unit, but Mason confirmed it refers to Old Vineyard Behavioral Health Services, then Old Vineyard Youth Services, a Universal property in Winston-Salem. In 2007, Mason, then Old Vineyard's CEO, helped arrange a deal with Centerpoint Human Services — a state-mandated regional mental health provider similar to Louisiana's Human Services Districts — to operate a number of adult emergency beds at the facility, following steep reductions in state Medicaid payments for mental health services, according to media reports.

In 2008, Mason was hired by Psychiatric Solutions Inc. (PSI), a controversial Tennessee-based company that was the subject of a highly critical investigation by ProPublica and the *Los Angeles Times* in 2008. PSI was then one of the largest private providers in the country. PSI placed Mason in charge of what Meridian's response to DHH describes as "a 400-bed adolescent psychiatric residential facility (PRTF) in Virginia that was struggling, not only financially, but with its poor clinical reputation." Within 18 months, PSI boasts, Mason "built a strong team," nearly doubled its patient census and increased its earnings.

reputation." Within 18 months, PSI boasts, Mason "built a strong team," nearly doubled its patient census and increased its earnings.

Mason confirmed that the facility referenced above is the Pines Residential Treatment Center, where he served as CEO from 2008 to 2010. The Pines operated three child and adolescent campuses, two in Portsouth, Va., and one in Norfolk, Va., totaling about 400 beds. In mid-2010, when Mason had been there for nearly two years, Norfolk's *Virginian-Pilot I*and Richmond's *Times-Dispatch* began publishing articles about one of the campuses, detailing a long list of problems, including serious injuries allegedly resulting from neglect, inadequate staff training, mishandling of medication — including incorrect instructions to give one child lithium and staff giving inaccurate information about emergencies, the *Virginian-Pilot* reported.

Earlier in 2009, the Virginia Department of Behavioral Health and Developmental Services licensing office recommended downgrading the Pines' license to provisional status, "the most serious sanction short of shutting down the facility," the *Times-Dispatch* wrote. However, according to the report (which also noted that PSI was a major gubernatorial campaign contributor with politically connected staff members), the state mental health commissioner at the time, James Reinhard, rejected the recommendation. Instead, state officials drafted a memorandum of agreement with the company to improve conditions, which didn't require public disclosure.

Reinhard was listed as a professional reference in Meridian's application to take over SELH.

Both newspapers reported that the Pines failed to live up to the agreement and was issued a provisional license later in the year. Mason denies that.

"Our licensure was never downgraded. I never operated under a provisional license while at the Pines," he said. "It was clear we took a lot of the toughest kids in that facility. It was a very large organization. ... We're proud of the work we did. We made a lot of strides to actually improve the treatment while we were there."

According to a 2010 Virginia inspector general report, the state issued an extensive corrective plan for the Pines in November 2009 — when its previous year's license expired — and the facility operated under heavy state supervision until, in March 2010, it was found to have made enough progress for a full license renewal. Its licensure status from November 2009 to March 2010 was retroactively designated "provisional."

Mason left the Pines after Universal bought out PSI in late 2010. He followed outgoing PSI CEO Joey Jacobs to Atlanta-based Acadia Healthcare, another large operator.

According to his bio, Mason no longer is interested in corporate chains.

"Having worked primarily for publicly traded corporations, Wes has seen the erosion of values and decreasing emphasis on safety and quality of care to satisfy the need for increasing revenue/profits to continuously keep 'Wall Street' happy," the bio reads.

The address Meridian lists on its website is a 14th-floor condo unit in Ft. Lauderdale, Fla. At least six other business entities — mostly investment LLCs — also are registered there, according to the Florida Secretary of State's online business registry. Most are owned or operated by Dawn Steinberg, Meridian's chief legal officer.

"We have offices in Silver Springs [Md.] and North Carolina," Mason said. "The office in Ft.

Meridian's chief legal officer.

