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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 7/21/15-7/23/15.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 1 of 3 staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired as a Personal Care Aide (PCA) on 04/07/15. -Her responsibilities included assisting residents with activities of daily living (ADLs) and providing personal care and supervision. -There was no documentation of a HCPR check. Interview on 07/22/15 at 11:15 am with the Administrator revealed: -A HCPR check was not performed on Staff A because she was not administering medications to the residents. -She was not aware all employees working within the facility were required to have a HCPR check	D 137		

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D 137	Continued From page 1 prior to hire. -The Business Office Coordinator was responsible for checking the HCPR on new hires. -She was responsible for making sure the HCPR checks were completed on new hires. Interview on 07/22/15 at 11:20 am with Business Office Coordinator revealed: -She did not complete a HCPR check on Staff A because she was hired as a PCA and would not be giving medications to the residents. -She was not aware all employees working within the facility were required to have a HCPR check prior to hire. -She was responsible for checking the HCPR on new hires and reported the information to the Administrator. -She was responsible for staff file audits. -She checked the HCPR for Staff A during survey and no substaintiated findings were noted on 07/22/15. Interview on 07/22/15 at 12:00 pm with Staff A revealed: -She was not aware of the HCPR requirement prior to employment. -Her daily responsibilities included assisting with ADLs and personal care for the residents.	D 137		
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.	D 270		

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D 270	Continued From page 2 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in regard to aggressive behaviors, inappropriate sexual behaviors, and other residents' fear of one resident's behaviors (Resident #4). The findings are: Review of Resident #4's current FL2 dated 6/16/15 revealed: -Admitted to the facility on 6/24/15. -Diagnoses included mental impairment, hypertension, and anxiety. -Documented recommended level of care was assisted living. -A physican order for Ativan 0.5mg (a medication used to treat anxiety) two times daily at 8:00 am and 5:00 pm. Review on 7/21/15 of Resident #4's progress notes revealed: -Documented on 6/24/15 at 2:00 pm Resident #4 was agitated, banged on the dining room table. -Documented on 6/27/15 at 2:00 pm and 10:00 pm Resident #4 beat on table during the whole lunch meal and banged on the bird cage after supper. -Documented on 6/30/15 at 1:00 pm Resident #4 used inappropriate language in front of other residents as well as the Activity Director. -Documented on 6/30/15 at 1:00 pm the Activity Director had ask Resident #4 to calm down and to not "speak like that". -Documented on 6/30/15 at 1:00 pm the Adminstrator and the Resident Care Coordinator (RCC) were notified of Resident #4's	D 270		

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inappropriate language.
-Documented on 7/14/15 at 1:00 pm Resident #4 become upset and yelled profanity at staff during his medication time which upset several residents.
-Documented on 7/14/15 at 1:00 pm Resident was redirected and escorted into the dining room.
-Documented on 7/14/15 at 1:00 pm Resident #4 continued to bang on the table at lunch as well as on his glass with his eating utensils.
-Documented on 7/15/15 at 4:40 pm Resident #4 was witnessed touching a female resident inappropriately.
-Documented on 7/15/15 at 4:40 pm Resident #4 had been spoken to by the Administrator and the Health and Wellness Nurse (HWN) on his inappropriate behavior.
-Documented on 7/15/15 the physican was notified Resident #4 inappropriately touched a female resident.
-Documented on 7/16/15 at 10:00 am Resident #4 continued to follow behind the female resident he touched inappropriately on 7/15/15.
-Documented on 7/17/15 at 10:30 am the physican office was contacted in regard to the Resident #4's behaviors.
-Documented on 7/20/15 at 2:00 pm Resident #4 was found in the lobby with the female resident he had touched inappropriately on 7/15/15, he was redirected by the staff back to his room.
-No documentation of Resident #4 actions during the encounter with the female resident on 7/20/15.

Attempt on 7/21/15 at 11:30 am to interview Resident #4 revealed he declined to be interviewed.

