STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051036	A. BUILDING: _____ B. WING _____	R 01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKVIEW COMMONS	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure each resident had tuberculosis (TB) upon admission to the facility in compliance with the control measures adopted by the Commission for Health Service for 1 of 7 sampled residents. (Resident #7) The findings are: Review of Resident #7's Resident Register revealed date of admission was 5/7/12. Review of Resident #7's immunization record revealed documentation of a TB skin test dated as given on 5/4/12 and read as negative on 5/6/12. Based on record review and interview, Resident #1 was non-interviewable. Interview with the Memory Care Coordinator on 1/30/15 at 3:30 p.m. revealed: -She found documentation of only one TB skin test for Resident #7.	D 234		

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D 234	Continued From page 1 -She thought Resident #7 had a 2-step TB skin test. -The facility's monitoring plan in place for residents' TB skin test was 1st step prior to admission and 2nd step within 14 days of admission date to the facility. -She would notify the nurse within 14 days of admission date to the facility, if resident needed a 2nd step TB skin test. -She was responsible for making sure the resident had a 1st and 2nd step TB skin test. -Administrative Assistant would be responsible for auditing a sample size of residents' TB skin tests weekly. -The Quality Insurance team would be responsible for auditing a sample size of residents TB skin tests quarterly. Interview with the facility's Administrator on 1/30/15 at 3:45 p.m. revealed: -She thought Resident #7 had a two-step TB skin test. -The facility's monitoring plan in place for residents' TB skin test was 1st step 30 days, prior to admission and 2nd step within 14 days of admission date to the facility. -Memory Care Coordinator was responsible for making sure the resident had the 1st and 2nd step TB skin test. Administrative Assistant would be responsible for auditing a sample size of residents' TB skin tests weekly. -The Quality Insurance team would be responsible for auditing a sample size of residents TB skin tests quarterly.	D 234		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

Division of Health Service Regulation

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D 338	Continued From page 2 An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interview: the facility failed to assure every resident was treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy as related to 4 out of 8 sampled residents being spoken to disrespectfully and 3 out of 8 sampled residents were dressed before 5:30am. The findings are: Three confidential resident interviews revealed: -Staff A staff talked to residents in a harsh, disrespectful manner. -"She will open the door, flip on the overhead light and almost yell my name____go pee." -"She flips on the overhead light while doing rounds and wakes us up." -"It is hard to go back to sleep after you have been spoken to like that." - "She turned on the overhead light and didn't turn it off. I had to get up to use the bathroom anyway so I turned it off. This was 2:30am 1/29/15." -"She gets residents dressed at 2:30am." - "Usually I sleep well at night but last night (1/29/15) she came in and flipped on the overhead light. I had to get up and turn it off. I have been awake for hours." -"Staff checks on residents at 11pm and 4am, open the door, turn on the overhead lights and check to see if we are breathing." -"I was told by the present Resident Care Coordinator(RCC) that notes had been left for staff A at the nurses station about not turning on	D 338		

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D 338	Continued From page 3 the overhead lights during rounds. I cannot recall the exact month but it was before January of this year." -"I am not mentally handicapped, I am physically handicapped. I do not like being spoken to like a child." -"Some of these residents would not speak up for fear of retaliation." Four confidential staff interviews revealed: -Staff had received a complaint from a resident that Staff A got her dressed at 2:30am, and this was reported to the Resident Care Coordinator. -Staff had been trained if residents did not want to get up right away staff were to honor their wishes. - Staff did not use flashlights but sometimes used bedside lamps during rounds. -They knew to turn lights off before exiting resident rooms. -If they overheard another staff talking or treating a resident disrespectfully; they knew to report it to management. Interview with the Resident Care Coordinator on 1/30/15 at 11:30am revealed: -Resident Care Coordinator was not aware of staff A speaking disrespectfully to residents. -During the training phase; staff were encouraged to use the bedside lamps when doing room checks. -The Resident Care Coordinator had not thought of using flashlights before. -The Resident Care Coordinator had left notes for staff A at the nurse's station about not turning on overhead lights back in December 2014. Interview with the Resident Care Coordinator on 1/30/15 at 4:40pm revealed:	D 338		

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D 338	Continued From page 4 -The Resident Care Coordinator had received a direct complaint from a resident on 1/21/15 about staff A getting residents up at 2:30am and turning on the overhead lights. -The Resident Care Coordinator had received a complaint from a staff member on 1/21/15 about another resident with the same issue. -These occurrences for both residents had happened 2 days in a row. -The Resident Care Coordinator had personally told staff A on 1/22/15 not to get residents up and dressed before 5:30am unless it was resident's choice. -The Resident Care Coordinator was not aware of any specific staff training in the past few months regarding respect and dignity. Interview with the Administrator on 1/30/15 at 4:45pm revealed: -Staff are trained in resident rights upon hire and then annually. Both require a signature by the employee. -New hires are required to read the facility policies and procedures and then shadow with a senior Personal Care Aide and or Medication Aide x 3 days. -The facility had no set time for residents going to bed. -The expectation of staff was that no resident was to get up before 5:30am unless there was a pending early appointment, procedure, or by resident's choice. -The Administrator was aware of a complaint 2 months ago involving same staff member. -The issue was addressed at that time and she was not aware of any recent complaints involving this staff member. -Their procedure for addressing resident complaints was to speak directly to the employee,	D 338		

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D 338	Continued From page 5 assure the resident that management would follow up and then actually follow up with the resident in 1-2 days. -The Administrator was not aware that someone had been woken up at 2:30am since in the past 2 weeks.. -The Administrator would investigate the complaints against staff A and corporate would be notified. Attempts were made to inteview staff A but no call back by end of survey. Review of Staff A's mandatory orientation paperwork revealed a signed copy of North Carolina Adult Home Bill of Rights.	D 338		