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D 000	Initial Comments The Adult Care Licensure Section and the Lee County Department of Social Services conducted a complaint investigation on 4/20/15 and 4/21/15. The complaint investigation was inititated by the Lee County Department of Social Services on 4/07/15.	D 000		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure policy and procedures were implemented for 1 of 1 resident (Resident #1) as evidenced by staff interventions for the resident's aggressive behaviors. The findings are: Review of Resident #1's hospital generated FL2 dated 2/5/15 revealed: - Diagnoses included health care associated pneumonia versus aspiration pneumonia, reactive airways and wheezing, mildly elevated liver function test, constipation, chronic Hepatitis, hypothyroidism, Down Syndrome with severe mental retardation, and history of collapsed lung.	D 271		

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- No documentation of behaviors
- No documentation of physical abuse.
- No documentation of verbal abuse.
- Documentation the resident was not oriented to person place or time.

Review of the current facility generated FL2 dated 3/10/15 revealed the following:
- Diagnoses included health care associated pneumonia versus aspiration pneumonia, reactive airways and wheezing, mildly elevated liver function test, constipation, chronic Hepatitis, hypothyroidism, Down Syndrome with severe mental retardation, and history of collapsed lung.
- No documentation of behaviors
- No documentation of physical abuse.
- No documentation of verbal abuse.
- Disorientation was documented as constant.
-Resident was semi ambulatory with limited use of wheelchair.
- Resident was incontinent bladder and bowel.
- Resident required assistance with bathing, feeding, and dressing

Review of Resident #1's Care Plan dated 3/24/15 revealed the following:
- Resident could be physically abusive, resistant to care and have disruptive or socially inappropriate behaviors.
- Resident could be injurious to self and others and had a history of developmental disabilities.
- Activities of Daily Living (ADL) listed as totally dependent for eating, toileting, bathing, dressing, and grooming and personal hygiene and as limited assistance for ambulation and transferring

Review of Resident #1's Resident Register revealed the facility admission date of 3/5/15.

Review of Resident #1's record revealed:

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- The resident was sent to a local hospital on February 27, 2015 for respiratory issues (pneumonia and low oxygen saturation) from a group home facility.
- The resident was discharged to a skilled nursing facility due level of care change to skilled level of care.
- The resident was discharged back to a local hospital by the skilled care facility on 3/5/15 for behavioral issues and for evaluation.

Review of a facility incident report (no date indicated) completed by Staff B, day shift Medication Aide (MA), revealed the following documentation:
- Resident #1 was combative and charging at Staff B.
- Efforts were made to try to calm the resident down.
-When attempting to leave the room, she noticed the resident on the floor kicking and banging his head.
- Staff B got on the floor and reached over resident's shoulder with one hand/arm.
- Staff B's other hand was on the dresser drawer to keep Resident #1 from hurting his head.
- When Resident #1 "stopped I asked if he was going to behave" and got no response.
- The resident was released and turned over and "that's when I noticed he (Resident #1) was turning blue".
- The report documented a staff reported starting CPR (cardiopulmonary resuscitation) and was told to stop due to the resident having a DNR (Do Not Resuscitate).

Interview on 4/7/15 at 1:00 pm with a Detective from the local police department revealed the following:
-An investigation was already underway and

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written statements and interviews had been conducted with staff and residents at the facility.
-The resident's (Resident #1) body had been sent to the State Medical Examiner's office for an autopsy.
- The medical examiner found a mark on the resident's forehead that would go along with the written statements where the adult [resident] was hitting his head against an object, but there were abrasions found on the neck that were inconsistent with the written statements of the staff.
- No one [at the facility] had mentioned restraining the adult [resident] by the neck or placing any pressure on the adult [resident] in that area of the body during the interviews completed on 4/1/15.

Subsequent interview on 4/15/15 at approximately 2:00 pm with the Detective from the local police department revealed:
- He had re-interviewed staff at the facility.
- He had spoken with the State Medical Examiner regarding his findings.
- The Detective reported the possibility of a homicide by asphyxiation ruling for the incident dated 4/01/15 involving Resident #1.

