Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010007	A. BUILDING: ______ B. WING ______	C 04/12/2016

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D 000	Initial Comments The Adult Care Licensure Section completed a Complaint Investigation from 04/05/16-04/08/16 and 04/11/16-04/12/16.	D 000		
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: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to supervise 2 of 6 residents sampled (#1, #2) in the Assisted Living dining room during the supper meal in accordance with the facility's established procedures resulting in an incident between the two residents in which Resident #2 was injured in a manner causing death. The findings are: Review of the "Resident Notes" for Resident #2 dated 04/02/16 revealed: -"Found resident laying on dining room floor unconscious. Staff member stated that resident was assaulted by another resident and sent to ER (emergency room). Contacted family member, doctor, administrator." -There was no time documented in the note. Review of the Emergency Medical Services	D 270		

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(EMS) Patient Care Records Report dated 04/02/16 at 5:48pm.revealed:
-EMS was notified at 5:37pm.
-EMS was dispatched and en route to the facility at 5:39pm.
-EMS arrived at the facility at 5:46pm.
-EMS found Resident #2 lying on the floor "after being hit/pushed by another resident and falling to the floor."
-Resident #2 landing on his back and hit his head, "followed by 2 minutes or more of loss of consciousness."
-Resident #2 was awake, denied pain, and answered yes or no when asked a question.
-Resident #2 was "confused but has dementia and is normally confused and normally talkative."
-Resident #2 departed the facility with EMS at 5:54pm for transport to the ER.
-EMS arrived with Resident #2 at the ER at 6:10pm.

Interview with the Executive Director (ED) of the facility on 04/05/16 at 10:08am revealed:
-The ED was not in the facility at the time of the incident between Resident #1 and Resident #2 on 04/02/16.
-The ED was told by staff that Resident #2 shook a cane at Resident #1 while in the dining room.
-Resident #1 hit Resident #2 in the face, causing Resident #2 to fall backwards and hit his head on the floor.
-Resident #2 became unconscious.
-Resident #2 was transported to the emrgency room and "passed away Sunday morning" (04/03/16).

Review of Resident #2's current FL-2 dated 12/03/15 revealed:
-Diagnoses included dementia, diabetes, hypertension, coronary artery disease, and atrial

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fibrillation.
-Resident #2 was intermittently disoriented.

Review of the Resident Register dated 12/22/15 revealed:
-Resident #2 was admitted to the facility on 12/22/15.
-Resident #2 required assistance with dressing, bathing, nail care, ambulation, toileting, grooming, and getting in/out of bed.
-Resident #2 required assistance with orientation to time and place.
-Resident #2 was forgetful.

Review of the "Initial Resident Assessment Plan" for Resident #2 dated 12/25/15 revealed:
-Resident #2 had "occasional" bowel incontinence and was "daily" incontinent of bladder.
-Resident #2 was ambulatory with an assistive device and required limited assistance with mobility and transferring.
-Resident #2 required extensive assistance with bathing/showering and dressing.
-Resident #2 required limited assistance with cutting food and "supervision" with "feeding."
-Resident #2 was "sometimes disoriented."
-Resident #2 was "forgetful-needs reminders."
-Resident #2 was a wanderer.
-Resident #2 was "having a hard time adjusting to assisted living (AL) ...Resident is known to have increase [sic] confusion in evening similar to sundowners. Staff requires [sic] to supervise and redirect frequently."

Review of "Trauma History and Physical" from the local hospital dated 04/02/16 revealed:
-Resident #2 presented to the hospital "after being pushed by another resident, falling, and striking his head."
-The "chief complaint" was documented as

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"assault."
-A computerized tomography (CT) test of Resident #2's head performed at 04/02/16 at 8:48pm revealed Resident #2 had an "extensive bilateral subarachnoid hemorrhage" of the brain. (A subarachnoid hemorrhage is bleeding in the area between the brain and tissues covering the brain).
-The document was electronically signed by the physician and dated 04/02/16.

Review of the Neurosurgical Consult from the hospital dated 04/02/16 and electronically signed by the physician on 04/06/16 revealed Resident #2 had an "extensive closed head injury after fall"; "no surgical intervention warranted at this time."

Review of a the results of a second CT for Resident #2 dated 04/03/16 at 4:04am revealed:
-"Extensive subarachnoid blood ...has significantly increased from prior study."
-"Bilateral subdural hematomas" have increased.
-The document was electronically signed by the physician and dated 04/03/16.

Review of the hospital "Discharge Information" generated 04/06/16 revealed:
-Resident #2 was discharged from the hospital on 04/03/16 at 12:30pm.
-Resident #2's "discharge disposition" was documented as "expired."

Review of the facility's Accident/Injury Report dated 04/02/16 revealed:
-A dietary aide reported Resident #2 "was struck in the face by another resident and fell backwards hitting head on floor."
-Resident #2 was unable to arouse.
-Resident #2 was taken to the emergency room (ER) and hospitalized.

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-Resident #2 was transported to the ER by ambulance at 5:45pm on 04/02/16.
-The Accident/Injury Report was signed by the Executive Director (ED) and dated 04/02/16.

Review of the "Report of Death to DHHS" dated 04/04/16 and signed by the ED revealed:
-Resident #2 "was struck in the face by another resident, fell backwards, and hit head."
-Resident #2 was sent to the local hospital for evaluation and treatment on 04/02/16.
-"Violence" was documented as the "event related to or resulting in the resident's death."

Confidential staff interview revealed:
-Resident #2 exhibited wandering behaviors; "he was everywhere."
-Resident #2 was "not cognitively all there."

A second confidential staff interview revealed:
-Resident #2 required "extra supervision" because Resident #2 was not oriented and required reorientation and redirection "constantly."
The staff member recalled that Resident #2 had been found in four different (named) resident's rooms.

A third confidential staff interview revealed:
-Resident #2 "always" wandered.
-It was common for Resident #2 to wander around the dining room and sometimes wander into the kitchen.
-Staff had to keep "a close eye" on Resident #2. The ED and "everyone" else was aware of Resident #2's wandering.

A fourth confidential staff interview revealed:
-Resident #2 required redirection "constantly."

