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	HAL022005	A. BUILDING: _____ B. WING _____	10/15/2015

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D 000	Initial Comments The Adult Care Licensure Section and the Clay County Department of Social Services conducted an annual survey on 10/14/15 through 10/15/15.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on record review, observation and resident and staff interviews, the facility failed to keep clean various surfaces in 3 of 10 resident rooms on the 200 hallway. The findings are: Observation on 10/14/15 at 10:15AM of the resident bathroom in room 210 revealed a black-brown stain on the vinyl flooring and circling the base of the commode (review of the most current census revealed one resident as occupying the room). Observation on 10/14/15 at 10:20AM of the resident bathroom in room 208 revealed a black-brown stain on the vinyl flooring and circling the base of the commode (review of the most current census revealed two residents as occupying the room). Observation on 10/14/15 at 10:30AM of resident room 206 revealed: - No residents present at the time of the	D 074		

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D 074	Continued From page 1	D 074		

observation (review of the most current census revealed the name of a recently deceased resident and that of another resident).
- Dried greenish-brown matter in an irregular shape approximately 6 inches across on the top of the heating/air conditioning unit that appeared to be stool.
- Dried brown matter smeared in numerous places on the inside of the vinyl shower curtain, the largest smear approximately 12 inches in length, that appeared to be stool.
- Dried greenish-brown matter on the inside bathroom door frame at the level of the light switch approximately the size of a dime, similar in appearance to that found on the heating/air conditioning unit.
- No housekeeping staff present in the vicinity of this room, but a Housekeeper was observed in another hallway with their cleaning cart.

Observation on 10/14/15 at 10:40AM of a sitting area in the 200 hallway revealed:
- The current resident of room 206.
- Based on the resident being verbally unresponsive to a simple greeting and simple questions, it was determined that the resident could not be interviewed.

Follow-up observations on 10/14/15 at 12:10PM and 2:30PM of resident room 206 revealed:
- Findings unchanged from those noted on 10/14/15 at 10:30AM.
- No housekeeping staff present in the vicinity of this room.

Interview on 10/14/15 at 4:25PM with a Supervisor revealed:
- Personal Care Aides (PCA) informed her on 10/13/15 (the day prior to the death of the resident in room 206) that he had loose stool and

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D 074	Continued From page 2	D 074		

it was "continuous."
- She administered an as-needed antidiarrheal medication as ordered and it "seemed to help."
- 10/13/15 was the first day that she was aware of that the deceased resident had diarrhea .

Follow-up observation on 10/15/15 at 8:10AM of resident room 206 revealed:
- Findings unchanged from those noted on 10/14/15 at 10:30AM.
- No housekeeping staff present in the vicinity of this room.

Interview on 10/15/15 at 9:15AM with a PCA revealed:
- She cared for the deceased resident in room 206 on 10/13/15.
- He had loose stool.
- He was occasionally incontinent of bowel, but he could communicate when he had to use the bathroom.
- If the resident had diarrhea he could still tell staff he had to use the bathroom, but there was usually not enough time to get him to the toilet.
- Upon the death of a resident, staff stripped the bed of linens and housekeeping staff would come to clean the room.
- There was still a resident who resided in room 206.
- Housekeeping was expected to clean "every day."

Follow-up observation on 10/15/15 at 10:20AM of resident room 206 revealed:
- Findings unchanged from those noted on 10/14/15 at 10:30AM.
- No housekeeping staff present in the vicinity of this room.

Interview on 10/15/15 at 12:30PM with a

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D 074	Continued From page 3 Housekeeper revealed: - There was only one housekeeper in the facility who worked first shift. - Care staff on second and third shift would have to address unexpected cleaning issues that could not wait for routine cleaning by the Housekeeper on first shift. - Care staff had access to the cleaning closet where supplies were kept for unexpected cleaning. - She had not found issues at the start of her shifts with unexpected cleaning matters that should have been addressed by the care staff of second and third shifts. - In addition to cleaning resident rooms each day she was also required to clean the dining room after breakfast and lunch and to clean common areas. - She tried to get to as many rooms as she could each day. - At the end of her shift she would stop and the following day she would pick up cleaning resident rooms where she left off. - She was off 10/13/15 and another housekeeper was scheduled to work. - Routine resident room cleaning included cleaning bathroom floors, sinks and the shower. - Routine shower cleaning included "wiping everything down" and to attend to any problems found. - She was not sure how often shower curtains were cleaned but she did look at them. - Many of the showers in resident rooms did not get used as residents were bathed in a common shower room. - After a resident was discharged from a room the mattress was sanitized and everything in the room was cleaned "real good." - She recalled staff bringing to her attention cleaning requirements in certain rooms but room	D 074		

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D 074	Continued From page 4 206 was not mentioned by the staff. Interview on 10/15/15 at 12:45PM with the Resident Care Coordinator (RCC), Administrator and Nurse Consultant revealed: - A housekeeping checklist was expected to be submitted each day by the Housekeeper but it did not contain a place to note unexpected areas of concern. - Routine cleaning of rooms was expected to be done daily, with other rooms checked more frequently if indicated. - Direct care staff were expected to address immediate cleaning issues between periods of routine cleaning by Housekeeping staff. - After a resident discharge the room was required to have a "deeper cleaning" with everything "wiped down" with "bleach water." - Shower curtains could be washed in the laundry. Follow-up observation on 10/15/15 at 12:55PM of resident room 206, accompanied by the RCC, Administrator and Nurse Consultant revealed: - Findings unchanged from those noted on 10/14/15 at 10:30AM. - No housekeeping staff present in the vicinity of this room. Confidential interviews with 4 of 4 alert and oriented residents residing on the 200 hallway revealed their rooms were "regularly cleaned" (but unsure of the frequency), housekeeping was "no problem" and was "good." Confidential interviews with one of three resident family members revealed: - The facility did not have "enough housekeeping staff." - A PCA sometimes cleaned [a named resident's] room because the PCA could not stand how dirty	D 074		