Observation on 7/21/15 at 11:30 am of Resident #4 revealed he appeared irritated, upset, stared

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D 270	Continued From page 4 at the surveyor and shook his head. Review on 7/22/15 of the facility incident report dated 7/15/15 for Resident #4 revealed: -An incident report was completed on 7/15/15 at 3:00 pm. -Documented Resident #4 was witnessed by the Business Office Manager (BOM) touching a female resident on her leg and chest, then kissed her on her lips. -Documented Resident #4 was spoken to about the inappropriate behavior by the BOM and his family was called on 7/15/15. -Documented the Administrator and the nurse were notified by the BOM on 7/15/15. -Documented the psychiatrist was notified of Resident #4's inappropriate behavior by the BOM on 7/15/15. Further review on 7/22/15 of Resident #4's record revealed: -A psychiatric consult completed on 7/21/15 by the facility contract psychiatrist. -Documented Resident #4 was disorganized and irritable and did not recall inappropriately touching the female resident on 7/15/15. -An order for medications of Seroquel 25 mg (a anti-psychotic used to treat acute manic episodes) nightly and Depakote 250 mg (used to treat mood disorders) two times daily. -An order for laboratory studies of ammonia level (help to determine the cause of changed behaviors) and a urinalysis. -New diagnosis included severe dementia with behavior. -Mental exam included documentation Resident #4 appearance disheveled, guarded, and hostile. -Behaviors were documented as cooperative. -Orientation was documented as to person and place only.	D 270		

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D 270	Continued From page 5 -Mood was documented as manic, irritable. Interview on 7/22/15 at 10:40 am with a Medication Aide (MA) revealed: -She was aware Resident #4's had inappropriate sexual behaviors toward a female resident on 7/15/15 in the common area at the facility. -Residents in the facility had told her they were concerned and very scared of Resident #4. -The facility Resident Care Coordinator (RCC) conducted daily stand-up meetings with the staff to discuss issues in the facility, Resident #4's behaviors were discussed as well as to monitor him closely. -1 on 1 care was initated for Resident #4 on 7/17/15 after he touched a female resident inappropriately. -She described 1 on 1 care for Resident #4 as follows " just keeping your eyes on him, so we know where he is all the time". -Resident #4 was loud and had "a smart mouth". -She was not scared of Resident #4 nor was she aware of any staff who was scared of him. Interview on 7/22/15 at 11:00 am with the female resident involved in the inappropriate sexual behavior incident that occurred on 7/15/15 revealed: -She was aware of a man in the facility who was nice to her. -She had spoken to him several time and he was interesting to talk to. -She could not recall his name nor what color hair he had. -He had never touched her inappropriately. -She could not recall the date, year, or month, nor the place she resided. Review on 7/22/15 of the female resident involved in the inappropriate sexual behavior	D 270		

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incident that had occurred on 7/15/15 current FL2 dated 4/7/15 revealed diagnoses that included dementia and depression.

Telephone call on 7/22/15 at 10:30 am with Resident #4's family was unsuccessful.

Interview on 7/23/15 at 8:40 am with a Personal Care Aide (PCA) revealed:
-She was aware Resident #4 had inappropriately touched a female resident.
-Resident #4 was to be monitored at all times, "Keep an eye on him".
-The facility had increased staffing on night shift on 7/17/15 to watch Resident #4 more closely.
-She was aware of two female residents that were afraid of Resident #4.
-She was aware one of the female residents' stayed in her room more often in the past month.
-She had spoken to the Business Office Manager (BOM) and the nurse last week about one female residents' concerns of Resident #4.
-She denied being scared of Resident #4.

Observation on 7/23/15 at 9:00 am of Resident #4 revealed he was dressed and laid across his bed sleeping.

Interview on 7/23/15 at 9:30 am with one resident revealed:
-She was fearful of Resident #4.
-Resident #4 told her he would come to her room at night to see her.
-She told him she had a gun and would shoot him in the leg.
-She was aware of other female residents who were scared of him.
-She had heard the staff escorted one female resident to her room because she was scared of Resident #4.

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D 270	Continued From page 7 Interview on 7/23/15 at 10:10 am with a second resident revealed: -She was hard of hearing. -She kept her door locked at all times. -She did not feel safe with Resident #4 in the facility. -Resident #4 lived directly across the hall from her room. -Resident #4 had made an inappropriate comment several weeks ago. -Resident #4 told her he would like to visit her at midnight in her room. -She was afraid to go out of her room when Resident #4 was in the hallway. -Resident #4 placed candy wrappers on her door and turned the wreath around that hung on her door. -She told family and friends in the facility about concerns for her safety. -Staff walked her back to her room when Resident #4 was in the hallway or they would watch from the nurses station until she had gotten to her room. -She had not spoken to the Adminstrator with her safety concerns until about 2 weeks ago. Interview on 7/23/15 at 10:30 am with a third resident revealed: -She was scared around Resident #4. -Resident #4 was rude and touched a female resident, "He played with her leg". -Another female resident was scared of him and did not come out of her room very much. -I have walked her back to her room because she was scared of Resident #4, he lived across the hall from her. -She had not told staff she was scared of Resident #4.	D 270		

