| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL029010 | A. BUILDING: _____ B. WING _____ | R-C 05/07/2015 |

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| D 000 | Initial Comments<br><br>The Adult Licensure Section conducted a follow-up survey and complaint investigation on 5/6/15 and 5/7/15. | D 000 | | |
| D 227 | 10A NCAC 13F .0702 (c) Discharge Of Residents<br><br>10A NCAC 13F .0702 Discharge Of Residents<br><br>(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:<br>(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or<br>(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure that notices of discharge and appeal rights were made for 1 of 2 sampled residents (Resident #2).<br><br>The findings are:<br><br>A. Review of Resident #2's current FL2 dated 4/08/15 revealed:<br>- Diagnoses included MR (Mental Retardation), reflux, neurotic, hypothyroid, psychosis, explosive, HTN (hypertension), CHF (Congestive Heart Failure)<br>- Date of admission was documented as 9/16/13.<br>-Level of care was documented as Domiciliary/Rest Home.<br>- Diet was pureed with honey thick liquids. | D 227 | | |

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| D 227 | Continued From page 1<br><br>Review of the Resident Register for Resident #2 revealed:<br>- Resident #2 had a Guardian.<br>- The Discharge/Transfer section of the Resident Register was incomplete.<br>- Notice of Discharge/Transfer date was not completed.<br>- "Initiated By" was documented as Administrator was and "Reason(s)" was left blank.<br>- The date of Discharge/Transfer was documented for 4/20/15; the section for "To" was documented for "went to hospital 4/16/15".<br>- No documentation of new facility address.<br>- No documentation that a copy of the notice was given to an identified person.<br>- The Discharge/Transfer section was not signed by Resident or Resident's Responsible Person.<br>- The Discharge/Transfer section was signed by the Facility Manager on 4/20/15.<br><br>Review of Resident #2's "Home Policies and Residents Rights" agreement signed on 9/16/13 by Resident #2's appointed Guardian revealed:<br>- "With the exception of an emergency, the Home shall give the family or social worker making placement a 30 day notice of intent to transfer or discharge a resident."<br>- "Abusive behavior (hitting, punching, slapping, cussing; residents or staff, throwing items or causing damage to any property or structure outside or within (facility name) will be cause for immediate discharge since it endangers the well-being of other residents. Immediate discharge will place the resident in and[sp] Alternate facility (most likely Statesville location) for temporary placement until permanent arrangements can be secured. Cost of Repairs will be billed to the resident".<br><br>Review of Resident #2's record revealed: | D 227 | | |

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| D 227 | Continued From page 2<br>-No documentation of notice of discharge and appeals rights were issued to Resident #2 prior to or after discharge from the facility on 4/20/15.<br><br>A notice of discharge and appeals rights was requested during survey from facility staff, but was not provided.<br><br>Review of Resident #2's Resident Care Notes from 4/01/15 to 4/15/15 revealed the following examples:<br>- On 4/01, Resident #2 did not sleep at all, pacing halls and going into residents' rooms.<br>- On 4/03, Very bad day for Resident #2. New nurse gave her bandaid, she tore it off and then ripped off her pinky fingernail at lunch.<br>- On 4/06, Resident #2 got mad at her roommate today and started hitting her head against the wall; screamed and cried all day.<br>- On 4/09, Resident did not sleep all night, had been upset all day and would not eat or sit down. Facility Nurse Practitioner (NP) and mental health provider were called. Added sleep medication.<br>- On 4/14, Starting at 5:30 am Resident #2 was crying loudly, throwing magazines, went into the medication room and disturbed the Medication Aide, started banging her head on the columns in the front lobby when announcements started, and continued to scream and cry throughout the day.<br>- On 4/15, Resident #2 was sitting down and getting right back up, disturbed the hair dresser, and stood outside the hair dresser door, which had to be locked while residents were in the shop, yelling and banging on the door.<br><br>Review of Resident #2's "Report of Health Services to Residents" dated 2/10/15 and 2/11/15 revealed:<br>- The resident was seen by a mental health provider and was to be tapered off psychiatric | D 227 | | |

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medications (Risperdal Consta Injection 50 mg, Zoloft 100 mg) and started on Remeron 7.5 mg (antidepressant) at bedtime.
- Resident #2 was referred to a second mental health provider.