Review of a written statement by Staff B, MA, to local police on 4/01/15 revealed:
- The MA heard a staff member shouting for assistance and went to see what was going on.
- She observed a television lying on the floor along with a few other items.
- The MA asked another staff member what was happening and was told Resident #1 was coming at her trying to hit her.
- The MA turned in time to grab Resident #1's hands and verbally directed him to stop.
- Resident #1 reportedly kept moving forward, pushing her until someone grabbed him and

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pulled him away.
- Resident #1 "then got on the floor trying to reach at us".
- Resident #1 was restrained by his buttocks and shoulders, when he started banging his head on the dresser drawer.
- Staff B placed her hand between his head and the dresser.
- When he calmed down "we turned him over and he was blue".
- The MA checked the pulse; there was none and called EMS. (No documentation CPR was initiated here.)

Attempt to contact Staff B by telephone on 4/08/15 was unsuccessful.

Interview on 4/13/15 (not certain of time) with the Detective at the local police department revealed Staff B had obtained legal council and was no longer available for interviews.

Observations of Resident #1's room on 4/07/15 at 2:15 pm revealed:
- A twelve foot by twelve foot room.
- The room had an entry door that connected to a short hallway that had access to a private bathroom.
- The room had two beds, one against the wall on each side of the room, along the short wall.
- Each bed had one night stand with a lamp.
- There were two straight back chairs, one for each resident in the room.
- Along the long wall of the room there were two dressers.
- There was a television sitting on top of the dresser nearest to the door.
- There were black, arched downward directed marks on the wall beside this dresser.
- The television had a crack in the console.

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D 271	Continued From page 5 Confidential interview with a resident revealed: - The resident reported having several incidents with Resident #1. - The resident was verbally cursed by the Resident #1. - The resident was yelled at and accused of stealing items from Resident #1. - The resident had seen Resident #1 fall out of bed on two occasions, yelled, and then accused him of pushing him (Resident #1) out of bed. - There no physical contact, no hitting. - There was no threatening behavior. - Resident #1 would just start yelling and cursing for no reason, and get angry and worked up, over apparently nothing. - The resident did not see the incident that occurred that resulted in Resident #1's death and had not spoken to anyone about the incident. Confidential interview with a second resident revealed: - He was in a wheelchair and did not ambulate independently. - He reported on the day of the incident, Resident #1 began yelling, cursing and threw a television to the floor. - Resident #1 threw a bottle of lotion at him. - Resident #1 began hitting himself (Resident #1) and throwing other items. - Staff came to the room and tried to tell Resident #1 to stop. - Staff took him out of the room to the living room, and he did not see anything that occurred after that. - He heard a staff member say that Resident #1 had died. Interview on 4/08/15 at 11:30 am with the Activity Director revealed:	D 271		

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- The Activity Director heard noises and shouts for help coming from one of the resident's rooms.
- The Activity Director followed the noise to Resident #1's room.
- Upon entering the room, she witnessed Resident #1 throwing a book, stuffed animal and hairbrush in the room.
- He was yelling at the staff members in the room, and attacking the staff members in the room.
- She verbally attempted to calm the resident, but he continued to fight and attack the other staff members.
- She left the room to call 911 and the administration staff, who was located at a sister facility.
- She came back to the room after making the calls and observed the resident lying on his stomach, on the floor, hitting his head on a dresser.
- A staff member, Staff B, was kneeling beside Resident #1 with one hand on the back of his shoulder, in an attempt to prevent him from struggling, and the other hand attempting to hold his head still, to prevent him from hitting his head on the dresser.
- At some point the resident stopped struggling and staff rolled him over, and then noticed that he had stopped breathing.
- Staff B, who had been holding his shoulder and head, began CPR immediately and only after another staff person (not identified) notified Staff B the patient had a DNR, did Staff B stop and wait for EMS to arrive.

Second interview on 4/10/15 at 3:00 pm with the Activity Director revealed:
- She was working the day the incident occurred with Resident #1 (4/01/15).
- She heard the shouting and yelling coming from the resident's room and staff members were

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calling for assistance.
- Upon entering the room, she reported seeing the resident hitting himself in the chest and stomach yelling "stop" and "no".
- Other staff members were verbally attempting to redirect him to get him to calm down.
- The resident threw a bottle of lotion and almost hit his roommate.
- She pushed the roommate out of the room in his wheelchair to remove him from the situation, and then went to the phone to call for assistance.
- She called the administrator and described the situation and then called emergency services.
-Upon reentering the room, the resident was on the floor not moving, and a staff member was performing chest compressions.
- She went back to the nursing desk to make sure emergency services were coming.

