STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014014	A. BUILDING: _____ B. WING _____	R 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROCKFORD INN	56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630

(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 and the Caldwell County Department of Social Services conducted a follow-up survey and complaint investigation on September 22, 23, and 24, 2015. The Caldwell County DSS initiated the complaint investigation on September 10, 2015.	{D 000}		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, personal care and supervision, medication administration, Health Care Personnel Registry, and resident	D 176		

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D 176	Continued From page 1 rights. The findings are: Interview with the Administrator-In-Charge on 9/22/15 at 3:15pm revealed the Administrator was present in the facility monthly for staff meetings, and daily at shift change. The Administrator was not on-site at the facility during the survey. Areas of non-compliance identified during the survey were: A. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 8 sampled residents (#5) received supervision in accordance with resident's needs concerning confusion associated with urinary tract infection. [Refer to D270 NCAC 13F .0901(b) Personal Care and Supervision. (Type A2 Violation.)] B. Based on observations, record reviews, and interviews, the facility failed to assure medications (Imdur, Sinemet CR, and Acetaminophen) were administered as ordered by a licensed prescribing practitioner to 1 of 4 residents (#9) observed during a morning medication pass. [Refer to D358 NCAC 13F .1004(a) Medication Administration.] C. Based on observations, record reviews, and interviews, the facility failed to assure medications (Imdur, Sinemet CR, and Acetaminophen) were administered as ordered by a licensed prescribing practitioner to 1 of 4 residents (#9) observed during a morning medication pass. [Refer to D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B	D 176		

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D 176	Continued From page 2 Violation.)] A plan ot protection was requested from the facility on 10/9/15. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 23, 2015.	D 176		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated, noncompliance continues. TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure 1 of 8 sampled residents (#5) received supervision in accordance with resident's needs concerning confusion associated with urinary tract infection. The findings are: Review of Resident #5's current FL2, dated	{D 270}		

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{D 270}	Continued From page 3 6/1/15 revealed: -Diagnoses of atrial fibrillation, muscle weakness, aftercare following joint replacement, history of TIA (transient ischemic attack), hypertrophy prostate, hypothyroidism, osteoarthritis and HTN (hypertension). -Resident was semi-ambulatory. -Resident #5's functional limitations included sight. -Resident's special care factors included PT (physical therapy) and OT (occupational therapy). Review of Resident #5's facility Admission Face Sheet dated 6/2/15 revealed: -Medical diagnoses of blindness of both eyes-impairment level not further specified, abnormal involuntary movements, unspecified acquired hypothyroidism, and osteoarthritis. Review of Resident #5's Care Plan dated 7/2/15 revealed: -Resident was a fall risk. -Resident required a tab alarm. -Resident required the use of a wheelchair. -Resident was sometimes disoriented. -Resident was forgetful and needed reminders. -Resident required assistance with all activities of daily living (eating- limited assistance; toileting-extensive assistance; ambulation/locomotion-limited assistance; bathing-extensive assistance; dressing-extensive assistance; grooming/personal hygiene-extensive assistance; transferring-limited assistance). Review of Resident #5's Licensed Health Professional Support Form, dated 7/2/15 revealed: -Diagnoses included dementia, falls. -Physical therapy and occupational therapy were ordered.	{D 270}		

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{D 270}	Continued From page 4 -Resident required ambulation with a walker and 1 person stand by. -Resident required one person assist to transfer. -Resident required the use of a tab-alert at all times. Review of Resident #5's Family Nurse Practitioner Note, dated 6/24/15 revealed: -Resident was seen for dysuria and increased confusion. -Resident was oriented x2 and slow of thought. -Resident was to be monitored to see if he was developing dementia. -Documentation included: "not sure if his intermittent confusion has to do with dementia or if he has a urinary tract infection (UTI)." Review of Resident #5's Family Nurse Practitioner Note, dated 7/15/15 revealed: -Resident was seen "for follow up for urinalysis that was obtained on 7/10/15 for increased behaviors by staff." - "Poor vision and does not distinguish objects well." Review of Resident #5's hospital laboratory services report, dated 7/10/15 revealed: -Urinalysis positive for nitrate, (indicating a urinary tract infection.) - "Macrobid was ordered on 6/29/15 for 7 days, and was completed" and signed by the Family Nurse Practitioner. Review of Resident #5's physician orders revealed: - On 6/2/15 continued use of a wheelchair, physical therapy and occupational therapy evaluation and treatment, use of tab-alert at all times to prevent falls. -On 6/24/15 obtained a urinalysis and C&S	{D 270}		