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Interview on 7/22/15 at 11:05 am with the Resident Care Coordinator (RCC) revealed:
-She recalled the incident on 7/15/15 when Resident #4 had touched the female resident inappropriately.
-She separated Resident #4 and the female resident, and called the families of both residents.
-They had initated 1 on 1 care for Resident #4 on 7/17/15 which included documentation that 30 minute checks had been completed.
-The facility increased staff on night shift between 10:00 pm to 6:00 am to monitor Resident #4, it was the primary assignment that staff person had during that time.
-During the day it was everyone's responsibility to watch Resident #4 which included housekeeping, nursing, management, dietary aides, MA's and PCA's.
-She was made aware of a female resident who was scared of Resident #4 about 2 weeks ago.
-The Business Office Manger (BOM) had showed/ offered to move the female resident to another room away from Resident #4.

Interview on 7/22/15 at 5:00 pm with a second PCA revealed:
-She worked the 10 pm to 6:00 am shift at the facility on 7/21/15 and was scheduled to work the shift on 7/22/15 also.
-She and Resident #4 had worked puzzles and watched television on 7/21/15 in the common area.
-The increased supervision and additional staff person started on 7/17/15.
-She documented 30 minutes checks on Resident 4's observation record.

Review of Resident #4's 30 minute check/ observation record revealed:
-The 30 minute checks were initated on 7/17/15

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at 3:00 pm.
-Documented 258 opportunities for 30 minutes checks from 7/17/15 at 3:00 pm to 7/22/15 at 4:00 pm, 30 minute checks were not completed for 16 times during monitoring of Resident #4.
-On 7/20/15 incomplete documentation of 30 minutes checks at 4:00 pm through 9:30 pm.
-On 7/21/15 incomplete documentation of 30 minute checks at 12:00 pm through 1:30 pm.

Interview on 7/22/15 at 2:30 pm with the Business Office Manager (BOM)revealed:
-She was aware Resident #4 was to be monitored due to he had inappropriately touched a female resident.
-The staff were to know where Resident #4 was at all times.
-She was made aware of a female resident who was fearful of Resident #4 two weeks ago.
-She offered to move the female resident to another room away from Resident #4.
-She had not spoken to the family of the female resident nor had the family spoken to her about concerns for safety.

Inteview on 7/22/15 at 2:45 pm with the Administrator revealed:
-The nurse assessed Resident #4 before his admission to the facility.
-She was aware Resident #4 had touched a female resident inappropriately on 7/15/15 at this facility.
-She had spoken to Resident #4's family and was informed this was a new behavior for Resident #4.
-She was aware staff watched him closely and extra staff was provided at night to sit with Resident #4.
-She was aware last week of a female resident who had concerns Resident #4 had placed candy

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D 270	Continued From page 10 wrappers on her door and turned the wreath around. -She reinforced to the female resident the staff watched Resident #4 and assured the female resident she was safe. -She had not notified the family of the female resident, nor had the family contacted her with any safety concerns. -She was aware Resident #4 had seen the psychiatrist on 7/21/15 and a new diagnosis of dementia and 2 new medications for mood/behaviors were initated. -The first time the psychiatrist saw Resident #4 was on admission for his of diagnosis anxiety. -They would re-evaluate Resident #4 in 2 weeks the effectiveness the new medications to determine if he was appropriate for the current assisted living facility or not. _____ The facility provided a Plan of Protection on 7/23/15 which included the following: -Immediate staff will provide 24 hour care, 1 on 1 supervision for 14 days or longer if indicated to Resident #4. -Psychiatrist evaluation for Resident #4 has been completed as of 7/21/15 and new meds and labs will be evaluated. -After 14 days of medications Resident #4 will be re-evaluated for further indication. -Arrange care plan meetings with families to voice concerns, reassurance, and offer to meet needs for security. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 8, 2015.	D 270		

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure referral for 1 of 6 sampled residents with a Podiatrist for nail care (Resident #2) and a follow-up for 1 of 5 sampled residents with elevated blood pressures outside the ordered parameters (Resident #3). The findings are: A. Review of Resident #2's current FL2 dated 05/27/15 revealed: -Diagnoses included prostate cancer, cirrhosis, dehydration, hyperkalemia, chronic kidney disease, and congestive heart failure. -Resident #2 was semi-ambulatory and needed assistance with bathing. Review of Resident #2's record revealed: -Resident #2 was admitted to the facility on 05/28/14. -No consent for or physician's order for podiatrist care. -No documentation of nail care provided by facility staff or Hospice. Observation on 07/21/15 at 10:50 am revealed: -Resident #2 sitting on the side of the bed without socks or shoes on his feet. -Resident #2's toenails on both feet were	D 273		