Review of a written statement made by the Activity Director to local police on 4/01/15 revealed:
- She reported being in the library and heard a loud noise and went to investigate.
- Resident #1 was observed throwing objects, yelling and attacking the staff members who were in the room.
- Verbal attempts were made by the staff in the room to calm him down.
- Reported leaving the room to call for assistance and upon returning he was on the floor, hitting his head on the dresser.
- EMS was called because he stopped breathing.

Confidential interview with a third resident revealed:
- The resident stated that on several occasions since coming to the facility, Resident #1 had confronted him in the television room by yelling and cursing at him.

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- The resident had seen Resident #1 tripping and having difficulty ambulating.
- The resident stated he had observed Resident #1 fall to the floor, while attempting to get up from the couch, on a couple of occasions.
-On those two occasions the resident got up, and yelled at whoever was in the room and accused them of pushing him to the floor.

Telephone interview on 4/08/15 at 2:00 pm with a Case Manager at Resident #1's former facility revealed the following:
- The facility was a MRDD (Mental Retardation Developmentally Delayed) group home.
- Resident #1 came to live at that facility in January 2013.
- The resident had a history of health issues and breathing issues.
- The resident had a long history of behaviors described as hitting and slapping himself, hitting others, cursing, making inappropriate sexual comments, swinging wildly with arms, throwing objects and lunging at others to the extent he would leap forward like he was attempting to fly, and fall on the ground.
- These behavioral issues were often exacerbated by resident's respiratory issues.

Telephone interview on 4/8/15 at 3:00 pm with the State of North Carolina Medical Examiner revealed:
- Resident #1 showed signs of petechial hemorrhage from lack of oxygen in both eyes, upper face and neck.
- There were abrasions visible on the outside of the forehead which were consistent with reports the adult [resident] was observed hitting his head against a dresser or the floor.
-There was an abrasion on the right side of the resident's neck and another abrasion on the back

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left of the neck.
-She stated internal inspection of the muscles of the neck revealed bleeding in the muscle tissue in the front right and back left of the neck.
-She stated bleeding of this nature comes from compression of the neck indicating that pressure was applied to the neck in a manner that compressed the muscle tissue in a manner and with enough force to cause the muscles to bleed.
-She stated this event would have caused restricted airflow to the lungs and would have been a contributing factor in the adult's [resident's] death.

Interview on 4/10/15 at 2:15 pm with Staff C, a personal care aide (PCA), revealed:
- The PCA had worked at the facility for over 1 year.
- The PCA's job duties included keeping a check on residents, assisting in personal care of residents such as bathing toileting grooming, assisting with eating and helping residents with other day to day activities.
- Staff C was working that day. (The day of the incident with Resident #1 on 4/01/15.)
- She was walking past the medication cart on her way to check on a resident when she heard a loud noise that sounded like a bang.
- She followed the sound to the first room on the left down the hallway from the front desk.
- She went to Resident #1's room, looked in the door, and saw Resident #1 sitting in a chair in his room.
- Resident #1 was yelling "Stop! Stop!" over and over again.
- She attempted to verbally redirect the resident; spoke in a calm manner in an attempt to find out why the resident was yelling.
- Resident #1 threw a foot stool across the floor.
- She entered the room and again asked the

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resident what was wrong.
- Resident #1 replied " Shut Up! Stop! Stop! ; Then threw an object across the room.
- The roommate commented "He has gone crazy! Someone needs to get him out of here before he hurts somebody. "
-She repeatedly attempted to ask the resident what was wrong, but only got responses in the form of "shut up" and "stop".