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{D 270}	Continued From page 5 (culture and sensitivity) for dysuria, due to increased confusion and resident talking to self. -On 7/10/15 obtained a urinalysis and C&S, due to urine having strong odor and increased confusion. -On 9/1/15 obtained a urinalysis and C&S. -On 9/9/15 discontinued Macrobid and begin Doxycycline for UTI, due to increased behaviors, talking to self, seeing unusual things, sitting on front porch and rolling to road, recent UTI. Per record review, Macrobid was ordered as a result of the urinalysis on 9/1/15. Review of Resident #5's September 2015 Medication Administration Record revealed: -On 9/4/15, administration began for Macrobid 100mg, 1 tablet twice a day and continued until 9/9/15. -On 9/9/15 Macrobid was discontinued. -on 9/9/15 administration began for Doxycycline 100mg, 1 tablet twice a day for 10 days. Review of Resident #5's Nurses Notes revealed: -On 6/24/15 home health obtained a urinalysis. -On 9/2/15 home heath obtained a urinalysis. -On 9/9/15 resident was at the road in his wheelchair, redirected back to the facility by staff, and placed on 10 minute checks. Review of Resident #5's facility Incident Report dated 9/9/15 at 8:15am revealed: -Resident was sitting on the front porch and rolled down the ramp to the road. -Resident stated he was going to sit on the porch across the street -Resident was redirected back to the facility. -Resident was put on 10 minute checks. -Resident was not allowed to sit on the front porch.	{D 270}		

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{D 270}	Continued From page 6 -Nurse Practitioner evaluated Resident #5 and changed the antibiotic to Doxycycline. Interview with Resident #5 on 9/10/15 at 10:00am revealed: -He was in his wheelchair, on the front porch by himself, and decided to go across the street. -The wheels of the wheelchair were in the road. -Someone came to him from behind and wheeled him back to the facility. Interview with Resident #5's family member on 9/10/15 at 10:00am revealed: -Facility staff informed the family on 9/9/15 that the resident went to the road. -The resident was suffering from a UTI, and "was talking out of his head." Confidential staff interview revealed: -Staff person was not at the facility when Resident #5 wheeled himself off of the porch. -Staff person heard that the resident was in the road and a car almost hit resident. -Resident revealed that he does not see well and thought he saw his friends sitting on the porch across the street. - Staff were trying to keep the incident "hush, hush," no elaboration noted. Interview with a facility resident on 9/10/15 at 12:39am and 9/9/23/15 at 12:25pm, revealed: -Resident was sitting on the front porch with Resident #5. -Resident #5 "went all the way across the road in his wheelchair." -This resident informed the Special Care Unit Care Coordinator (SCC) Resident #5 went across the road. -SCC went after resident.	{D 270}		

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{D 270}	Continued From page 7 Interview with SCC on 9/10/15 at 1:05pm revealed: -SCC completed the Incident Report concerning Resident #5 crossing the road. -Resident #5 wheeled himself onto the road. -A man and lady in a silver car stopped and appeared to be upset, stating to the SCC, "Can' t you watch them (residents) any better than that?" -SCC and another staff person brought resident back to facility. -Resident was placed on 10 minute checks. -Resident #5 was not allowed to go on the porch alone. Review of the facility's security camera video on 9/10/15 at 1:15pm revealed: -On 9/9/15 at 8:14am, Resident #5 and another resident were sitting on the front porch together, looking straight ahead, (across the road.) - On 9/9/15 at 8:17am, resident walked to the other side of the porch, and Resident #5 wheeled himself down the concrete ramp from the front porch. -The video did not display activity beyond the ramp. Interview with Resident #5's family member on 9/23/15 at 8:30am revealed: -Family member was informed of the incident on the morning of 9/9/15. -Family member was informed that resident went toward the highway and a car stopped for him. -Resident #5 stated that he wanted to sit on the porch of the house across the street. Observation of the state maintained secondary road in front of the facility revealed: - The posted speed limit on the road was 35 miles per hour. - The edge of the road was approximately 60 feet	{D 270}		

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{D 270}	Continued From page 8	{D 270}		

from the end of the ramp attached to the front porch of the facility.
- The house across the street from the facility was approximately 180 feet from the front of the porch.