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thickened.
-The resident's toenails on the right foot were observed as follows: The first toenail was 1/4 inch thick with light brown discoloration and extended 1/2 inch over the end of the toe; the second toenail was curved 1/4 inch over the end of the toe and flush with the skin; the third toenail curved over the top of the toe with 1/2 inch flush with skin underneath the toe; the fourth and fifth toenails extended 1/4 inch over the top of the toe.
-The resident's toenails on the left foot were observed as follows: The first toenail was 1/2 inch thick, grew to the left of the toe instead of straight, and extended over the top and side of the toe 1/2 inch and had rough edges; the second, third, fourth, and fifth toenails extended 1/4 inch over the top of the toes.
-No redness or skin irritation was noted on the toes.

Interview on 07/21/15 at 10:55 am with Resident #2 revealed:
-He knew his toenails were long.
-"A man comes here to cut people's toenails."
-He was not a diabetic.
-He had "asked a man to cut them before, but he didn't."
-He "turns staff down sometimes" for nail care because he didn't want his toenails cut at the time.

Further interview on 07/22/15 at 8:40 am with Resident #2 revealed:
-He did not know the last time his nails were cut.
-He did want his nails cut.

Interview on 07/22/15 at 10:30 am with the Resident Care Coordinator (RCC) revealed:
-She had recently been hired as the RCC.
-The facility had a podiatrist come to the facility

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every three months.
-The podiatrist was scheduled to return in September.
-Some residents went to a podiatrist outside of the facility.
-The facility could schedule a visit to a podiatrist in the event that a resident needed nail care prior to when the podiatrist was scheduled to come to the facility.
-Nursing, including the RCC and Personal Care Aides (PCA) were responsible for identifying residents that needed nail care.
-The RCC and the PCA's "make a list of the residents that need to be seen".
-The RCC faxes the list of residents to be seen to the podiatrist's office prior to his visit.
-The facility did not have a current list of residents that received podiatry care, but "diabetics are seen every three months."
-The facility did not have a current list that identified residents who went to a podiatrist outside of the facility and ones that were to be seen by the podiatrist that came to the facility.
-She did not know if Resident #2 had been seen by the podiatrist.
-She was not aware of Resident #2's nails needing to be trimmed.

Observation on 07/22/15 at 10:55 am in Resident #2's room revealed:
-RCC assessed Resident #2's nails and stated "We will get an appointment to take him to a podiatrist because they need to be trimmed before the podiatrist returns in September."
-Resident #2 told the RCC his toes hurt "when you mash it."
-Resident #2 agreed to have a podiatrist provide nail care.

Interview with a Personal Care Aide (PCA) on

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D 273	Continued From page 14 07/22/15 at 11:20 am revealed: -She was assigned to provide care to Resident #2. -Her responsibility was to inform the Medication Aide (MA) or RCC if a resident needed nail care. -She had reported to a previous RCC "several months ago" that Resident #2 needed nail care. -She thought a podiatrist would need to trim his nails because of how thick they were. -She had also informed a MA several months ago, but she could not recall which MA. -She had observed Resident #2 refuse nail care in the past when it was mentioned to him by staff. Telephone interview on 07/22/15 at 2:15 pm with the Podiatrist office staff revealed: -They had no record of being requested to provide podiatry care for Resident #2. -Resident #2 had not been provided care by the Podiatrist that visited the facility quarterly. Interview on 07/23/15 at 9:35 am with a Hospice Nurse revealed: -Resident #2 had been admitted to Hospice in March 2015. -"The facility is responsible for nail care." -She had visited Resident #2 on 07/21/15, but had not noted the need for nail care. -She would be doing a "full assessment" on 07/23/15. -She did not know if any other Hospice staff had requested the facility to obtain nail care for Resident #2. Interview on 07/23/15 at 9:50 am with the Health and Wellness Director revealed: -She had been employed at the facility for one week. -It was the responsibility of the Health and Wellness Director to schedule Podiatry	D 273		

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appointments for residents.
-She was not aware that Resident #2 needed toenail care to be provided.
-She would follow-up with the RCC and ensure arrangements were made for nail care.

The Administrator was not available for interview.

B. Review of Resident #3's current FL2 dated 5/7/15 revealed:
-Diagnosis included Hypertension, Mitral and Aortic Stenosis.
-A physician's order for Coreg 3.125 mg (used to treat hypertension) twice daily.