Continued interview on 4/10/15 at 2:15 pm with Staff C, PCA, revealed:
- She walked over to the chair where the resident was sitting and leaned over to get better face to face contact and calmly tried to redirect the resident.
- She had never seen this type of behavior from this resident before today.
- The resident, while sitting, grabbed her by the shirt (scratching her on the chest in the process), began pulling her toward him and began hitting her with his other hand (using a closed fist).
- The PCA was hit repeatedly on the shoulder, back of shoulder, and on the lower neck.
- The PCA turned slightly so the hitting was on the back and shoulder and neck area and not on the face and chest.
- The PCA tried to push off with one hand and began yelling for assistance from other staff members.
-She was not sure of how long she was in the grip of the resident.
- She stated that it was all happening so fast.
- She was able to gather themselves and pull back and break free of the resident's grip.
- She was very scared and did not realize how strong the resident was until he had grabbed and held on to her.
- An additional staff member arrived in the room and began asking the resident "what's wrong? "

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several times but the resident only responded "NO! NO!" repeatedly and "Stop! Stop!"
- Resident #1 was seated in the chair when he pulled his shirt up and started slapping himself on the stomach repeatedly.
- Both staff members began trying to back out of the room when the resident lunged at them from the seated position in the chair but settled back in the chair.
- The resident picked up a bottle of lotion and threw it across the room.
- Staff C grabbed the roommate's wheelchair in an attempt to remove him from the area when a third staff member, who had entered the room, grabbed the chair and took the roommate out of the room to safety.
- At this time Staff C was still in the room, along with two other staff members and the resident.
- Staff C stated she attempted to leave the room because her chest was burning from being scratched and she wanted to see how badly she was injured.
- The resident stood up and threw a 19 inch portable television off a dresser and onto the floor and yelled "no and stop" repeatedly.
- At that point, the resident stood and lunged at the MA, Staff B, grabbed the MA, and began hitting the MA with a closed fist.
- She could not remember how many times Staff B was hit but estimated the number between three and four times.
- Staff B managed to get free of the resident and all staff began trying to back out of the room when he lunged again, tripped, and fell to the floor.
- The resident hit his head on the front of a dresser when he fell.
- The resident attempted to push himself back up but was unable to on the first attempt.
- He began banging his head against the floor

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and on the front of the dresser repeatedly, and kicking and thrashing his legs up and down.
- Staff B directed other staff members to grab the resident's legs in an attempt to stop the resident from hurting himself, and Staff B knelt down by Resident #1's shoulder, placing her hand on the back of the resident's shoulder (trying to keep him from hurting himself).
- Staff C was turned with her back to Staff B, squatted (not sitting on) over the buttocks of the resident, trying to gain control of his thrashing legs, but was unable to do so.
- The resident was too strong and she was not able to gain control of the resident's legs to fully control them.
- The Staff B had her back to Staff C and was trying to hold the resident's shoulder to the floor and with the other hand, Staff B was trying to hold the resident's head still to prevent him from hitting his head on the floor, any more.
- Staff C denied ever sitting on the resident and denied ever putting any weight on the resident's body during this event.
- Staff C denied being able to see what Staff B was doing, and did not have a view of the resident's head or neck area.
- The Activity Director was directed Staff B to grab the loose arm.
- Staff C stopped trying to grab the resident's legs, stood up, stepped over the resident, and tried to leave the room.
-Staff C did not remember if the resident had stopped moving before she stood up of after, but did note the resident stopped moving and Staff B let the resident go and rolled the resident over.
- This was when all staff noticed Resident #1's color was not right and he appeared to be turning blue.
- Staff B immediately started CPR and was doing CPR for a brief period of time until someone (not

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identified) said "Wait he has a DNR" and she stopped.

Review of the written statements made by Staff C, PCA, to local police on 4/1/15 revealed:
- On 4/1/15 at 6:15 pm she heard a noise coming from a resident's room. (Noise was described as loud bumping noises followed by yelling.)
- She reported going to the resident's room and observing Resident #1 throwing things around the room.
- She gave verbal redirection in an attempt to redirect behavior.
- Resident #1 grabbed her and began hitting her in the back on the neck and upper back area with open and closed fists.
- Resident #1 scratched her across her chest when he grabbed her.
- She reported yelling for assistance and continuing to try to break free from Resident #1 until finally being able to pull free and back up. (Resident #1 remained sitting in the chair.)
- She continued to try to verbally redirect behavior while attempting to determine what was wrong with the resident.
- Resident #1 began throwing more objects around the room and then attacked the Medication Aide,Staff B.
- Resident #1 threw a television.
- Resident #1 then fell on the floor and started hitting his head on the dresser.