Interview with Resident #5 on 9/23/15 at 9:44am revealed:
-Resident #5 was in his wheelchair on the front porch, and "rolled across the street to sit on the front porch," (of the house across the street from the facility.)
-Resident #5 was going back across the road (headed back to the facility) and a car stopped.
-Someone grabbed Resident #5's wheelchair and stated "Let's get out of the way."
-Resident #5 did not know who helped him back to the facility.

Interview with Resident #5's family member on 9/23/15 at 9:44am revealed:
-Staff informed family member that Resident #5 "never made it across the road, his wheelchair hit the curb and it kicked the wheelchair all the way around."
-Resident #5 had a kidney infection and "his brain went hay-wire."

Interview with SCC on 9/23/15 at 12:38pm revealed:
-SCC was in the main dining room on the morning of 9/9/15.
- Someone said Resident #5 was "off the porch."
-SCC "grabbed" another staff person and they brought Resident #5 back to the facility.
-The incident occurred during hours of heavy school traffic (an elementary school was next door to the facility).
-Cars in both lanes of the road had stopped.
-The police officer that directed traffic at the

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{D 270}	Continued From page 9 school had already left. -Resident #5 told the SCC that he was going to the porch across the street. -Resident #5 was suffering from a UTI at the time of this incident. -SCC did not believe Resident #5 was legally blind. Attempts to contact the Nurse Practitioner on 9/24/15 at 3:19pm were unsuccessful. _____ On 9/10/15 and 9/22/15 the facility provided the following plan of protection: - Any resident with a diagnosis of blindness will be directed to the back patio. - Immediate intervention, Resident #5's power of attorney requested resident not be allowed on front porch without them present. - To ensure resident's safety, any resident with a diagnosis of blindness will be directed to the back patio. If resident still wants to sit on front patio, a staff member will sit with them.. - Staff will make rounds every 15 minutes to the front patio to ensure the safety of all residents on the front patio. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 23, 2015.	{D 270}		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358		

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D 358	Continued From page 10	D 358		

by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure medications (Imdur, Sinemet CR, and Acetaminophen) were administered as ordered by a licensed prescribing practitioner to 1 of 4 residents (#9) observed during a morning medication pass.

The findings are:

Review of Resident #9's current FL2 dated 8/4/15 revealed:
- Diagnoses of dementia, Parkinsonism, coronary artery disease, and osteoarthritis.
- An admission date of 8/1/12.
- Medication orders for Imdur 30mg, 1 tablet daily, Tylenol (Brand name Acetaminophen) 325mg, 2 tablets three times a day, and Sinemet 50/200 CR, 1 tablet twice daily. (Imdur is a time released long acting medication used to treat coronary artery disease, Sinemet is a long acting time released medication used to treat tremors associated with Parkinsonism, and Tylenol is a non-narcotic analgesic used to treat mild to moderate pain.)

Observation of the morning medication pass on 9/23/15 at 10:14am revealed:
- The Medication Aide (MA) prepared 8 oral medications to administer to Resident #9.
- The MA crushed all of Resident #9's medications in tablet form, including Imdur 30mg and Sinemet CR 50/200.