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D 074	Continued From page 5 it was. - There were often cobwebs behind [a named resident's] bed.	D 074		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews, the facility failed to assure one staff person was on the premises at all times that had completed within the last 24 months a course on Cardio-Pulmonary Resuscitation (CPR) and choking management, for 4 of 13 days on third shift from 11:00PM to 7:00AM. The findings are: Review of Staff A's personnel file revealed:	D 167		

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D 167	Continued From page 6 -No documentation of current CPR certification. -Hire date of 8/7/13 and currently a Supervisor/Medication Aide. Review of the facility employee third shift schedule for 10/1/15 through 10/13/15 revealed: -One Medication Aide/Supervisor and three personal care aides were routinely scheduled. -Either Staff A, Staff B, or Staff C were routinely scheduled as the Medication Aide/Supervisor. Interview with the Resident Care Coordinator on 10/15/15 at 3:15PM revealed: -Three personal care aides and one CPR qualified Medication Aide/Supervisor (either Staff A, Staff B, or Staff C) routinely worked third shift. -The Supervisor, Staff D, made the schedule. Interview with Staff D on 10/15/15 at 3:20PM revealed: -She routinely scheduled either Staff A or Staff B or Staff C to work third shift. -Staff A worked as the Medication Aide/Supervisor on third shift on 10/8/15, 10/10/15, 10/11/15, and 10/12/15. -The three personal care aides who worked on 10/8/15, 10/10/15, 10/11/15, 10/12/15 were not CPR certified. -The facility was "supposed to have a copy" of Staff A's CPR certification card but they had misplaced it. -Staff A had not been able to find the original CPR certification card. Interview with Staff A on 10/15/15 at 2:30PM revealed: -She was CPR certified and thought it would expire in 6 months. -She did not have a copy of the card with her. -She routinely worked from 7:00PM to 7:00AM as	D 167		

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D 167	Continued From page 7 the Medication Aide/Supervisor. Review of personnel records for Staff B and C revealed they had current CPR certification. Interview with the Administrator on 10/15/15 at 4:30PM revealed they would obtain a copy of Staff A's CPR card and fax it to the surveyor. As of 10/21/15, the facility did not provide any documentation that Staff A was CPR qualified. A Plan of Protection provided by the facility revealed: -The facility management will assure a minimum of one staff member with valid and current CPR training on the premises at all times. -To assure CPR coverage is provided at all times to all facility residents, the facility will schedule a CPR class as soon as a certified instructor is available. -Records of CPR certification will be maintained by the Business Office Manager and the Care Manager to assure availability of proof. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2015.	D 167		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this	D 465		

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D 465	Continued From page 8	D 465		

Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to assure third shift staffing hours met the special care unit staffing requirements based on census.

The findings are:

Review of the facility staff schedule for October 1, 2015 through October 13, 2015 revealed 1 Medication Aide/Supervisor and 3 personal care aides for third shift from 11:00pm to 7:00am.

Review of the daily census sheets for October 1, 2015 through October 13, 2015 revealed the following census (which did not include any residents out on therapeutic leave, in a rehabilitation facility or in the hospital):
10/1: 48
10/2: 50
10/3: 50
10/4: 50
10/5: 49
10/6: 48
10/7: 48
10/8: 49
10/9: 49
10/10: 49
10/11:49
10/12: 49
10/13: 49

Interview with the Resident Care Coordinator on

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D 465	Continued From page 9 10/15/15 at 3:15PM revealed: - They did not have a sufficient number of staff available who were willing to work third shift. - They had just re-hired a previous employee who began working on third shift on 10/14/15. - This re-hired staff would increase the third shift staffing to a total of 5 staff. (Five staff are required [1 staff for 10 residents] on third shift for a census of 50 residents in a special care unit.) - The facility did have some second shift staff who had stayed over after 11:00PM to help cover third shift, but that information was not "readily available." -A supervisor, Staff D, was in charge of the employee schedule. Confidential interview with one of three family members during the survey revealed: - It seemed there was not sufficient staff in the "late evening." - The facility needed "more help." - The residents needed more attention with personal care such as assistance with dental care. - The resident rooms needed to be cleaned more frequently. Interview with 3 third shift staff revealed the following duties were required: - Making rounds every two hours. - Laundry and then placing laundered items back in resident's rooms. - Routine cleaning of certain facility areas. - Assisting residents in the morning with getting up, toileting and dressing. - Third shift staff were supposed to take a one hour meal break but sometimes they only took 30 minutes so the floor could be covered and other staff could take a meal break. - They sometimes had residents who wandered in	D 465		

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D 465	Continued From page 10 the halls at night, but none on a routine basis. Interviews with 2 third shift staff revealed: - Recently the facility had only been scheduling a total of 4 staff for third shift. - They usually had 1 Medication Aide/Supervisor and 3 personal care aides on third shift. Interview with the Administrator on 10/15/15 at 3:00PM revealed she was not aware third shift was not staffed with sufficient hours to meet the rule requirements.	D 465		
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 interview and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Training On Cardio-Pulmonary Resuscitation. The findings are: Based on record review and interviews, the facility failed to assure one staff person was on the premises at all times that had completed within the last 24 months a course on Cardio-Pulmonary Resuscitation (CPR) and	D912		

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D912	Continued From page 11 choking management, for 4 of 13 days on third shift from 11:00PM to 7:00AM. [Refer to 10A NCAC 13F .0507 (Type B Violation).]	D912		