Review of a statement made to the local police department by Staff C, PCA, on 4/13/15 at 3:40 pm revealed:
- She worked on 4/1/15 at 6:15 pm performing routine duties.
- She reported assisting Resident #1 since his arrival at the facility and had observed no behaviors or other problems with the resident.

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D 271	Continued From page 14 - She heard a loud banging noise coming from the direction of Resident #1's room. - She saw Resident #1 throwing a footstool across the room. - Resident #1 was sitting in a chair in the room. - She squatted next to the chair and asked Resident #1 what was going on and why he was throwing stuff. - Resident #1 grabbed her shirt collar and yelled "Shut Up" . - Resident #1 hit her in the head a couple of times. (Some closed fist; some open fists.) - She called for night shift medication aide (MA), Staff A, to come assist. - She broke free of Resident #1's grip as Staff A was entering the room. - Resident #1 threw a lotion bottle at his roommate and almost hit him in the head. - Staff C wheeled Resident #1's roommate to the door and passed him off to the Activity Director. - Staff C observed, from the door, Resident #1 lunge at Staff B, and she told the Staff B to watch out. - Resident #1 was on the floor, lying on his stomach, kicking and swinging. - Staff B was lying across Resident #1's back in a diagonal manner with her head near the resident's head. - Staff C stated she briefly held the resident's ankles to prevent him from kicking her and then released her hold to assist another staff member in getting off the floor. - Staff C was not able to see Staff B's, left hand or arm. - Staff B's right arm and hand were near Resident #1's head and the dresser. - She thought Staff B was trying to prevent Resident #1 from banging his head into the dresser. - She overheard Staff B, ask Resident #1 "are	D 271		

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you going to be good?"
- She overheard Resident #1 say "OK".
- She heard a staff member ask Resident #1 to get up.
- She observed Resident #1's face as he was turned over and noted that it did not look right; he was turning blue. (The entire incident was from 6:13 pm to 6:30 pm)
- She ran out of the room to call 911.

Interview on 4/10/15 at 3:30 pm with the night shift MA, Staff A, revealed:
- She reported coming to work early the day of the incident with Resident #1 ,(4/01/15) as was her usual routine. (Medication Aides worked 12 hour shifts.)
- She heard the PCA, Staff C, calling for assistance from her by name.
- Upon entering the room, she found Staff C leaning over a chair in which Resident #1 was sitting.
- Staff C's shirt was pulled up over her shoulder, she was struggling to get free from Resident #1, and the resident was hitting the PCA in the back of the neck and upper shoulder area.
- Staff A stepped out of the room, yelled to another staff person down the hall for additional assistance, and entered the room.
- Resident #1 was now sitting in the chair and Staff C was backing away from the resident.
- Staff A made numerous attempts to verbally engage Resident #1 in an effort to cease the behaviors.
- The resident was sitting in the chair rocking back and forth and continually saying "stop" and "no", repeatedly.
- Staff B arrived in the room and more attempts to verbally redirect the resident were made.
- Resident #1 then stood up and pushed a television off of the dresser next to the chair (It hit

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the wall and fell to the floor) and then threw a bottle of lotion and an electric razor at the staff and the other resident in the room.
- The Activity Director removed the resident's roommate from the room.
- Staff A left the room to get more assistance from additional staff in the building.
- Upon returning to the room, she observed Resident #1 stand and start moving towards the Staff B with his arm raised.,
- She stated at one point he lunged or leaped at Staff B with both arms outstretched and landed on the floor.
- Resident #1 was sitting on the floor on his buttocks kicking his leg up and down, and then rolled over and began "flopping like a fish", kicking his legs and banging his head on the floor and the base of the dresser.
- Staff B knelt down beside him and was trying to hold him still.
- Staff B instructed Staff C, the PCA, to hold his legs still and instructed her (Staff A) to try to control his arm movement.
- Staff C was squatting over the lower half of Resident #1's body attempting to hold his legs still, and she (Staff A) was trying to hold his arm still.
- Staff B had her right arm around Resident #1's head and neck area and her right hand was on the dresser in an attempt to stop him from hitting his head on the dresser; her left arm was around Resident #1's neck and underneath Resident #1.
- Staff A left the room to retrieve the resident's Medication Administration Record (MAR) and left Staff B and Staff C in the room with the resident. (The incident happened so fast and so sudden that she was not sure if the resident was still breathing when she got up to leave the room.)
-She next heard someone say "Oh Lord what happened" and then she (Staff A) was instructed

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by administration, who had entered the building, to make copies of the resident's MAR for EMS (Emergency Medical Services) when they arrived.