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-Resident #2 had been found by staff members in other residents' rooms.
-Resident #2 was not allowed to go out the front entrance door of the facility for safety reasons because Resident #2 might wander off or fall.
-Resident #2 got out of the front door of the facility in December 2015 or January 2016 and was found in the front parking lot of the facility.
-The staff member thought another resident's family member had found Resident #2.

A fifth confidential staff interview revealed:
-Resident #2 was confused and where he was or what he was supposed to be doing.
-Resident #2 would go into other resident's rooms.
-Resident #2 was not supposed to go out the front door of the facility because he would "wander off."
-Resident #2 exited the front door of the facility twice without staff knowledge.
-"It seems like he (Resident #2) should have been" in the memory care unit.

Interview with the Executive Director (ED) on 04/05/16 at 10:08am revealed:
-A Dietary Aide was the first staff member to respond to Resident #2 on 04/02/16.
-There was one Supervisor and two Medication Aides who also responded to the incident.

Interview with the ED on 04/06/16 at 10:15am revealed:
-The ED expected Dietary Aides (DAs), Personal Care Aides (PCAs), and Medication Aides (MAs) to supervise residents in the dining room at meals.
-The ED expected a PCA to be in the dining room during all meals.
-THe ED e expected the MA's to work their way

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down the hall to the dining room when administering medications around the meal times.
-All staff were trained at hire on the facility expectation for supervision of residents in the dining room during meals.
-All staff received training on caring for residents with dementia and handling behaviors; all staff received the same training.

Observation of the dining room during the supper meal in the Assisted Living (AL) section of the facility on 04/05/2016 from 5:45pm to 6:15pm revealed staff were in the dining room during the observation period.

Observation of the breakfast meal in the AL dining room on 04/06/16 from 07:50am-08:18am revealed there were two PCA staff members standing in the dining room during the observation period.

Observation of the lunch meal in the AL dining room on 04/07/16 at 12:06pm revealed there was one PCA staff member standing in the AL dining room and one MA standing at the half wall outside of the AL dining room.

Interview Resident #2's family member/Power of Attorney (POA) on 04/08/16 between 3:00pm and 5:15pm revealed:
-The POA visited Resident #2 mostly on weekends.
-When visiting Resident #2, the POA did not observe staff in the AL dining room to monitor residents during meals.
-When dietary staff went into the kitchen for food, there were not any staff members present in the AL dining room to watch residents.
-The POA recalled staff were present in the Memory Care Unit (MCU) dining room at meals.

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Interview with Resident #2's family member on 04/08/16 between 3:00pm and 5:15pm revealed the family member had not observed NA, MA, or PCA staff in the AL dining room during all meals.

Interview with two other members of Resident #2's family on 04/08/16 between 3:00pm and 5:15pm revealed:
-The family members visited Resident #2 on 04/02/16.
-The family members were in the AL dining room with Resident #2 at 4:34pm on 04/02/16 and did not observe any staff members present in the AL dining room at that time.
-After the family members left the facility on 04/02/16, the family members had a discussion about the lack of supervision of residents in the AL dining room.

Review of Resident #1's current FL-2 dated 05/08/2015 revealed diagnoses included Subdural Hematoma, Hepatic Lobectomy, Glaucoma, History of Drug Abuse, History of Alcohol Abuse, Vitamin Deficiency, Gastro-esophageal Reflux Disease, Hypertension, and Coronary Artery Disease.

Interview with the facility Executive Director (ED) on 04/05/2016 at 10:05am revealed:
-Resident #1 punched Resident #2 on the left side of face during dinner service in the facility dining room on 04/02/2016 after Resident #2 shook a cane at Resident #1.
-Resident #1 was currently seeing the Psychiatrist either bimonthly or monthly.
-Resident #1 was currently seeing the Psychotherapist weekly.

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Review of Med Room Fax Reports to Resident #1's Primary Care Physician (PCP) revealed:
-On 04/02/2015, Resident #1 punched a dietary staff in the arm for not giving him ice cream quick enough.
-On 05/02/2015, Resident #1 "was aggressive toward another resident. Mental status has changed. This is a second [occurrence]. Requesting resident to be sent out."
-On 04/02/2016, Resident #1 "physically assaulted another resident and was discharged."

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 01/31/2008.

Review of the Resident Assessment Plan for Resident #1 completed 02/10/2016 revealed:
-Resident #1 was assessed to be verbally abusive, physically abusive, and disruptive behavior/socially inappropriate.
-There had been no inappropriate behaviors noted lately.
-Resident #1 was currently receiving medications for mental illness/behavior.
-Resident #1 was currently receiving Mental Health Services.
-Safety measures to implement included monitor behaviors.

Interview with a Resident on 04/05/2016 revealed:
-A resident "had a problem in the dining room."
-A "man put a walker near him."
-"[Resident #1 named] was sitting down and the other man was standing up with walker in his face."
-The resident did not remember what Resident #1 said to Resident #2 but remembered Resident #1

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saying "something like don't put that in my face but the man did."
-Resident #1 "pushed him down, the man fell and hit his head on floor."
-"Got along good with [Resident #1 named]."
-"Never seen [Resident #1 named] hit anybody."

Interview with a second Resident on 04/05/2016 revealed:
-Resident #1 was gone from the facility.
-Resident #1 pushed Resident #2 on the floor in the dining room.
-Resident #2 had a cane in his hand, and raised it up to Resident #1.
-Resident #1 told Resident #2 to sit down.
-Resident #1 got up and pushed Resident #2.

Interview with a Medication Aide on 04/08/2016 at 9:50am revealed:
-The MA was not aware of any residents whose behavior the staff had to monitor.
-The staff "kept an extra eye " on Resident #3 because he was a wanderer.
-The MA denied knowledge of any specific plan for monitoring Resident #1's behaviors.

Review of a Provider Visit Form for Resident #1 dated 03/23/2016 revealed:
-The resident was seen for follow up psychiatric care.
-The resident's mood was "good" and there were "no conflicts".