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D 358	Continued From page 11 - The MA prepared 1 tablet of Tylenol to administer to Resident #9 instead of 2 as ordered by the physician. Interview with the MA at 10:15am on 9/23/15 revealed: - She was not aware Imdur and Sinemet CR were time released medications that could not be crushed. - She was not aware she had only prepared 1 tablet of Tylenol 325mg instead of 2 for Resident #9 until the MA and surveyor counted the prepared medications in the plastic medication cup. - She did not believe the facility had a "do not crush" list of medications available for her use. - She normally crushed Resident #9's medications and mixed them with applesauce prior to administering them due to the resident's swallowing difficulties. Per observation at 10:20am on 9/23/15, the MA discarded Resident #9's crushed plastic bag of medications and prepared her medications again, this time with 2 tablets of Tylenol and without crushing Imdur and Sinemet CR. Observation of the notebook containing all the resident's Medication Administration Records (MARs) on the 300 hall revealed: - An extensive list of medications that cannot be crushed. - Imdur and Sinemet CR were both found on the list of medications that cannot be crushed. Review of Resident #9's September 2015 MARs revealed entries for both the Imdur 30mg and Sinemet CR 50/200, but neither entry contained a warning, "do not crush."	D 358		

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D 358	Continued From page 12 Observation of Resident #9's medications on hand at 10:30am on 9/23/15 revealed plastic containers of both Imdur 30mg and Sinemet CR 50/200, and neither contained auxiliary labels stating, "do not crush." Interview with Resident #9 on 9/24/15 at 11:55am revealed: - She was not aware of and could not identify the medications she was taking. - She was not sure if the MA routinely crushed her medications. Review of the facility's policy on the administration of medications revealed: - "Instruct resident not to chew, crush, or dissolve or tamper with enteric coated tablets or long acting medications." (Enteric coating of tablets is one method used by drug manufacturers to delay the absorption of medications, prolong their action, and minimize stomach upset.) - "Some tablets may be crushed or capsule contents placed in food or applesauce for those residents who cannot or will not swallow medications whole. Check and make certain the medications may be crushed, contact pharmacy or physician." Review of the manufacturer's recommendations for both Imdur 30mg and Sinemet CR 50/200 revealed they may be cut in half, but were not to be crushed before administration.	D 358		
{D 438}	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry	{D 438}		

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{D 438}	Continued From page 13 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: FOLLOW-UP TO A TYPE A2 VIOLATION. Based on these findings, the previous Type A2 Violation was abated, noncompliance continues. TYPE B VIOLATION. Based on observations, record reviews, and interviews, the facility failed to protect residents by not investigating allegations of injury of unknown source (hip fracture) for 1 resident of 8 sampled residents (#7), an impaired staff on duty, and not reporting to the Health Care Personnel Registry. The findings are: A. Review of Resident #7's current FL2 dated 5/28/15 revealed: -Diagnoses of Alzheimer's Dementia, a history of stroke, seizure disorder (generalized tonic-clonic), and chronic obstructive pulmonary disease. -An admission date of 5/28/15. -Resident was intermittently disoriented. -A recommended placement of special care unit-assisted living. Review of Resident #7's care plan dated 6/28/15 revealed: -Resident was noted as total assist on her care plan for toileting, bathing, dressing, and grooming. -Resident was noted as limited assistance for eating, ambulation, and transfer.	{D 438}		

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	HAL014014	A. BUILDING: _____ B. WING _____	R 09/24/2015

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{D 438}	Continued From page 14 Continued review of Resident #7's record revealed a fall risk assessment completed on 5/29/15 with a score of 9. (A score of 10 or greater indicated an increased fall risk.) Review of nursing notes in Resident #7's record revealed: -8/3/15, Primary Medical Provider (PMP) evaluated for knee pain, ordered X-ray of right knee, called mobile X-ray. -8/4/15, X-ray showed arthroplasty without complication, Tylenol ordered from MD. -8/5/15, Medication Aide (MA) administered Tylenol as ordered, resident still complains of right leg pain, no bruising, but pain on touch of right leg, continue to monitor. -8/6/15, resident still complained of leg pain, no bruising, there is some swelling and pain to touch, PMP evaluated on 8/3/15, MD notified and spoke with Nurse Practitioner (NP), consulted family, to send to ER to evaluate and treat. -8/6/15, notified emergency medical services, sent to local emergency room to evaluate and treat. - 8/6/15, received update from hospital, resident admitted, diagnosis hip fracture. Per review, the Administrator-in-Charge (AIC) completed all the nursing notes above dated 8/5/15 and 8/6/15. Review of a Physician's progress note dated 8/3/15 revealed: - Resident #7 was evaluated due to right knee pain. - Resident had no fall or injury. - Resident #7 previously had right knee repaired. - Resident was pleasantly confused with no complaints of pain.	{D 438}		