-Review of Resident #3's record revealed:
-A physician's order dated 6/4/15 for daily blood pressure (BP) checks with parameters to recheck BP in 2 hours if systolic is greater than 160.

Review of Resident #3's Vital Signs and Weight Record for May 2015 revealed:
-BP checks were documented daily from 5/1/15 to 5/31/15 with the BP ranged between 134/82 to 173/82.
-Two of 4 BP rechecks were not done on the following dates:
-On 5/14/15, BP was 164/83 and no documentation of a BP recheck in 2 hours.
-On 5/24/15, BP was 173/82 and no documentation of a BP recheck in 2 hours.

Review of Resident #3's Vital Signs and Weight Record for June 2015 revealed:
-BP checks were documented daily from 6/1/15 to 6/30/15 with the BP ranged between 134/75 to 195/63.
-One of 5 BP rechecks were not done on the following dates:
-On 6/8/15, BP was 167/67 and no

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documentation of a BP recheck in 2 hours.

Review of Resident #3's July 2015 Vital Signs and Weight Record on 7/21/15 revealed:
-BP checks were documented daily from 7/1/15 to 7/21/15 with the BP ranged between 118/68 to 181/76.
-Five of 5 BP rechecks were not done on the following dates:
-On 7/9/15, BP was 163/74 and no documentation of a BP recheck in 2 hours.
-On 7/14/15, BP was 181/76 and no documentation of a BP recheck in 2 hours.
-On 7/18/15, BP was 170/72 and no documentation of a BP recheck in 2 hours.
-On 7/19/15, BP was 172/75 and no documentation of a BP recheck in 2 hours.
-On 7/20/15, BP was 169/80 and no documentation of a BP recheck in 2 hours
-There were 2 days where there was no documentation of a daily BP check, on 7/5/15 and 7/17/15. It could not be determined if a BP recheck should have been done or not on these dates.

Review of Resident #3's July 2015 Vital Signs and Weight Record on 7/22/15 revealed:
-On 7/9/15, BP 163/74 and documentation of a BP recheck result of 150/72. The documentation was initialed by a medication aide (MA).
-On 7/14/15, BP 181/76 and documentation of a " fall called EMS rechecked at 11am" BP recheck result of 139/72. The documentation was initialed by a MA.
-On 7/20/15, BP 169/80 and documentation of a BP recheck result of 149/76. The documentation was initialed by a MA.
-The additional documentation noted on the Vital Signs and Weight Record on 7/22/15 was not documented on the Vital Signs and Weight

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D 273	Continued From page 17 Record when reviewed on 7/21/15. Interview with a MA on 7/22/2015 at 9:05am revealed: -She had added the missing BP rechecks today (7/22/15) on the Vital Signs and Weight Record for the days that she had worked during the month of July 2015. -She had gotten the missing information "from my notes. I forgot to document the missing BP rechecks until today". Review of her work notes included Resident #3's name and BP recheck results for 7/9/15, 7/14/15, and 7/20/15. -"I went back today and filled in the sheet." Interview with another MA on 7/21/15 at 12:00pm revealed that she had not worked on any of the days the BP rechecks were not done. Interview with Resident #3 on 7/22/15 at 2:00 pm revealed: -"They check my BP every morning. It is never frightening high, but they recheck it if it is a little high". -"I get dizzy when it is low, but not high". -She did take blood pressure medications. Interview with Resident #3's primary physician at 7/23/15 at 9:30am revealed: -She was not aware BP rechecks are not being done as ordered between May to July 2015. -The facility had made her aware of the BP and fall on 7/14/15. She did not feel the resident's BP was related to the fall. -Facility staff should be conducting BP checks and rechecks as ordered. -She was not aware the BP ranges were "that high" between May to July 2015.	D 273		

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D 273	Continued From page 18 -Her office staff would contact the facility staff to make an appointment for Resident #3.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 3 of 3 sampled female residents (Resident #5, #6 and #7) were free from mental abuse as evidence by female residents' fears and inappropriate language by one male resident (Resident #4). The findings are: A. Review of Resident #4's current FL2 dated 6/16/15 revealed: -Diagnoses included mental impairment, hypertension, and anxiety. -Recommended level of care was assisted living. Review of the Resident Registry for Resident #4 revealed an admission date to the facility on 6/24/15. Review on 7/21/15 of Resident #4's progress notes revealed: -Documented on 6/24/15 at 2:00 pm Resident #4 was agitated, banged on the dining room table. -Documented on 6/27/15 at 2:00 pm and 10:00	D 338		