Review of the written statements made by Staff A to local police on 4/01/15 revealed:
- On 4/01/15 at 6:13 pm she heard Staff C calling for her to come assist her.
- Upon entering the room, she found Resident #1 throwing objects at roommate and Staff B.
-Verbal attempts were made to divert behavior and to try to calm Resident #1 down.
-Resident #1 sat down in a chair but then pushed a television off a dresser, threw a lotion bottle, and electric razor almost hitting his roommate.
-Resident #1 attempted to get out of the chair, slipped and fell to the floor and continued to hit his head on the bottom of the dresser (in front of him).

Review of statement made to the local police department on 4/15/15 at 9:55 am by Staff A revealed:
- Staff A reported being scheduled to work 7:00 pm to 7:00 am on 4/01/15.
- She revealed she came to work early, arriving at 6:10 pm on 4/01/15.
- She walked to the nurse's desk and heard Staff C calling for her to come help.
- She observed, upon entering Resident #1's room, Staff C with her shirt pulled over her shoulder and Resident #1 had his right arm raised in the air towards Staff C.
- Staff A reported yelling down the hallway for additional assistance (Staff B).
- She observed Resident #1 sitting in a chair, rocking back and forth, yelling "No! No!"
- She observed Resident #1 knock a television off of a dresser onto the floor.
- She reported leaving the room to seek

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additional help.
- Upon returning to the room, she observed Resident #1 get out of the chair with his right armed raised, and coming towards staff members.
- She stated Resident # 1 fell to the floor, landed on his butt, and started kicking his legs and swinging his arms.
- She observed Resident #1 roll over onto his stomach and begin "flopping around like a fish" and banging his head on the bottom of the dresser.
- She observed Staff B laying across Resident #1's back in a diagonal position with her head near resident #1 ' s head.
- She reported taking over holding Resident #1's arm from another person that had a bad knee.
- She reported having to use both hands to hold resident's wrist to the floor.
- She revealed Staff B's right arm was around Resident #1's head and neck area, and her right hand was on the dresser.
- Staff B's left arm was around Resident #'1 neck, up underneath him.
- Staff A reported she out of the room, leaving Staff B and Staff C in the room with Resident #1.
-Staff A reported overhearing the Administrator saying "Oh Lord! What Happened?"
- Staff A revealed being told by the Administrator to make copies of Resident #1's MAR for EMS.
- She walked back to the room with EMS and observing Resident #1 lying on the floor and his face looked blue.
-Staff B and the Administrator were kneeling beside Resident #1.

Interview on 4/10/15 at 4:00 pm with a contract Nurse revealed:
- The Nurse was at the facility on that day (4/01/15) conducting chart reviews for the facility.

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- She heard yelling and shouting coming from one of the resident's rooms.
- She went to the room and observed Resident #1 hitting staff members, swinging his arms uncontrollably, and continually yelling stop and no.
- Resident #1 then sat down in a chair and continued to yell.
- Other staff members arrived and were verbally trying to redirect and calm Resident #1.
- Resident #1 stood up and lunged at the day shift MA, fell to the floor, and began thrashing about kicking his legs and flailing his arms.
- Resident #1 rolled over on his stomach, began kicking his legs and banging his head on the floor and the base of the dresser he was lying next to.
- The Nurse left the room to determine if the administration had been called and if 911 had been called.
- When the Nurse returned to the room Resident #1 was lying on his back and the day shift MA was doing chest compressions.

Review of the written statements made by the contract Nurse to local police on 4/01/15 revealed the following:
- She heard a loud noise and upon entering the room observed Resident #1 hitting and kicking.
- She reported Resident #1 could not be controlled.
- Resident #1 sat in a chair and started yelling, then got up and charged everybody (hitting and swinging his arms).
- Resident #1 lost his balance, fell, and began to bang his head on the bottom of a dresser.
- Resident #1 continued to kick and hit while on the floor.
- Resident #1 was turned over on his stomach; he continued to kick.
- More help (other staff) was called for to assist.