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{D 438}	Continued From page 15 - Resident was a poor historian, history comes from family, states she seems to have right knee pain - Resident #7 not currently ambulating, plan X-ray, Tylenol for pain. Review of the mobile x-ray radiology report dated 8/3/15 for Resident #7 revealed: - The report noted right knee replacement. - No acute complications, arthroplasty. Interview with a nursing assistant on 9/24/15 at 9:45am revealed: - Resident #7 was not at the facility very long. - Resident #7 had to have assistance with bathing and transfer. - She was not aware of any falls by Resident #7 at the facility. Interview with a second nursing assistant on 9/24/15 at 9:50am revealed: - "We (staff) did pretty much everything for Resident #7." - "Resident #7 usually only took a 1 person assist, but occasionally it would take 2 to help encourage her." - She was not aware of any falls by Resident #7 while she was at the facility, and did not recall any complaints of leg pain. Interview with the Special Care Unit Coordinator (SCC) at 10:05am on 9/24/15 revealed: - Resident #7 was very easy to care for and very pleasant. - Resident was very easy to redirect. - Family visited frequently and were very supportive. - Resident #7 was a 1 person assist with pretty much all her ADL's (activities of daily living.) - She was not aware of any falls by Resident #7	{D 438}		

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{D 438}	Continued From page 16	{D 438}		

while at the facility.
- Resident #7 had some right leg pain, "more of like a catch," i.e. a sudden sharp pain, then pain was gone.

Interview with Resident #7's power of attorney and family member on 9/24/15 at 10:15am revealed:
- Resident #7 passed away on 8/25/15 at a skilled nursing facility.
- Family member believed Resident #7 fell while at the facility.
- No one at the facility would admit to the family that Resident #7 had fallen.
- She and another family member visited Resident #7 daily.
- Resident #7 was "doing fine" until 8/3/15, then she began to complain of knee pain.
- Family member asked staff what had happened that day (8/3/15) and was told, "they (staff) had to put her (Resident #7) in a wheelchair."
- The family member wasn't sure what that meant, but believed she may have fallen that day (8/3/15.)
- The facility's physician saw Resident #7 later on 8/3/15, and ordered an X-ray of her knee.
- The family member was told by staff the X-ray was negative except for the knee replacement and signs of arthritis.
- Staff gave Resident #7 Tylenol for pain.
- Resident #7 continued to have leg pain, and on 8/6/15 the facility sent her out to the local emergency room.
- Examination in the emergency room revealed Resident #7 had a hip fracture.
- The Nurse Practitioner at the emergency room told the family member, "it must have been a fall to crush the femur like that."

Interview on 9/24/15 at 2:00pm with the

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{D 438}	Continued From page 17 Orthopedist who repaired Resident #7's hip fracture revealed he believed "a fall most likely caused the hip fracture." Interview with the Administrator-in-Charge (AIC) on 9/23/15 at 2:20pm revealed: - She had not reported anything to the Health Care Personnel Registry related to Resident #7's hip fracture. - The AIC didn't believe it was an injury of unknown origin. - The AIC thought Resident #7's hip fracture was related to the prior knee replacement on the same leg. B. Review of Staff #A's personnel file on 9/15/15 revealed: -Staff A was hired as a Personal Care Aide. -She was hired on 4/20/15. -The Health Care Personnel Registry check was completed on 4/16/15. -The Criminal Background Check was completed on 4/29/15. -The pre-employment drug test was completed on 4/16/15. Interview with Supervisor on 9/24/15 at 9:20am revealed: -On 9/11/15 at approximately 2:00pm Staff A arrived at the facility to pick up her check. -Staff A "Acted like she was out of it." -Staff A was sent home by the Supervisor. -Staff A returned to work on 9/11/15 to work a 3:00pm shift. -Staff A, was sent home because she "was not acting like herself". -Staff A "could have been under the influence, but it was more of an embarrassment to me." -On 9/12/15 "close to 2nd shift, I received a call from Supervisor/Medication Aide regarding Staff A	{D 438}		