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pm Resident #4 had beat on table during the whole lunch meal and banged on the bird cage after supper.
-Documented on 6/30/15 at 1:00 pm Resident #4 used inappropriate language in front of other residents as well as the Activity Director.
-Documented on 6/30/15 at 1:00 pm the Adminstrator and the Resident Care Coordinator (RCC) were notified of Resident #4's inappropriate language.
-Documented on 7/14/15 at 1:00 pm Resident #4 become upset and yelled profanity at staff during his medication time which upset several residents.
-Documented on 7/14/15 at 1:00 pm Resident #4 continued to bang on the table at lunch as well as on his glass with his eating utensils.
-Documented on 7/15/15 at 4:40 pm Resident #4 was witnessed touching a female resident inappropriately.
-Documented on 7/16/15 at 10:00 am Resident #4 continued to follow behind the female resident he touched inappropriately on 7/15/15.
-Documented on 7/20/15 at 2:00 pm Resident #4 was found in the lobby sitting with the female resident he had touched inappropriately on 7/15/15, he was redirected by the staff back to his room.

Review on 7/22/15 of Resident #4's record revealed:
-A psychiatric consult completed on 7/21/15 by the facility contract psychiatrist.
-Documented Resident #4 was disorganized and irritable and did not recall inappropriately touching the female resident on 7/15/15.
-An order for medications Seroquel 25 mg (a anti-psychotic used to treat acute manic episodes) nightly and Depakote 250 mg (used to treat mood disorders) two times daily.

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-An order for laboratory studies ammonia level (help to determine the cause of changed behaviors) and a urinalysis.
-New diagnosis included severe dementia with behavior.
-Mental exam included documentation Resident #4 appearance disheveled, guarded, and hostile.
-Behaviors were documented as cooperative.
-Orientation was documented as to person and place only.
-Mood was documented as manic, irritable.

Refer to interview on 7/22/15 at 10:40 am with a Medication Aide (MA).

Refer to interview on 7/22/15 at 11:05 am with the Resident Care Coordinator (RCC).

Refer to interview on 7/23/15 at 8:40 am with the Personal Care Aide (PCA).

Refer to interview on 7/23/15 at 11:05 am with the the Activity Director.

Refer to interview on 7/22/15 at 2:30 pm with the Business Office Manager (BOM).

Refer to interview on 7/22/15 at 2:45 pm with the Administrator.

B. Review of Resident #5's current FL2 dated 4/7/15 revealed:
-Diagnoses included dementia, depression and glaucoma.
-Documentation ambulatory status was with walker.

Review of the Resident Registry for Resident #5 revealed an admission date to the facility on 6/20/14.

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D 338	Continued From page 21 Interview on 7/23/15 at 10:30 am with Resident #5 revealed: -She was scared to be around a male resident (Resident #4) that lived at the facility. -The male resident was rude and touched another female resident, "He played with her leg". -A female resident (Resident #6) was scared of him and did not come out of her room very much. -"I walked Resident #6 back to her room because she was scared of the male resident, he lived across the hall from her." -She had not spoken to staff or the Administrator about her concerns for safety. C. Review on 7/22/15 of Resident #6's current FL2 dated 1/12/15 revealed: -Diagnoses included hyperthyroidism, coronary artery disease, and diverticulitis. -Documentation of Resident #6 was ambulatory. -Resident functional limitation was documented as hearing. -Documentation the resident was oriented. Review of the Resident Registry for Resident #6 revealed an admission date to the facility on 1/29/15. Observation on 7/21/15 during initial tour between 10:45 am and 11:30 am revealed Resident #6's door was locked and Resident #6 did not answer door when surveyor knocked on door. Observation on 7/22/15 at 12:00 pm second attempt to interview Resident #6 revealed door was locked but the housekeeper said Resident #6 was hard of hearing and opened the door after confirmation Resident #6 was in her room. Interview on 7/22/15 at 12:00 pm and on 7/23/15	D 338		