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D 271	Continued From page 20 Review of Emergency Medical Services (EMS) log records on 4/20/15 revealed the following: -EMS was called on 4/1/15 at 6:28 pm -EMS arrived on the scene at 6:30 pm. -EMS found patient unresponsive and not breathing with no pulse. -Patient was lying in the middle of the floor in the supine position with pants to his knees. -Patient was cyanotic in the face with no other trauma bleeding or other various injuries. -Law enforcement arrived at 6:50 pm. -Patient was transported to Emergency Department at 7:36 pm. Interview 4/21/15 at 2:30 pm with the Administrator revealed: - The Administrator was working at the sister facility on the same property on 4/1/15. - She received a call from Activity Director reporting a resident had become violent and was assaulting staff members at the lower facility. - She arrived at the facility to find Resident #1 lying on the floor, on his back, with day shift MA, Staff B, performing chest compressions. - She immediately asked for the resident's record and told someone to call 911, make copies of MAR for EMS, and she began assisting Staff B by checking for a pulse. - Finding no pulse in the neck or in the arm, the resident's record was checked and the DNR was noted. - She directed Staff B to cease chest compressions. - EMS arrived and pronounced the resident. Law enforcement arrived and began their investigation. - She gave instructions to her staff present during the incident to write out written accounts of what happened on 4/01/15.	D 271		

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- She stayed in the building while staff were interviewed by police.
- Her first impression was that Resident #1 got upset and over excited and had a heart attack or a respiratory event that caused him to expire.
- During her internal investigations she determined that staff may have contributed to the situation and suspended one staff member.

Review on 4/20/15 of the Administrator's written report of facility internal investigation dated 4/17/15 revealed the following:
- All staff members present during the incident were interviewed.
- Staff members reported Resident #1 became combative and hostile towards staff and was fighting staff.
- Resident #1 fell on the floor and began hitting his head on a dresser.
- Staff B was holding the resident down on his stomach trying to keep him from biting, spitting, and hitting her.
- Staff B had one hand on his shoulder and one hand on his head to keep him from hurting himself.
- When the resident calmed and staff members rolled him over, he was no longer breathing.
- Interview with the Activity Director revealed Staff B had her arm across the nape of the neck of Resident #1 during the altercation and Staff C was sitting on his buttocks while Staff A was holding his arm.

Telephone interview on 4/20/15 at 12:42 pm with a Care Manager at the previous facility for Resident #1 revealed:
- The resident lived at a group home because of his down syndrome diagnosis.
- Resident had a history of falling on his face as a result of lunging forward.

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D 271	Continued From page 22 - Sometimes he would act out without any apparent cause. - Sometimes he would have "something medical going on." - The facility would rule out any medical issues when the resident exhibited severe behaviors (Sent to hospital to check for infection). - "It was not unusual for the resident to throw a television or anything like that." - Staff tried to redirect the resident during bad behaviors. - The resident did not necessarily target his head; would beat on his chest, or try to hurt himself in a variety of ways. - Resident did have physical altercations with others that were not provoked. - The resident had a hospitalization in late January 2015 and was discharged from the hospital with an order for oxygen. - The facility was not able to keep residents requiring oxygen therapy so the resident was discharged. Telephone interview on 4/21/15 at 9:30 am with a detective from the local police department revealed: - Preliminary investigation was done on 4/01/15 including interviews and written statements. - After receiving the report from the State Medical Examiner's office, he conducted additional interviews and obtained additional written statements. - Staff were interviewed again on 4/13/15 and 4/14/15 and rough diagrams were created. - The officer determined that a staff member used her arm to contain a resident to protect staff and other residents. - An interview with the resident's roommate revealed the resident was "cutting up" and putting his hands on staff.	D 271		