Interview with the Psychotherapist on 04/06/2016 at 12:05pm revealed:
-Resident #1 was being followed for depression, irritability, and coping.
-When Resident #1 hit somebody in April 2015, the resident was seen for therapy.
-The Psychotherapist had never witnessed

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Resident #1 presenting with aggressive behavior.
-The Psychotherapist had seen Resident #1 irritable, and was aware Resident #1 had arguments.
-Resident #1 would get irritable about placement times, wanting to get his money, wanting to get food items out of the vending machine and not having the money.
-Resident #1's character was very quiet, very little to say unless the resident was asked directly.

Confidential interview with a resident revealed:
-The resident was present in the AL dining room on 04/02/16 and observed the incident between Resident #1 and Resident #2.
-The cook was in the kitchen at the time of the incident.
-A NA or MA was supposed to "watch" residents during meals but only one dietary aide was in the dining room "serving coffee" at the time of the incident.
-The the dietary aide should be asked about being in the dining room at the time of the incident "to be sure" the dietary aide was present.
-One staff member [named] arrived after the incident had already taken place and that staff member called other staff members for help.

Confidential interview with a second resident revealed:
-There were usually two dietary staff members present in the AL dining room during meals: one served meals and one served drinks.
-NA, PCA, MA staff "sometimes come in (the AL dining room during meals) but not usually."
-The resident was present in the dining room when the incident occurred between Resident #1 and Resident #2 on 04/02/16.
-"I don't think a single staff was in there"when the incident occurred between Resident #1 and

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Resident #2 on 04/02/16.
-"Staff came running in about a minute after" (the incident).
-"A couple of aides" and kitchen/dietary staff entered the AL dining room "right after" the incident occurred.

Confidential interview with a third resident revealed:
-The resident was in the AL dining room when the incident occurred between Resident #1 and #2 and observed the incident.
-"Nobody was in there to help him" (Resident #2).
-Staff were supposed to "observe" the residents in the dining room "so nothing like that happens."
- "I know it's a rule that there is supposed to be somebody in there" (the dining room).

Confidential interviews with twelve different staff members revealed:
-Ten of the twelve staff members reported it was facility procedure for at least one Nursing Assistant (NA), Personal Care Aide (PCA), or Medication Aide (MA) to monitor the facility dining rooms during all meals.
-NAs and PCAs were supposed to stand in the dining room at meals to monitor for choking, make sure residents did not fight, cut food, and open packages.
-It was standard procedure for one PCA to stand in the dining room and "watch" residents.
-PCAs were supposed to supervise and monitor residents during meals and dietary staff were supposed to serve the meals to the residents.
-Staff reported that the facility procedure to have NA, PCA, or MA staff monitor residents during meal time was not followed at all meals.
-Staff were received training on the procedure for supervision of residents in the dining room at their time of hire.

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-Staff reported it was standard procedure for dietary staff to use the intercom system to call PCA, NA, or MA staff for assistance in the AL dining as needed.
-Staff "noticed" on Monday,(04/04/16) that NA, PCA, and MA staff began monitoring all meals in the AL dining room. Prior to 04/04/16, only dietary staff were consistently in the AL dining room during meals

Confidential interviews with staff members on duty at the time the incident occurred on 04/02/16 revealed:
-Two staff were alerted to the incident on 04/02/16 by hearing screams coming from the AL dining room.
-Four staff reported they did not observe a NA, PCA, or MA in the Assisted Living (AL) dining room upon entering the AL dining room and finding Resident #2 on the floor.
-Staff reported there was one Dietary Aide (DA) staff member present in the AL dining room when the incident occurred between Resident #1 and Resident #2 on 04/02/16.
-Staff reported there was not any staff at all present in the AL dining room at the time of the incident on 04/02/16.
-Staff reported the PCA staff on duty was in and out of the AL dining room at the time of the dinner meal on 04/02/16.
-Staff reported the PCA who was responsible for monitoring the AL dining room at the time of the incident on 04/02/16 was not in the AL dining room.

Interview with the ED on 04/06/16 at 10:15am revealed:
-The ED was told by staff that when the incident occurred on 04/02/16 between 5:20 and 5:30pm, the PCA was in and out of the dining room

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bringing other residents to the dining room for the meal.
-The MA was just finishing the medication pass and was coming around the corner of the hallway toward the AL dining room when the incident occurred.
-The ED was told that half of the assisted living residents were in the dining room when the incident occurred on 04/02/2016.

Interview with the ED on 04/07/16 at 12:58pm revealed:
-The facility did not have a written policy on supervision of residents while in the dining room.
-The ED expected residents to be supervised during all meals by the dietary staff, PCA, and MA staff.
-There were two PCAs scheduled: one PCA was supposed to be getting residents to the dining room and the second PCA was supposed to be in the dining room for supervision.
-The ED expected the MA to start the medication pass on the adjacent hall and work towards the dining room area and park the medication cart outside of the dining room at meals.
-The ED expected dietary staff to be in the dining room at meals to serve food.

Interview with the ED on 04/07/16 at 3:30pm revealed the ED expected the supervision in the dining room to consist of the PCAs and MAs making sure everyone was eating, monitoring residents for choking, and monitoring residents' behaviors.

____

Review of the Plan of Protection submitted by the facility and dated 04/06/16 revealed:
-If a behavior is identified, the resident will immediately be removed from the area.

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-An attempt will be made to de-escalate or re-direct the resident.
-The physician/mental health provider will be notified.
-The resident will be placed on acute charting for 72 hours.
-The facility will implement the mood and behavior tracking form.
-The mental health provider will be notified to provide additional training on identifying difficult behaviors and interventions.
-Training will be ongoing.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 12, 2016.

D 273 — 10A NCAC 13F .0902(b) Health Care — D 273

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:
TYPE A2 VIOLATION

Based on record reviews and interviews, the facility failed to notify the physician of the health care needs of 1 of 6 residents sampled (#2) related to behaviors exhibited by the resident and failed to notify the physician about the recommendation by a psychotherapist that the resident was not able to safely function in assisted living.