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at 10:10 am with Resident #6 revealed:
-She was hard of hearing and always kept her door locked.
-She had expressed fear of the male resident (Resident #4) directly across the hall from her room.
-The male resident had lived at the facility for a month.
-The male resident had made an inappropriate comment to Resident #6 several weeks ago that he would like visit her in her room at midnight.
-Resident #6's daughter as well as the male residents' family were present when the male resident made the inappropriate comment.
-Resident #6 told him no, and was very upset.
-The male resident was in the hallway sometimes when Resident #6 was leaving room, and she is scared to go out.
-The male resident placed candy wrappers on her door and turned the wreath around which hung on her door.
-She had spoken to the Business Office Manager (BOM) and staff about 2 weeks ago with concerns that candy wrappers and her wreath had been turned around.
-She had not spoken to the Administrator or BOM until last week of the comment the male resident made about coming in her room at midnight.
-She had spoken to her family as well as her friends in the assisted living community in regards to her fear of the male resident across the hall.
-She did attended activities,but now was afraid to go out of her room.
-She was aware the male resident (Resident #4) was in the living room area and had inappropriately touched a female resident last week.
-She was aware staff watched the male resident closely.
-She knew of 2 other female residents in the

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facility who were scared of the male resident.

Interview on 7/22/15 at 1:45 pm with Resident #6's family member revealed:
-She visited Resident #6 weekly.
-Resident #6 told her the male resident (Resident #4) made an inappropriate comment several weeks ago.
-She was not present at that visit but another family member was.
-She said Resident #6 was very uncomfortable around him, "scared".
-She had not spoken to the Administrator or any staff with her concerns or safety for Resident #6 nor was she aware if any family member had spoken to the Administrator.

Interview on 7/22/15 at 2:10 pm with Resident #6 other family member revealed:
-Resident #6 always locked her door due to the valuables in her room.
-She was present on the day the male resident (Resident #4) made the inappropriate comment to Resident #6.
-The male resident (Resident #4) had made the comment that he would like to be invited in Resident #6's room at midnight.
-The male resident's family were present at that time also.
-Resident #6 told the male resident "NO".
-Resident #6 had taken the male resident very seriously and was afraid he might try to come in her room.
-In the past month Resident #6 stayed in her room more and had not been as social.
-She had not spoken to any one at the facility about this, and was unsure if Resident #6 had either.

Refer to interview on 7/22/15 at 10:40 am with a

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D 338	Continued From page 24 Medication Aide (MA). Refer to interview on 7/22/15 at 11:05 am with the Resident Care Coordinator (RCC). Refer to interview on 7/23/15 at 8:40 am with PCA. Refer to interview on 7/23/15 at 11:05 am with the the Activity Director. Refer to interview on 7/22/15 at 2:30 pm with the Business Office Manager (BOM). Refer to interview on 7/22/15 at 2:45 pm with the Administrator. D. Review of Resident #7's current FL2 dated 4/3/15 revealed: -Diagnoses included diabetes, chronic diarrhea, hip replacement and headaches. -Documentaion the Resident was oriented. -Functional limitations were documented as sight. Review of the Resident Registry for Resident #7 revealed an admission date to the facility on 8/2/12. Interview on 7/23/15 at 9:30 am with Resident #7 revealed: -She was alert and oriented. -She was fearful of a a male resident (Resident #4) who lived at the facility. -The male resident told her he would come to her room at night to see her. -She told the male resident, "I have a gun and would shoot him in the leg". -The male resident never came to her room. -She stated Resident #6 was afraid of the male resident, "She is scared to death of him".	D 338		

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D 338	Continued From page 25 -She had not told staff she or the other female resident was fearful of the male resident (Resident #4). Refer to interview on 7/22/15 at 10:40 am with a Medication Aide (MA). Refer to interview on 7/22/15 at 11:05 am with the Resident Care Coordinator (RCC). Refer to interview on 7/23/15 at 8:40 am with the PCA. Refer to interview on 7/23/15 at 11:05 am with the the Activity Director. Refer to interview on 7/22/15 at 2:30 pm with the Business Office Manager (BOM). Refer to interview on 7/22/15 at 2:45 pm with the Administrator. Observation on 7/23/15 at 11:30 am the male resident (Resident #4) was moved to a room at the opposite end of hall 93 feet away from Resident #6 room. _____ Interview on 7/22/15 at 10:40 am with a Medication Aide (MA) revealed: -She was aware the male resident (Resident #4) had inappropriately touched a female resident on 7/15/15. -The incident happened in the common area with other residents around . -Residents' in the facility were concerned and very scared of the male resident (Resident #4) -In daily stand-up meetings conduced by the RCC and nurse, they addressed the male residents' behaviors.	D 338		

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BROOKDALE UNION PARK	1316 PATTERSON AVENUE MONROE, NC 28112

(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 338	Continued From page 26	D 338		

-Staff was told to monitor the male resident (Resident #4) closely and to know where he was at all times.
-She said Resident #4 was loud and had "a smart mouth".