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{D 438}	Continued From page 18 sleeping while on duty". -Staff A was sent home and advised not to return to work, until she spoke with the AIC. -"I told [named AIC] about both incidents for Staff A". -The facility conducts random drug testing if needed. -The AIC determined when and if random drug testing was conducted at the facility. Review of facility records revealed the special care unit (where Staff A was assigned) had 1 extra staff above the minimum staffing requirements assigned to the special care unit. Interview with Staff A on 9/24/15 at 9:50am revealed: -On 9/11/15 she was standing in the hallway to receive her check. -While standing in hallway, she kissed a male resident on the cheek and hugged him. -"I did not think I did anything wrong, but I was sent home." -On 9/12/15 Staff A was very sleepy during 1st shift and "dozed off." -She was sent home for this incident. -On 9/23/15 Staff A was terminated for kissing and hugging a resident and "dozing off"." Interview with the AIC on 9/24/15 at 11:50am revealed: -On 9/12/15, Supervisor informed her of the two incidents involving Staff A. -Staff A was suspended for the weekend. -AIC informed Staff A "If I hear about anything again, you will be terminated." -Staff A worked the following weekend. -Staff A was terminated for "not pulling her weight." -We can do random drug testing.	{D 438}		

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{D 438}	Continued From page 19 -Health Care Personnel Registry (HCPR) was not contacted concerning Staff A. -She did not feel like the incident with Staff A warranted her being reported to the HCPR. Review of facility Policies and Procedures on 9/24/15 revealed: - "No employee shall work, report to work, or be present on the facility premises or in the facilities vehicle while under the influence of alcohol or controlled substances." - "The unlawful or unauthorized manufacture, distribution, possession, sale or use is prohibited on the facilities premises." -"Any violation of this substance abuse policy will result in the employees dismissal, unless any law requires otherwise." - "The facility reserves the right to take any and all appropriate and lawful actions necessary to enforce this substance abuse policy." - "We also reserve the right to drug test any employee ." - "The facility reserves the right to test any employee, for drugs and alcohol upon demand when circumstances and/or behavior warrants suspicion of substance abuse or possession on the job." _____ On 9/22/15 the facility provided the following plan of protection: - The facility will immediately contact (9/22/15) the HCPR and do a facility investigation of neglect, with a 5 day report to follow. - In the future, the facility will contact the HCPR immediately concerning allegations of abuse, neglect, exploitation, fraud or misappropriation, or injury of unknown source.	{D 438}		

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{D 438}	Continued From page 20 - Any allegations of abuse, neglect, exploitation, fraud or misappropriation, or injury of unknown source is to be reported to the Supervisor/Medication Aide, and the Supervisor/Medication Aide is to report the administration. - The administration will do an investigation based on this reporting. - Facility has a staff meeting scheduled to go over how to report any complaints of allegations. - Facility has scheduled monthly staff meeting to re-educate staff and new staff on how to report any complaint or allegation of any kind. - Administrator, Supervisor/Medication Aide, and Special Care Unit Coordinator will hold weekly meetings and make round to speak with resident about any concerns. - Any findings will be reported immediately. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2015.	{D 438}		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents were free from neglect related to failure to investigate allegations of injury of and unknown source, staff impaired while on duty, supervision of resident with confusion associated with a urinary tract infection, management of facility, and to report to the Health Care Personnel Registry,	{D914}		

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{D914}	Continued From page 21 and supervision. The findings are: A. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 8 sampled residents (#5) received supervision in accordance with resident's needs concerning confusion associated with a urinary tract infection. [Refer to D270 10A NCAC 13F.0901(b) Personal Care and Supervision, (Type A2 Violation.)] B. Based on observations, record reviews, and interviews, the facility failed to protect residents by not investigating allegations of injury (hip fracture) of unknown source for 1 of 8 sampled residents (#7), an impaired staff while on duty, and not reporting to the Health Care Personnel Registry. [Refer to D438 10A NCAC 13F .1205 Health Care Personnel Registry, (Type B Violation).] C. Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, personal care and supervision, medication administration, Health Care Personnel Registry, and resident rights. [Refer to D176 10A NCAC 13F .0601(a) Management of Facilities. (Type A2 Violation.)	{D914}		