The findings are:

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Interview with Resident #2's family members, including his Power of Attorney (POA) on 04/08/16 at 3:00pm revealed:
-Resident #2 and Resident #6 were married, lived together at their private residence, and received support and assistance from family members until Resident #6 was injured and required rehabilitation services.
-During the time Resident #6 was receiving rehabilitation services, Resident #2 was moved from home into the Assisted Living (AL) section of the facility (on 12/22/15).
-When Resident #6 was discharged from rehab, Resident #6 was also moved into the AL section of the facility (01/25/16).
-Resident #2 and Resident #6 initially lived together in the same room of the AL section of the facility until Resident #6 was moved to the Memory Care Unit (MCU) of the facility (on 03/01/16).

Review of Resident #2's current FL-2 dated 12/03/15 revealed:
-Diagnoses included dementia, diabetes, hypertension, coronary artery disease, and atrial fibrillation.
-Resident #2 was intermittently disoriented.

Review of the Resident Register dated 12/22/15 revealed:
-Resident #2 was admitted to the facility on 12/22/15.
-Resident #2 required assistance with dressing, bathing, nail care, ambulation, toileting, grooming, and getting in/out of bed.
-Resident #2 required assistance with orientation to time and place.
-Resident #2 was forgetful.

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Review of the "Initial Resident Assessment Plan" for Resident #2 dated 12/25/15 revealed:
-Resident #2 was ambulatory with an assistive device and required limited assistance with mobility and transferring.
-Resident #2 required extensive assistance with bathing/showering and dressing.
-Resident #2 required limited assistance with cutting food and "supervision" with "feeding."
-Resident #2 was "sometimes disoriented."
-Resident #2 was "forgetful-needs reminders."
-Resident #2 was a wanderer.
-Resident #2 was "having a hard time adjusting to assisted living (AL) ...Resident is known to have increase [sic] confusion in evening similar to sundowners. Staff requires [sic] to supervise and redirect frequently."

Interview with the Executive Director (ED) on 04/06/16 between 10:15am and 10:50am revealed:
-Resident #2's spouse, (Resident #6) was admitted to the facility 01/25/16.
-Both Resident #2 and Resident #6 resided together in the Assisted Living (AL) area of the facility for about a month.
-When Resident #6 was moved into the facility, Resident #2 took on a calmer role and Resident #6 took the more aggressive role by banging on tables and doors, screaming, cursing, and verbally abusing Resident #2.
-Resident #6 was moved to the Memory Care Unit (MCU) of the facility on 03/01/16.
-The ED completed Resident #2's Assessment and Care Plan after Resident #2 had been living in the facility for 3 days.

Review of the Resident Notes revealed:
-12/26/16: Resident #2 did not have any complaints. Staff had been re-directing Resident

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#2 "due to still going in other resident rooms ..."
-12/28/16: Resident #2 was "talking inapropriate [sic] to staff and touch [sic] staff in inappropriate [sic] places. Resident was redirected back to his room and was asked not to touch or talk inappropriate [sic] ..."

Review of correspondence between Resident #2's family member/Power of Attorney (POA) and the ED dated 01/07/16 revealed Resident #2 was found sleeping in a chair in another resident's room and "frightened her."

Review of correspondence between Resident #2's and Resident #6's Power of Attorney (POA) and the ED dated 01/26/16 revealed:
-Resident #2 and Resident #6 were "very disoriented today."
-Resident #2 pushed Resident #6 ' wheelchair into a door, hitting Resident #6's leg.
-"We keep trying to redirect him to not push her in her wheelchair."

Interview with the ED on 04/06/16 at 10:15am revealed the ED had talked to Resident #2's physician about his medications and obtained referral, evaluation, and treatment for mental health services to address the behaviors Resident #2 was exhibiting.

Review of the Reason for Visit/Request/Physician Orders form dated 12/28/15 revealed:
-The ED notified Resident #2's Primary Care Physician (PCP): Resident #2 exhibited "wandering, agitation, and increased confusion."
-The ED requested the PCP refer Resident #2 to the facility's contracted outside mental health provider to "evaluate behaviors and treat as necessary."
-The PCP responded "agree with referral as

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above."
-The document was signed by the PCP and dated 12/30/15.

Review of the "Request for Healthcare Services Patient Authorization" revealed:
-Resident #2's POA signed the request for psychiatry and psychotherapy for Resident #2.
-The ED signed as a witness on the document.
-The document was dated 12/28/15

Review of the "Psychotherapy Initial Visit" with a service date of 01/20/16 revealed:
-The chief complaint was "confusion."
-Resident #2 was "cooperative" and "friendly."
-Resident #2 "wanders halls repeatedly asking for the location of the bathroom."
-Resident #2 required "prompting for all tasks, including to eat meals (e.g need reminders for each bite)."
-Resident #2 was unable to function well in his current environment.
-Resident #2's overall score was 6/30 on the Montreal Cognitive Assessment (MoCA). (MoCA is a thirty point screening tool used by health professionals to screen and assess for cognitive function).
-In the section titled "Treatment Recommendations", the box beside "psychiatric medication management" was marked.
-"Client is not appropriate for psychotherapy due to his severe cognitive impairment. He is not currently evidencing any agitation or distress. He does not appear able to function safely in ALF given the level of his impairment, so would benefit form a placement targeted toward individuals with memory problems."
-The document was electronically by the psychotherapist and dated 01/22/16.

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Interview with Resident #2's psychotherapist on 04/06/16 at 12:10pm revealed:
-The psychotherapist had only evaluated Resident #2 on one occasion.
- Resident #2 was not oriented and was unable to perform activities of daily living (ADLs).
-The psychotherapist referred to Resident #2's MoCa score and the "Initial Psychotherapy Visit" dated 01/20/16 which noted Resident #2 was better suited for the MCU.

A second, telephone interview with the contracted psychotherapist on 04/07/16 at 4:28pm revealed:
-Based on the provider's observation of Resident #2 and Resident #2's behaviors presented to the provider from the staff, Resident #2 was not oriented, could not figure out where his room was, and he could not eat or find the restroom without reminders; Resident #2 could not "manage his day."
-In hindsight, the provider may not have chosen to use the word "safe" in the "Initial Psychotherapy Visit" note dated 01/20/16 because Resident #2 was not a safety threat to himself of others.
-The psychotherapist's recommendation for MCU was based on Resident #2's ability to function in AL and the fact that he could not perform his ADLs.
-The psychotherapist recommended that Resident #2 was better suited for the MCU because the MCU was a "smaller space" and Resident #2 would receive more individual attention and supervision in the MCU.
-The psychotherapist did not write orders for MCU; the PCP was responsible for writing orders for MCU.
-The psychotherapist did not usually notify the PCP of her recommendations and did not know if Resident #2's PCP was aware of her

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recommendation for Resident #2.
- The psychotherapist did not know the facility's policy on notifying the PCP of her recommendations.