"We have offices in Silver Springs [Md.] and North Carolina," Mason said. "The office in Ft. Lauderdale is just an office where we run some of our corporate communication out of."

Meridian's application to DHH does provide a bit more insight into the company. It's described as a "behavioral health offshoot of Meridian Senior Living LLC." Meridian Senior Living is a large senior care operator based in North Carolina. The company manages homes in 12 states.

"They are sister companies. Neither one wholly owns the other," said Allen Osborne, an independent risk management consultant and business development employee for the company.

Meridian Senior Living was founded by Hickory, N.C., attorney Charles Trefzger, who, before creating the company in 2010, managed dozens of assisted care facilities in that state for decades under a number of other company names.

Trefzger has encountered problems at some of those facilities as well, according to state records and media reports. A home managed by Trefzger was hit with $10,000 in state fines after a man with Alzheimer's wandered out onto the street where he was hit by a car and killed in 2004. According to a 2009 article in the Raleigh *News & Observer*, state officials cited another facility he managed for a monthslong bed-bug infestation and heard complaints about errors in medicine dispensation.

"Trefzger's homes have accumulated fines of close to $100,000 for 20 top-level or second-rank violations since 2003," the *News & Observer* article says.

Of the company's current North Carolina portfolio of 48 facilities, state records posted online show that 12 have been cited for state violations since 2006.

But Osborne, the company's risk management consultant, says that in many cases problems existed in those facilities before the company took them over from another operator — which it often did at state regulators' insistence.

"In a great many cases, part of the company's role came from either, No. 1, being asked by the state, or in some cases by investors, to manage problem facilities and, for lack of a better term, to turn them around," Osborne said. "Of the facilities that Meridian manages in North Carolina, that's probably about a third of the facilities they manage. They were facilities that had problems, and Meridian solved the problems."

Regarding the bedbug infestation, Osborne said bedbugs are an extremely common problem in congregant living situations. The company eradicated the infestation quickly and safely, he said, and found other accommodations for residents while it was exterminating.

Meridian Senior Living is currently in a dispute with the state of North Carolina over fines for failure to order and distribute medicine to Alzheimer's patients at another facility in New Hanover County, N.C. County inspectors originally recommended that the home cease admissions because of the alleged violations.

"We made the recommendation to suspend admissions," Wanda Marino, assistant director of the New Hanover County Department of Social Services, said in a phone interview. "The state is not on the same page as the counties."

the same page as the counties."

That the facility — an assisted care center — has one of a number of relatively new units called "memory care" for Alzheimer's patients, including services once only available in nursing homes, said Osborne, who declined comment on specifics in this case, citing privacy laws.

"I'm not trying to blame any problems on the state, but I can tell you that when you open up a memory care facility, it's still new enough that you always have procedural issues that come up," Osborne said. "That's exactly what happened in the most recent situation. ... I can tell you that none of the citations involve a Type A penalty [the most serious classification] or anything that would be a danger to a resident."

Gambit provided various media reports about The Pines residential treatment center in Virginia and Meridian Senior Living facilities to Pastorick, who responded with a written statement attributed to DHH.

"The Louisiana Department of Health and Hospitals takes very seriously the health and welfare of residents and patients who receive treatment in all licensed facilities around the state. Ensuring this means being meticulous when reviewing potential providers before licensing these entities," it reads, adding that the state checked the company and its principals against a federal database of providers excluded from providing Medicare/Medicaid services in any state, as well as lists of companies ruled ineligible to receive federal contracts. "The Cooperative Endeavor Agreement (CEA) that gives Meridian the ability to provide services at Southeast also gives DHH strong oversight of the company's activities, ensuring that Meridian is providing the required level of care agreed upon in the CEA."

Meridian appears to be on a fast track to take over SELH. Mason signed agreements with the state and St. Tammany Parish on Dec. 5. Last week, the state Civil Service Commission approved DHH's layoff plan in a 4-3 vote, over the objections of members of the Committee to Save Southeast Louisiana Hospital, which includes a number of hospital staff.