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D 271	Continued From page 23 - An official report had not been received from the State Medical Examiner. Telephone interview on 4/20/15 at 9:35 am with the State Medical Examiner revealed: - An autopsy had been performed on a resident from the facility. - The primary cause of death was asphyxiation. - Results showed abrasions on the left side of the neck and hemorrhaging in the neck muscle and bulk of pressure was on the left side. - No official autopsy report had been generated because results for toxicology and microscopic slides were still being processed. Review of staffing records on 4/20/15 and 4/21/15 for four staff including, including Staff B, revealed a staff training on "Managing Aggressive or Combative Behaviors" conducted on 8/17/14. The facility provided a Plan of Protection on 4/20/15 as follows: - Immediately residents will be assesed for care and services according to the care plans and current needs. - Additional care will be provided for any identified resident requiring additional needs or assistance. - Staff will be inserviced on being aware and recognizing increased needs and notifying the Resident Care Coordinator or Administrator upon recognition. The facility provided an additional Plan of Protection on 4/21/15 as follows: - Immediately inserviced staff on residents' rights. - Resident rights training will be scheduled with the Ombudsman as soon as possible for staff and residents. - The Administrator will be responsible to facilitate inservices.	D 271		

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D 271	Continued From page 24 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 20, 2015.	D 271		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to report to the North Carolina Health Care Personnel Registry (HCPR) an allegation of abuse by staff resulting in death of a resident (Resident#1). The findings are: Review of Staff B's record revealed: - She worked as a nursing assistant/medication aide(MA). - She was hired on 07/14/14. - She passed her MA test on 02/28/08 and was completed her medication skills checklist on 07/16/14. - She had current Cardiopulmonary Resuscitation training. Review of Resident #1's current FL2 dated 03/10/15 revealed: - Diagnoses included chronic Hepatitis C, Down	D 438		

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Syndrome with severe mental retardation, constipation, hypothyroidism, history of collapsed lung, reactive airway and wheezing, mild elevated liver function test, and health care associated pneumonia.
- The resident was disoriented constantly.

Review of Resident #1's Resident Registry revealed a facility admission date of 03/05/15.

Review of Resident #1's current care plan dated 03/24/15 revealed:
- Documentation included "exhibits poor judgement requires constant redirection" and "resident observed interactive with some resident positively, but he was easily angered and difficult to calm down, but at times appears to be adjusting well".

Review of Resident #1's record revealed a current Do Not Resuscitate order dated 02/11/15.

Review of Report of Death to DHHS form dated 04/02/15 revealed:
- Documentation included "Resident became violent with his roommate, started throwing items, e.g. TV, lamp objects on nite stand and around room. Staff came in to see what was going on. He became physically violent with staff members trying to calm him down. Resident fighting and fell to floor".

Review of the Emergency Medical Services (EMS) report dated 04/01/15 revealed:
- Documentation included "arrived to find male patient unresponsive and not breathing, and "with no pulse".
- "Patient was cyanotic in the face with no other trauma bleeding other obvious injuries noted".

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D 438	Continued From page 26 Interview on 04/20/15 at 12:40 pm with a representative from the HCPR revealed the HCPR received notification of the incident on 04/17/15. Interview on 04/21/15 at 2:30 pm with the Administrator revealed: - She was aware that HCPR should be notified within 24 hours. - She was not aware, during the initial days following the incident, that anything wrong could have possibly happened, so there was no reason to report anyone to the HCPR. - She completed both the 24 hour report and the 5 day report on 04/16/15, both of which included the name of the staff. - She was responsible for submitting reports to the HCPR. On 04/21/15, the facility Administrator submitted a Plan of Protection which included: - The Administrator will review the rules and requirements regarding notification of the HCPR for appropriateness for reporting incidents, occurrences or accusation. - The Medication Aides and the supervisor will be inserviced on proper reporting to the HCPR and to the Administrator. - An inservice on HCPR reporting will be scheduled. - The Administrator will monitor for compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, June 5, 2015.	D 438		
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:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053027	A. BUILDING: _____ B. WING _____	C 04/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 27 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure all residents receive care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to personal and supervision and contacting the Health Care Personnel Registry. The findings are: A. Based on interviews and record reviews, the facility failed to ensure policy and procedures were implemented for 1 of 1 resident (Resident #1) as evidenced by staff interventions for the resident's aggressive behaviors. [Refer to Tag D 0271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation).] B. Based on interviews and record reviews, the facility failed to report to the North Carolina Health Care Personnel Registry (HCPR) an allegation of abuse by staff resulting in death of a resident (Resident#1). [Refer to Tag D 0438, 10A NCAC 13F .1205 Health Care Personnell Registry (Type B Violation).]	D912		