Interview on 7/23/15 at 8:40 am the PCA revealed:
-She was aware two female residents were afraid of a male resident (Resident #4)
-She was aware one of the female residents' stayed in her room more often in the past month.
-She spoken to the Business Office Manager (BOM) and the nurse last week about the female residents' concerns and fears regarding the male resident (Resident #4)

Interview on 7/22/15 at 11:05 am with the Resident Care Coordinator (RCC) revealed:
-She recalled the incident on 7/15/15 when a male resident (Resident #4) touched a female resident inappropriately.
-They initated 1 on 1 care for the male resident (Resident #4) on 7/17/15 at 3:00 pm two days after the inappropriate sexual behavior incident had occurred.
-They increased staffing on night shift 10:00 pm to 6:00 am to monitor the male resident (Resident #4).
-She was made aware of a female resident who was scared of a male resident (Resident #4) about 2 weeks ago.
-The Business Office Manger (BOM) had showed/offered to move the female resident to another room away from the male resident.

Interview on 7/23/15 at 11:05 am with the Activity Director revealed:
-She said a female resident (Resident #6) did not come out of her room much in the past month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 27 -She said Resident #6 and her family member told her on 7/22/15 that Resident #6 had been scared to come out of her room because of the male resident (Resident #4) across the hall. -She had directed them to speak to the Administrator and the BOM office with their concerns. -She was not aware if they had spoken to the Administrator or not on 7/22/15. -The Activity Director had not spoken to the Administrator or the BOM on 7/22/15 with the concerns of the family and the female resident. Observation on 7/23/15 at 11:30 am the male resident (Resident #4) was moved to a room at the opposite end of the hall 93 feet away from Resident #6's room. Interview on 7/22/15 at 2:30 pm with the Business Office Manager (BOM)revealed: -She was aware a male resident (Resident #4) had inappropriately touched a female resident on 7/15/15. -The staff were to know where the male resident was at all times. -One female resident came to my office 2 weeks ago with concerns the male resident had placed candy wrappers on her door and turned her wreath around. -The female resident (Resdient #6) said the male resident (Resdient #4) had made an inappropriate comment several weeks ago about coming over to her room at midnight. -She had offered to move the female resident (Resident #6) to another room away from the male resident (Resident #4). -She had not spoken to the family of Resident #6, nor had the family of Resident #6 spoken to her about concerns for safety.	D 338		

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D 338	Continued From page 28 Inteview on 7/22/15 at 2:45 pm with the Administrator revealed: -The nurse at the facility assessed the male resident (Resident #4) prior to his admission to the facility. -The facility was unaware of inappropriate behaviors Resident #4 had prior to arriving at the facility. -She was aware Resident #4 had touched a female resident inappropriately on 7/15/15 at the facility. -Staff watched him closely and extra staffing was used at night to sit with Resident #4. -Resident #6 had told her last week a male resident (Resident #4) had placed candy wrappers on her door and turned the wreath around. -She told Resident #6 the staff continued to monitor the male resident (resident #4) closely and assured the female resident she was safe in the facility. -She had not notified the family of Resident #6, nor had the family contacted her with any safety concerns. -Was aware Resident #4 had seen the psychiatrist on 7/21/15 and a new diagnosis of dementia and 2 new medications for mood/behaviors were initated. -They would re-evaluate Resident #4 in 2 weeks the effectiveness the new medications to determine if he was appropriate for the current assisted living facility or not. The facility provided a Plan of Protection on 7/23/15 which included the following: -Immediately the male resident (Resident #4) will be moved to another room located at the other end of the hall, away from Resident #6. -One on one sitting in room with the male resident for 24 hours a day starting today 7/23/15 for the	D 338		

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D 338	Continued From page 29 remainder of 14 days. -A meeting with Resident #6's family at 2:30 pm today 7/23/15 to discuss care and concerns. -Increase supervision with the male resident for the reminder of 14 days to determine if appropriate for current facility. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 8, 2015.	D 338		
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 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding Supervision, and Resident Rights. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision in regard to aggressive behaviors, inappropriate sexual conduct, and residents' fear of one other resident's behaviors (Resident #4).[Refer to Tag 0270,10A NCAC 13F. 0901(b)(Type B Violation).]	D912		

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D912	Continued From page 30 Based on observations, interviews, and record reviews, the facility failed to assure 3 of 3 sampled female residents (Resident #5, #6 and #7) were free from mental abuse as evidence by female residents' fears and inappropriate language by one male resident (Resident #4). [Refer to Tag 0338, 10A NCAC 13F. 0909(Type B Violation).]	D912		