Current SELH employees have had to wait since July, when the state first announced the hospital's closure, to find out if they might be able to stay on under new management. Not all have been able to stay. Dr. Avery Buras, a child psychologist for SELH, said he couldn't afford to wait for the state. He's been looking for work since last summer and has decided to take a job in Biloxi, Miss.

"We were granted a 15-minute interview two weeks ago," Buras said. "I think that fulfills their promise to look at us first. I was open to staying, but no one ever got to us or told us what the plans were."

Mason says he plans to give preferential treatment to current employees in hiring decisions.

"We have made offers. Several key leaders have been identified and have already accepted offers," he says, adding that 90 percent of the hospital's staff will comprise current employees.

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Wilmington Nursing Home Fined $2,000 In Death

Posted: Wed 12:15 PM, Dec 25, 2013

An assisted living home in Wilmington has been fined $2,000 for not taking a patient who fell to the doctor. Authorities say the patient suffered a broken neck and died several days later.

The StarNews of Wilmington reports (http://bit.ly/K5827m) the state Division of Health Services Regulation found the Hermitage House resident fell on April 29 and had bruises on the face the next day. The patient slid out of bed on April 30 or May 1, but wasn't taken to the doctor until May 2. The emergency room physician found the patient had a broken neck. The patient died a few days later.

A spokesman for Meridian Senior Living which operates Hermitage House says the fine doesn't indicate a serious problem, but workers should have gotten the patient help sooner.

Skip navigation

Di Dc

NC Division of Health Service Regulation

Adult Care Licensure Section

- What We Do
- Citizens
- Providers
- A-Z Index
- Search DHHS:

- Home
- Adult Care Licensure Section
- Facility Inspections, Ratings and Penalties

Woodhaven Court

- Facility Information
- Statements of Deficiencies
- Star Rating
- Penalties

Facility Information

License Number:	HAL-084-009
Site Address:	1930 Woodhaven Court Albemarle, NC 28001-6309
County:	Stanly
Capacity:	76 Beds

Statement of Deficiencies

Statements of Deficiencies (form used by the state to document inspections) are posted for adult care facilities with survey dates beginning November 1, 2014 and deficiencies or violations were identified.

Note: A Yes under the column, IDR Pending, indicates the facility has requested Informal Dispute Resolution (IDR), a process that gives a facility the opportunity to dispute all or some of the findings of a state inspection. If the Statement of Deficiency is changed as a result of IDR, the web page will be updated.

Inspection Type	Document Type	Inspection Date	Pages	IDR Pending
Constr Biennial Follow-up	Statement of Deficiency with Plan of Correction	11/3/2016	4	No
Constr Biennial Follow-up	Statement of Deficiency	11/3/2016	4	No
Constr Biennial	Statement of Deficiency with Plan of Correction	8/17/2016	11	No
ACLS Annual	Statement of Deficiency with Plan of Correction	6/2/2016	8	No
ACLS Annual	Statement of Deficiency	6/2/2016	8	No
ACLS Follow-up	No Deficiencies Cited	5/21/2015		No
ACLS Complaint	Statement of Deficiency with Plan of Correction	1/30/2015	42	No
ACLS Complaint	Statement of Deficiency	1/30/2015	39	No

Star Rating

Star Ratings are based on the results of DHSR inspections and some inspections by the County Department of Social Services (DSS).