Interview with the ED on 04/06/16 at 10:50am revealed:
-The psychotherapist completed an exit conference with facility staff (Medication Aide, Supervisor, or ED) on the date of her visit and sent her notes for each resident to the facility later.
-It was facility procedure to read the psychotherapist's notes and then file the notes in the resident's record.

Interview with the ED on 04/07/16 at 3:30pm revealed:
-The ED notified the "nurse, [name]" at Resident #2's PCP office about the psychotherapit's recommendation; "so the doctor was aware."
-The ED did not know the date that she notified the nurse at PCP office about the psychotherapist's recommendation.
-The ED was busy and "did not write everything down."
-The ED would check to see if she documented the date she (the ED) notified the PCP on her calendar.
-The ED "talked" to Resident #2's family about the psychotherapist's recommendation but did not know the date she talked to the family.
-The ED would check her calendar to see if she documented when she talked to Resident #2's family.

Review of the Resident Notes dated 03/06/16 revealed Resident #2 was found in the "dr. office sitting on the weight chair voiding and having a bowel movement ...staff explained to resident that

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that was not a bathroom ..."

Review of the Resident Notes dated 03/10/16 revealed
-"Staff had had to redirect resident all morning."
-Resident #2 was assisted to the restroom by staff and was found five minutes later sitting in the shower chair "making a bowel movement."

Interview with the ED on 04/06/16 at 10:50am revealed the ED thought Resident #2 had been started on a new medication on 03/17/15 which could have caused him to have diarrhea and incontinence.

Review of Resident #2's physician orders revealed there was a new order dated 03/14/16 for Tanzuem 30mg. subcutaneously once a week (Tanzuem is a medication used to treat diabetes).

Interview with the ED on 04/07/16 at 3:30pm revealed:
-Resident #2's physician was not notified of his toileting behaviors.
-The ED did not consider Resident #2 to be having inappropriate toileting behaviors because Resident #2 went into the bathroom, but was not able find the toilet.
-There was only one incident when Resident #2 urinated in an inappropriate place and one incident when Resident #2 defecated in an inappropriate place.

Confidential staff interview revealed:
-Resident #2 was "a very nice man" who liked to walk and follow staff around.
-Resident #2 wandered and tried to go into other residents' rooms.
-Resident #2 was "not cognitively all there."
-Resident #2 was "very flirtatious" and

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"sometimes would say nonsense things."
-The staff member had not observed Resident #2 exhibit any aggressive behaviors to other residents and was easily re-directed.

A second confidential staff interview revealed:
-Resident #2 required redirection "constantly."
-Resident #2 had been found by staff members in other residents' rooms.
-Resident #2 was not allowed to go out the front entrance door of the facility for safety reasons because Resident #2 might wander off or fall.
-Resident #2 got out of the front door of the facility in December 2015 or January 2016 and was found in the front parking lot of the facility.

A third confidential staff interview revealed:
-Resident #2 was confused and liked to follow people around.
-Resident #2 was unsure where he was or what he was supposed to be doing.
-Resident #2 would go into other resident's rooms.
-Resident #2 was not supposed to go out the front door of the facility because he would "wander off."
-Resident #2 exited the front door of the facility twice without staff knowledge.
-"It seems like he (Resident #2) should have been" in the memory care unit.

A fourth confidential staff interview revealed:
-Resident #2 was confused; Resident #2 knew who he was but did not know where he was.
-Resident #2 wandered "constantly" and went into the kitchen and other residents' rooms.
-The staff member was told by another staff member that Residents #2 was going to be moved from the Assisted Living (AL) area of the facility into the Memory Care Unit (MCU).

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-Resident #2 had not been moved from AL to MCU.
-The staff member did not know why Resident #2 was not moved to MCU.

A fifth confidential staff interview revealed:
-Resident #2 wandered around the dining room and sometimes wandered into the kitchen.
-The ED was aware of Resident #2's wandering.
-The ED had told staff that Resident #2 and Resident #6 were going to be moved from AL to MCU on 03/01/16.
-"We were all counting down" (until Residents #2 and #6 were moved to the MCU).
-Resident #6 had "episodes" and was moved to MCU on 03/01/16.
-Resident #2 was not moved to MCU; the ED told staff she (the ED) wanted to get Resident #6's medications "straightened out first" before moving Resident #2 to the MCU.

Telephone interview with the Licensed Practical Nurse (LPN) and Registered Nurse (RN)/Nurse Manager at Resident #2's PCP office on 04/07/16 at 4:06pm revealed:
-The LPN documented all calls received from the facility in each patient's record.
-The LPC scanned all documents received from the facility by fax into each patient's record.
-The LPN reviewed Resident #2's record and noted that the facility requested a referral for Resident #2 to mental health services and the PCP wrote orders on 12/30/15 for the referral.
-The PCP office did not have any other documentation or notification on file for Resident #2 from the facility regarding Resident #2's psychotherapy or psychiatry evaluation or treatment.
-The LPN did not recall being notified by the ED by telephone or fax about Resident #2's

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psychotherapist's recommendation.
-If the ED had notified the PCP office of the psychotherapist's recommendation, there would be documentation in Resident #2's record.
-The RN/Nurse Manager reviewed Resident #2's record from December 2015-April 2016 and did not find any correspondence or notification received from the facility regarding Resident #2's psychotherapy or psychiatry evaluation/treatment or the recommendation of the psychotherapist.