Review Resident #2's record revealed the facility Nurse Practitioner (NP) encounter notes dated 2/12/15 documented the following:
- Resident's orientation is confused.
- "Staff report that patient has struck a couple of the workers and pulls off her fingernails and toenails".
- The NP ordered Depakote 500 mg at bedtime (used to treat mental disorders).

Review of Resident #2's documentation for a visit to third mental health provider dated 3/30/15 revealed:
- Resident #2's behaviors were described as pinching self, sobbing, picking nails and uncontrollable.
- Medications for mental disorders (Zoloft 100 mg, Risperidol 2 mg and Remeron 7.5 mg) were ordered.

Review of the facility NP encounter notes dated 4/15/15 revealed:
- "Resident presents with anxiety state, unspecified".
- "Resident is noted pacing the halls and crying".
- "Staff report she has been like this all night".
- "Staff is looking into having patient admitted to an inpatient unit".
- No order to discharge Resident #2 or documentation for change of level of care.

Interview on 5/6/15 at 10:45 am with the Facility Manager revealed;
- Resident #2 was sent to a local hospital on

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| D 227 | Continued From page 4<br><br>4/16/15 for a psychiatric admission for medication management. (Involuntary commitment initially but Guardian signed commitment paper).<br>- Resident #2 started "acting out" (exhibiting behaviors like not sleeping, walking in residents' rooms, reaching out and touching other residents) in December 2014 and January 2015.<br>- Resident #2 was unable to communicate verbally with residents or staff.<br>- Resident #2's Guardian signed hospital "Request for Voluntary Admission to the Behavioral Unit" on 4/17/15. (A copy was provided.)<br>- No Discharge Notice was given because she was harming herself and others. She was sent to the behavior unit of a local hospital.<br>- The Guardian was made aware the resident was not coming back to the facility by the Facility Manager and the Guardian had talked with the Administrator.<br><br>Interview on 5/6/15 at 11:30 am with the facility Nurse Practitioner (NP) revealed:<br>- The NP had agreed with a referral to a mental health provider in February 2015.<br>- She managed Resident #2's medical conditions and medications.<br>- She was not routinely managing Resident #2's psychological medications since February 2015.<br>- She did prescribe some medications for behaviors during the period from February 2015 to March 2015 when Resident #2 was unable to see a mental health provider.<br>- Resident #2 was appropriate for skilled nursing based on her swallowing difficulty with risk for aspiration pneumonia.<br>- She had not been contacted by the local hospital prior to 5/05/15 when the hospital was trying to discharge Resident #2, nor did she contact the hospital. | D 227 | | |

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| D 227 | Continued From page 5<br>- She had spoken to the Guardian and a skilled nursing facility on 5/05/15 for possible placement.<br>- Resident #2 was non-compliant with thickened liquids and pureed diet (She drank water from the water fountain and consumed food and snacks in her room.)<br><br>Telephone interview on 5/06/15 at 12:00 pm with the patient placement representative for the local hospital revealed:<br>- Resident #2 was ready for release from the hospital (Geriatric Behavior Unit).<br>- Resident #2's medications had been adjusted and behaviors were stable.<br>- Resident #2 was not exhibiting dangerous behaviors.<br>- The hospital FL2 being used for discharge listed the resident to be discharged to an assisted living facility.<br>- Notes from the hospital Social Worker documented Resident #2's Guardian was informed on 4/22/15 by the Administrator that Resident #2 was close to needing a feeding tube and would not be admitted back to the facility because the facility could not meet the resident's needs.<br>- The Social Workers notes documented the Guardian had not received a Notice of Discharge or appeal rights from the facility as of 4/29/15.<br><br>Telephone interview on 5/06/15 at 2:20 pm with Resident #2's Guardian revealed:<br>- Resident #2 was not able to commincate verbally.<br>- Resident #2 liked to hold hands, lay her head on your shoulder, and give people a hug.<br>- He was aware Resident #2 had recently been referred to a mental health provider because he had taken her to the appointment.<br>- The first mental health provider took her off all | D 227 | | |