Stars	Score	Issue Date	Merits	Demerits	Inspection Type	
Tv (2)	83	6/23/2016	7	4	Annual	View Worksheet
Or (1)	77.5	6/9/2015	8.75	0	Follow-up	View Worksheet
(ZERO STARS) (0)	68.75	2/23/2015	0	33.5	Complaint	View Worksheet
Th (3)	102.25	12/19/2014	1.25	0	Follow-up	View Worksheet
Th (3)	101	9/12/2014	4.5	3.5	Annual	View Worksheet
Th (3)	96.5	2/20/2013	4.5	8	Annual	View Worksheet
Th (3)	97	9/12/2011	7	0	Annual	View Worksheet
Tv (2)	89.5	7/26/2010	5	0	Follow-up	View Worksheet
Tv (2)	84.5	5/27/2010	4.5	20	Annual	View Worksheet
Th (3)	102.5	5/19/2009	2.5	0	Annual	View Worksheet

Penalties

Penalties imposed during the last 36 months are listed.

Penalty Issued Date	Penalty Amount	Penalty Type	Rule Cited	Reason for Issuance Nature of Violation	Current Status	Amount Paid	Date of Paymen
8/20/2015	$18,000.00	Type A1	10A NCAC 13F .0902(b) Li Health Care; 10A NCAC 13F .1002(a) Li Medication Orders; G.S. 131D-21(2) and (4) Li	Facility failed to notify physician for one resident regarding lab collections for thyroid stimulating hormone not being able to be obtained; failed to notify physician of changes in the resident's mental status; and failed to clarify one of the resident's medication orders used to treat thyroid imbalance ordered on hospital discharge summary but not on admitting FL-2 resulting in resident not receiving the medication for 4 months. Resident was hospitalized, diagnosed with long standing low thyroid levels resulting in a coma and the resident subsequently dying.	12/08/2016 Settlement Agreement for $10,000.00; Appealed 09/17/2015		

Penalty Issued Date	Penalty Amount	Penalty Type	Rule Cited	Reason for Issuance Nature of Violation	Current Status	Amount Paid	Date of Paymen
8/20/2015	$2,000.00	Type A2	10A NCAC 13F .1009(a) Li Pharmaceutical Care; G.S. 131D-21(4) Li Declaration of Residents' Rights	Facility failed to ensure medication reviews by pharmacist included identification of discrepancies with medication orders for a thyroid hormone replacement upon admission to facility for one resident.	12/08/2016 Settlement Agreement Penalty Eliminated; Appealed 09/17/2015		

Li Denotes link to site outside of N.C. DHHS.

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- Rules and Regulations
- Glossary
- Jobs at NC DHSR
- Directions
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This page was last modified on December 5, 2016.

Division of Health Service Regulation

TREFZGER HOMES

	Home	Date	Amount
1.	The Covington	12/22/16	$ 2000.00
2.	Rich Square Manor	6/14/16	$ 2000.00
3.	Mitchell House	11/25/15	$ 4000.00/$12,000
4.	Oliver House	1/13/15	$ 2000.00
		1/31/17	$ 1000.00
		Patient Killed – Run Over by Jeep	
5.	Seven Oaks Assisted Living	8/19/14	$ 12,200.00
		6/14/16	$ 4000.00
6.	Caswell House	9/17/15	$ 500.00
7.	Autumn Village	10/16/14	$ 1000.00
8.	Kingsbridge House	3/8/16	$ 29,600.00
9.	Bryson Senior Living	5/24/16	$ 20,400.00
		5/24/16	$ 26,600.00
10.	Ashe Gardens Memory Care	11/26/14	$ 1000.00
11.	Alamance House	3/15/16	$ 500.00
12.	Haywood House	6/18/15	$ 500.00
13.	Castle Creek Memory Care	5/24/15	$ 4000.00
14.	Chatham Commons	6/2/16	$ 2000.00
15.	Clayton House	5/20/15	$ 500.00
16.	Magnolia	12/8/16	$ 7000.00
		12/8/16	$ 4000.00
17.	Wellington House	10/16/14	$ 3000.00
		5/20/15	$ 3000.00
		9/30/15	$ 5000.00
18.	Springs of Catawba	6/14/16	$ 7500.00
19.	Country Time Inn	10/16/14	$ 2000.00
20.	New Bern House	12/22/16	$ 2000.00

TOTAL FINES/PENALTIES $157,300.00