Telephone interview with Resident #2's family member/POA on 04/12/16 at 10:30am revealed:
-The POA received notification from a facility staff member by telephone that Resident #2 had gotten out of the front door of the facility around 01/07/16 and had fallen in the parking lot.
-The POA expected Resident #2 "not to be in the parking lot."
-"The whole reason for putting them [Resident #2 and Resident #6] in the facility was the keypad" which provided saftey at the doors.
-The POA was not notified by the ED or other facility staff about the psychotherapist's recommendation that Resident #2 did not appear to be able to function in AL and was better suited for MCU.
-The POA expected to be "advised" by the facility about Resident #2's needs and plan of care.
-If the POA had been made aware of the psychotherapist's recommendation, the POA would have assured Resident #2's PCP was notified.
-The POA had a discussion with the ED within the first 30 days of Resident #2's admission to the facility about the possibility that Resident #2 may require the increased supervision provided in the MCU but was told that it was common for residents to experience a transition period of approximately 30 days.

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-Resident #2 seemed to transition appropriately to the AL section and there was not a plan to transfer Resident #2 to MCU.
-The POA had a discussion with the ED about separating Resident #2 and Resident #6.

Review of correspondence between the ED and Resident #2 and Resident #6's POA dated 02/29/16 revealed:
-Resident #6 was "still continuing with behaviors" and would be moved to the MCU on 03/01/16.
-Resident #2 would be monitored to see how he was "going to adjust" with Resident #6 in MCU.

Interview with the ED on 04/07/16 at 3:30pm revealed:
-The ED looked at each resident individually when considering placement in AL and MCU.
-The ED considered each resident's diagnoses, ability to perform ADLs, and whether the resident was adjusting to living in the facility.
-The only reason the ED considered housing Resident #2 in the MCU was because the ED thought Resident #2 would benefit from extra "TLC."
-When the ED assessed Resident #2 "he did not need" MCU.
-Resident #2's wife (Resident #6) "needed" to be in the MCU; Resident #2 and Resident #6 "needed to be separated."
-The ED had a discussion with Resident #2 and Resident #6's family in February (2016) about their plan of care and determined Resident #2's current plan of care would not be changed and he would continue to be monitored.

Interview with Resident #2's family members on 04/08/16 between 3:00pm and 5:15pm revealed:
-The family had shared their concerns with multiple facility staff members (a named

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Supervisor, a MA, the Business Office Manager (BOM), and the ED) about staff failing to check on Resident #2, staffing concerns, lack of supervision at the facility's front desk and having to wait 20 minutes for staff to answer the door for the family to enter the facility, Resident #2 being found unshaved, staff "talking gruffly" to Resident #2, and Resident #2's room being found dirty.
-Staff (supervisor, BOM, and ED) told the family they would correct their concerns; the family was told "we'll take care of that."
-If the ED had any safety concerns or thought Resident #2 need to be in the MCU "why didn't she let us know?"

Interview with the ED on 04/12/16 at 2:50pm revealed:
-The ED discussed moving Resident #2 to the MCU with the POA in February (2016) and the family was not in agreement with moving Resident #2 to the MCU.
-Resident #2 "was fine" living in the AL section of the facility and was "finally" oriented to his room after Resident #6 was moved to MCU.
-Resident #2's new roommate "took him under his wing."

Interview with the ED on 04/06/16 at 10:15am revealed:
-The ED would not have kept Resident #2 in AL section of the facility if the ED felt Resident #2 was unsafe in AL.
-The ED made the decision to keep Resident #2 in the AL section of the facility after observing Resident #2 interact with his wife (Resident #6).

Telephone interview with Resident #2's PCP on 04/07/16 at 1:33pm revealed:
-Resident #2 had dementia and anxiety and had been prescribed medication for those diagnoses.

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-The PCP last evaluated Resident #2 on 03/14/16 for elevated blood sugars; Resident #2 was "jovial" and knew who his children were during that visit.
-Resident #2 had problems with his short term memory, had declined over the past few years, and couldn't care for himself so he was admitted to the AL facility.
-The facility notified the PCP of Resident #2 being confused on 12/28/15 and the PCP wrote an order on 12/30/15 to refer Resident #2 to the facility's contracted mental health provider.
-The PCP expected Resident #2 to be confused because Resident #2 had dementia.
-The facility had not notified the PCP that Resident #2 was exhibiting other behaviors after 12/28/15.
-The facility had notified the PCP (after 12/28/16) that Resident #2 had fallen and had elevated blood sugars.
-The facility was usually good about notifying the PCP; the PCP did not understand why the facility did not notify him of Resident #2's inappropriate toileting or sexually inappropriate behaviors.
-The PCP expected to be notified by the facility if Resident #2 was having behavior problems, improper toileting, or change in status.
-The PCP was "dependent" on the facility to notify the PCP of changes in Resident #2's condition.
-The PCP was not notified of the psychotherapist's recommendation that Resident #2 was not safe or appropriate for AL.
-The PCP expected to be notified by the facility that the psychotherapist recommended Resident #2 was better suited for MCU.

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Review of the Plan of Protection dated 04/08/16 revealed:
-The facility would "immediately" implement a

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tracking form/system to ensure all orders/recommendations received from licensed providers had been followed through and documented in the Resident Notes.
-The Care Managers and Administrator would be responsible for monitoring the tracking system.
-The facility would conduct a chart audit beginning 04/11/16 to ensure the residents health care needs for referral and follow up had been met.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 12, 2016.

D 338 — 10A NCAC 13F .0909 Resident Rights — D 338

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 1 of 6 residents (#5) sampled was treated with dignity and respect as evidenced by staff refusing to change Resident #5's soiled bed linen, requiring the resident to sit in a chair, and speaking to the resident in a disrespectful manner after episodes of incontinence.

The findings are:

Review of Resident #5's current FL-2 dated

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02/09/16 revealed:
-Diagnoses included unspecified debility, gait abnormality, muscle weakness, obesity, insomnia, chronic pain, schizophrenia, depression, anxiety, and hypertension.
-Resident #5 was incontinent of bowel and bladder.
-Resident #5 was semi-ambulatory.

Review of Resident #5's most current "Resident Service Plan" dated 04/13/15 revealed:
-Resident #5 required extensive assistance with toileting.
-Resident #5 was "daily" incontinent of bladder.
-Resident #5 was occasionally incontinent of bowel "(less than daily)."
-Resident #5 was ambulatory with an assistive device.
-Resident #5 had "limited" range of motion and strength in her upper extremities.