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her medications in February 2015 in order to get a baseline for treatment.
- Subsequently there was a problem with the provider not being to take her as a patient and she was referred to a second mental health provider.
- This took about 6 weeks to get her back on her medications. (He and the facility tried to get her an earlier appointment but were unsuccessful.)
- The facility called him on 4/15/15 to advise him the facility was sending Resident #2 to the Behavior Health Unit of a local hospital the next day, 4/16/15, due to inappropriate behaviors.
- He was fine with the facility sending Resident #2 to the hospital to help regulate her medications.
- He was told on 4/16/15 by the Facility Manager Resident #2 would be coming back to the facility.
- The Facility Manager called him on Tuesday, 4/21/15, to inform him Resident #2 would not be readmitted to the facility.
- The facility had not contacted him regarding Resident #2's belongings.
- He had not spoken to a facility staff person in over a week.
- The facility had not sent him any paper work regarding a Notice of Discharge for Resident #2.
- He had not received a 30 day Notice of Discharge with the Adult Care Home Hearing Request Form or any other paper work.

Interview on 5/6/15 at 3:30 pm with a Personal Care Aide revealed:
- She had not seen Resident #2 harm any other resident.
- Resident #2 did like to put her head on your shoulder.
- Resident #2 had exhibited more restless behaviors since her medications were stopped in February 2015, but she had not observed Resident #2 being aggressive toward staff or

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residents.

Interview on 5/06/15 at 3:40 pm with Resident #2's roommate revealed:
- Resident #2 would sit in the bathroom and cry.
- Resident #2 kept her up some nights by stirring around in the room.
- The resident was more anxious and cried all the time after her medications were stopped.
- Resident #2 was not aggressive toward her.
- She was acting more anxious before her medications were changed in February.

Interview on 5/06/15 at 4:10 pm with 2 residents in a room around the corner from Resident #2 revealed:
- Resident #2 came to their room occasionally.
- Resident #2 liked to look at the dolls in the room.
- Resident #2 would scratch herself sometimes to get a bandaide.
- Resident #2 did yell a lot, cry a lot, and put her head on your shoulder and lean up against you.
- Resident #2 would walk into anybodies room but she was not aggressive.

Telephone interview on 5/6/15 at 4:28 pm with the hospital Social Worker reaveled:
- Resident #2 was very tearful, with no understanding why she was in the hospital.
- Resident #2 was hard to verify what she did or did not understand.
- Resident #2 was assessed as qualifying for assisted living level of care.
- The resident has a risk of aspiration but does not require nursing care.
- She stated she was not seeing any documentation in the hospital notes for being "at risk for harm to herself or others".
- She was made aware on 4/22/15 that the facilty

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| D 227 | Continued From page 8<br>was not taking Resident #2 back to the facility.<br><br>Telephone interview on 5/7/15 at 11:30 am with the Corporate Administrator revealed:<br>- Resident #2 was not on the census anymore.<br>- The Administrator decided on 4/17/15, after the resident did not sleep all night at the hospital, the facility would discharge Resident #2.<br>- Routinely the hospital calls the facility for follow-up after a resident had been admitted for behaviors and the hospital was informed the facility would not be taking the resident back (exact date not given).<br>- Resident #2 had lost weight, and was a danger to other residents.<br>- The facility did an Immediate Discharge per the facility policy.<br>- The facility had not issued a Notice of Discharge with the Adult Care Home Hearing Request Form.<br>- She did not feel the facility had to do a Notice of Discharge if the resident was a danger to other residents. | D 227 | | |