Observation of Resident #5 on 04/05/16 at 11:50am revealed:
-Resident #5 was in a wheelchair on the 300 hall.
-Resident #5 was shuffling her feet to propel the wheelchair.
-Resident #5 had oxygen intact by nasal cannula.
-Resident #5 had a Reid sleeve on her left hand/arm. (A Reid sleeve is a compression device used in the treatment of swelling in the extremities).
-Resident #5 was dressed for the season.

Observation on 04/06/16 at 11:12am revealed:
-Resident #5 was sitting in her room on the right side of her specialty hospital bed.
-Resident #5 had oxygen intact by nasal cannula.
-The oxygen concentrator was turned on and adjusted to deliver 2 liters of oxygen per minute.
-Resident #5 had a Reid sleeve on her left upper

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extremity.
-There was a sign posted above the head of Resident #5's bed which read Resident #5 required two person transfer.

Interview with Resident #5 on 04/06/16 at 11:12am revealed:
-Resident #5 wore oxygen at all times.
-Two staff members did not assist her to transfer "usually."
-Staff assisted Resident #5 with bathing, washing her hair, dressing, and toileting.
-Resident #5 was able to walk, but "not far."
-Staff answered her call bell "pretty good."
-Staff "sometimes" administered Resident #5's scheduled 8:00am and 4:00pm medications late.
-Resident #5 had not discussed her concerns with the Executive Director (ED) of the facility.
-Resident #5 had told her family member about her concerns and notified that family member whenever she experienced concerns or problems.

Observation of Resident #5 on 04/08/16 at 11:15am revealed Resident #5 got out of bed with the use of her walker, walked a few steps with the walker, and pivoted onto the chair scale with minimal assistance from staff.

Telephone interview with Resident #5's family member on 04/11/16 at 4:10pm revealed:
-Resident #5 was incontinent.
-Staff woke Resident #5 from sleep every two hours to "make her walk to the bathroom so she won't wet the bed."
-The family member was concerned that Resident #5 was "having a lot of problems" with a Personal Care Aide (PCA), Staff A.
-Staff A "punishes" Resident #5 by refusing to change her bed linen when it was wet with urine.

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-The problem had "been going on as long as I can remember."
-Staff A "gets mad at her (Resident #5) and made her sit up in the chair four to five hours if she wets the bed."
-Staff A waited all day or until the next shift came on duty to change Resident #5's soiled bed linen.
-There had been "about 10" instances when the family member visited Resident #5 and found Resident #5 sitting in the chair because her bed linen was "wet."
-The bed linen was wet only when Staff A was caring for Resident #5.
-The last time the family member made that observation was "last Tuesday" (04/05/16).
-"I don' t think that's right."
-"That's abuse."
-The family member was unsure if Resident #5 had told the ED about Staff A.

Interview with Resident #5 on 04/12/16 at 09:37am revealed:
-Resident #5 thought staff was supposed to provide her assistance with toileting.
-Staff used to toilet her every two hours which included waking her up every two hours to go to the bathroom but stopped "two or three weeks ago."
-"I think they were trying to stop me from wetting the bed."
-"It aggravated me" and caused Resident #5 to lose sleep.
-Resident #5 was not sure of the time frame that staff were waking her up every two hours for toileting, but "it was a while."
-Resident #5 did not know why staff stopped waking her from sleep to go to the bathroom but thought maybe it was because she told them when she was wet and needed to be changed.
-Staff A would not change Resident #5's bed linen

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when she had an incontinent episode that wet the bed.
-Staff A told Resident #5 "since you wet the bed you've got to get up to the chair so I can change the bed."
-Staff A left Resident #5 in the bedside chair and then left the wet bed linen on the bed "for hours" or until another staff took over.
-Sitting in the bedside chair "feels ok for an hour or so" but after that, the chair was "very uncomfortable."
-Resident #5 could not get out of the chair and return back to the bed when she wanted to because the bed linen was wet.
-Staff A told Resident #5 "you are lazy" and "you did it on purpose" (wet the bed).
-Staff A told Resident #5 "you laid there and peed on yourself."
-Staff A was the only staff member that required Resident #5 to change her own disposable brief.
-"I can do it, but it takes me a long time" and made her tired.
-All of the other staff provided her with toileting assistance whenever she asked.
-Resident #5 did not know why Staff A "accuses" her of wetting the bed on purpose; "I can't help it."
-Resident #5 did get "irritated" with the staff members "a long time ago" (unsure of the date) and would not get out of the bed to go to the bathroom.
-Resident #5 had not refused to get out of bed to go the bathroom after that incident.
-Resident #5 told her family member about Staff A, but did not notify any other staff or the ED about Staff A.
-"There is no reason to tell anyone else because if I tell anyone then [Staff A] will think of some other way to punish me."

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Review of the Resident Notes dated 10/31/15 revealed:
-"Resident (#5) is refusing to get out of bed to toilet herself."
-"Aides are going to resident's room every 2 hours to do rounds and resident refuses to get up."
-"Resident is voiding on herself and all over her bed and then is arguing with staff when they can't come immediately and change her bed."
-"Med-Tech spoke with resident and explained to her that if she toileted herself when aides did Q (every) 2 hr. rounds than [sic] she would not void on her bed."
-"The resident stated that staff was going to do what she said and when she wanted it."
-"The Med-Tech also told the resident that when the aide is giving a shower or with another resident they couldn't stop what they were doing to change her bed."
-"The resident stared that, that [sic] is what we are here for to be at her "beck and call."
-"The Med-Tech made the resident aware that we have a lot [sic] of residents that need our time and assistance and we had to make ourselves available to there [sic] needs as well."
-"Will continue to monitor."

Review of the Resident Note revealed there was no other documentation related to Resident #5's toileting or changing of bed linen.

Review of Resident #5's physician orders revealed there were no physician orders for a toileting regime or to wake Resident #5 from sleep every two hours to be toileted.

Interview with Staff A on 04/12/16 at 9:15am revealed:
-Staff A was employed at the facility as a Personal

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D 338	Continued From page 34 Care Aide (PCA). -Resident #5 required assistance with showering, changing her "pull up" and changing her pants. -"Sometimes she wets." -Staff A helped Resident #5 with "whatever she needs." -Resident #5 "knows if she is wet or dry." -Resident #5 would "change herself" if Staff A got her brief ready for her. -It was facility "policy" to check incontinent residents every two hours. -PCAs were responsible for changing and providing incontinence care to incontinent residents. -PCAs were responsible for changing resident's bed linen when soiled. -Staff A had no knowledge of any resident in the facility having a specified toileting program ordered by a physician. -Resident #5 did not have any skin breakdown but thought she had a history of a "sore" on her bottom. -Staff A awakened incontinent residents from sleep every two hours to check and change them. -Staff A awakened Resident #5 from sleep to go to the bathroom every two hours whenever she (Staff A) was assigned to Resident #5's hall. -When/if a resident did not want to get up at the two hour toileting check, Staff A would "come back to them" after checking on the next resident. -It was not facility procedure for PCAs to document two hour incontinent checks or when a resident's bed linen was changed. -Resident #5 "lays in bed all day; she is able to walk but wants to lay in bed." -Resident #5 did not like to roll herself to the dining room or sit up in the chair. -Resident #5's bed linen was changed whenever Resident #5 asked for it to be changed or whenever she said she was wet.	D 338		

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-Staff A did not recall the last time she changed Resident #5's bed linen.
-Staff A had not observed any facility staff member or any management member talking rudely or disrespectfully to any resident.

Observation on 04/12/16 at 09:30am revealed Resident #5's skin was intact on her buttocks and her disposable brief and bed linen were dry.

Observation of Resident #5 on 04/12/16 at 4:50pm revealed Resident #5 was assisted to the bathroom for toileting by one PCA.

Interview with Resident #5 on 04/12/15 at 5:07pm revealed:
-When awake, Resident #5 was "mostly able" to tell when she needed to urinate or defecate.
-When asleep, Resident #5 "sometimes" urinated or defecated in the bed.
-Resident #5 did not know she had wet the bed until "I wake up."

Confidential interview with three differnet straff members revealed the staff denied observing any staff member treating or speaking to any resident disrespectfully.

Confidential interview with a resident revealed:
-There had been occasions when Staff A told the resident there was not enough staff working so Staff A could not assist the resident with showering (at the resident's scheduled shower time).
-Staff A told the resident that she (Staff A) would assist the resident to shower; the resident got undressed and had to wait (undressed) for Staff A "maybe 20 minutes or so."
-The resident had to use the call bell ito call for staff assistance.

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Confidential interview with a second resident revealed facility staff treated the resident "fine" and provided assistance as needed.

Interview with a Medication Aide on 04/12/16 at 9:10 am revealed:
-PCAs were responsible for changing and providing incontinence care to incontinent residents.
-PCAs were responsibe for changing soild linen when the linen is found to be soiled.
-The MAs helped the PCAs change incontinent residents and linen as needed.
-Incontient residents were spoosed to be checked every two hours.

Interview with the Executive Director (ED) on 04/12/16 at 11:55am revealed:
-The facility did not have a toileting program.
-Incontinent residents were checked every two hours.

Interview with the ED on 04/12/16 at 2:50pm revealed:
-All residents were supposed to receive rounds every two hours; if the resident was incontinent, toileting was offered at that time.
-It was not facility procedure to document two hours rounds.
-PCAs were responsible for toileting residents.
-Incontinent residents received toileting assistance in accordance with their care plan and Activities of Daily Living (ADL) Task chart.
-Staff were aware of the "heavy wetters" and the type of assistance they required based on the Quick Medication Administration Record (MAR) Task sheet.
-When a resident's assessment was entered, the care plan generated the Quick MAR task sheet

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and ADL care plan sheet.
-PCAs are responsible for documenting on the ADL care sheet once every shift.
-When an incontinent resident was asleep "we would wake them."
-Residents with specific types of incontinence "need to be gotten up" (for toileting).
-"Residents need to get up to maintain as much function as possible."
-The ED could not recall receiving any complaints from residents who were awakened from sleep every two hours for toileting.
-Bed linens were supposed to be changed three times weekly on the resident's shower days and as needed.
-The PCA assigned to the hall was responsible for changing bed linens or a "MA can do it as needed."
-The ED expected soiled/wet bed linen to be changed as soon as the staff sees it and changed the resident.
-The ED could not recall receiving any complaints about delays in linen being changed or dirty bed linen.

Interview with the ED on 04/12/16 at 5:35pm revealed Staff A was a resident advocate.

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Review of the Plan of Protection submitted by the facility dated 04/12/16 revealed:
-Management would initiate an internal investigation related to allegations.
-Staff A would be suspended pending investigation.
-A twenty four hour and five day report would be completed and submitted to HCPR.
-Resident rights training would begin immediately on all shifts.

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D 338	Continued From page 38 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 27, 2016.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failied to assure staff treated residents with dignity and respect. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 6 residents (#5) sampled was treated with dignity and respect as evidenced by staff refusing to change Resident #5's soiled bed linen, requiring the resident to sit in a chair, and speaking to the resident in a disrespectful manner after episodes of incontinence. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type B Violation)].	D911		
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.	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010007	A. BUILDING: ______ B. WING ______	C 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LELAND HOUSE	1935 LINCOLN ROAD LELAND, NC 28451

(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
D912	Continued From page 39 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are: Based on record reviews and interviews, the facility failed to notify the physician of the health care needs of 1 of 6 residents sampled (#2) related to behaviors exhibited by the resident and failed to notify the physician about the recommendation by a psychotherapist that the resident was not able to safely function in assisted living. [Refer to Tag D273, 10A NCAC 13F.0902(b) Healtcare Referral and Follow Up (Type A2 Violation)].	D912		
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, interviews and record reviews, the facility failed to assure each resident was free of abuse and neglect by failing to supervise residents in the Assisted Living dining room during meals. The findings are:	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 40 Based on observations, record reviews, and interviews, the facility failed to supervise 2 of 6 residents sampled (#1, #2) in the Assisted Living dining room during the supper meal in accordance with the facility's established procedures resulting in an incident between the two residents in which Resident #2 was injured in a manner causing death. [Refer to Tag D270, 10A NCAC 13F.0901 Personal Care and Supervision (Type A1 Violation)].	D914		