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C 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 3/30/16 through 4/1/16 and on 4/4/16 with a telephone exit on 4/5/16.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up for 1 of 6 residents (#1) who exhibited threatening behaviors with a knife and for 1 of 6 residents (#3) who refused two medications without staff notifying the prescribing physician. The findings are: Interview with the Supervisor-in-Charge (SIC) on 3/30/16 at 8:15am revealed: -He came to work at this facility in March, 2016 as the SIC and had been there less than 1 month. -He lived at the facility and was on duty 7 days and nights weekly except from 9:00am to 7:00pm on Thursday when a Relief Staff person came in. -The facility had a census of 6 residents when he arrived, but currently had 5 residents because Resident #1 was discharged two weeks ago to a "sister facility." -While Resident #1 resided in this facility, he had a roommate, Resident #3. -Resident #1 was transferred to a sister facility where a private room was available because he	C 246		

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C 246	Continued From page 1 was exhibiting threatening behaviors to his roommate. A. Review of Resident #1's last FL2 when he resided in this facility, dated 9/9/15, revealed he had diagnoses of dementia, chronic kidney disease, hypertension, and diabetes mellitus with no information related to inappropriate behavior. Review of Resident Register revealed Resident #1 was admitted to the facility on 9/11/15 and discharged on 3/14/16. Review of Resident #1's Assessment and Care Plan, dated 2/19/16, and completed by Staff E, a Co-Administrator, revealed "No concerns at this time." Interview with Resident #3 on 3/3/0/16 at 8:45am revealed: -He had a roommate, Resident #1, until recently. -Resident #1 had some dementia and could not remember things. -Resident #1 had a wrist watch that had quit working, so Resident #3 volunteered to take the watch to have it repaired/replace battery. -When Resident #3 brought the watch back to Resident #1, the watch was one hour off and Resident #1 could not get it to set correctly. -Resident #1 was very upset and accused the watch repair shop of taking out the mechanics of the watch. -Resident #1 was so upset that he came into the living room where Resident #3 was standing and where the Relief Staff, Staff D, was sitting on the couch, waved his open pocket knife around and kept saying to Resident #3, "I'm going to cut you, again and again." -Resident #1 was "mad and physically shaking when he made the threats.	C 246		

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"I backed up and sat down on the couch."
-When Resident #1 threatened him, Staff D went into the kitchen to call another SIC, Staff E, from a sister facility to come over to help.
-Resident #1 finally calmed down and put the knife in his pocket and the Relief Staff did not take the knife away from Resident #1.
-When the former SIC, Staff A, came back to the facility that evening, Resident #3 reported the knife incident to him.
-Resident #3 did not know the date or time of the incident, but it happened "around the holidays," in November or December, 2015.
-Resident #3 remembered the incident happened around the holidays because when he reported the knife incident to Staff A, Staff A said it was best to not ruin the holidays by reporting the incident and that he would get the knife away from Resident #1.
-Staff A continued to ask Resident #1 for the knife, but it took 3 days for Resident #1 to give the knife to Staff A.
-Resident #3 reported he was very afraid for the three days and nights he had to sleep in the same room with Resident #1 retaining a knife.
-Resident #1 was always thinking others had stolen his money or underwear and could not remember where he had placed things.
-After Staff A was "fired," Resident #1 woke up Resident #3 in the middle of the night with a cane in the air threatening to beat him up.
-The new SIC reported the cane incident to management and soon afterwards, Resident #1 was transferred to another facility.

Interview with Staff D, the Relief Staff, on 3/31/16 at 9:26am revealed:
-She was at the facility when Resident #1 pulled out his knife and threatened Resident #3.
-She did get up and go in the kitchen when

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C 246	Continued From page 3 Resident #1 threatened Resident #3 with a knife so Resident #1 would calm down. -She did not call Staff E to come over to the facility. -She did not ask Resident #1 for the knife. -She did not tell any other staff about the incident since it blew over and no one was hurt. -She knew now that she was supposed to have reported the incident. -She did not document the incident in any records. Interview with Resident #1 on 3/31/16 at 8:15am revealed: -He did not mention any incidents about his knife being taken away, his watch not working, nor about any items that were stolen from him. -He did report that he sometimes walked with a "stick." -He did not know why he had to move to another facility. Attempted telephone Inteview with Staff A, the previous SIC, on 4/5/16 at 2:21pm was not successful. Interview with the Administrator on 3/31/16 at 12:25pm revealed: -She was not aware of the knife incident until "today." -She had not seen any documentation of the knife incident. -She did not know Resident #1 had a knife and she did not know Staff A took it away from him. -She became aware of Resident #1's threatening behaviors after Staff A was no longer working there. -Staff were supposed to write incident/accidents/behavior issues on the eMAR under chart notes.	C 246		

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C 246	Continued From page 4 -She had not been reading all the chart notes, but expected Staff A to call her with all incidents/accidents/behaviors. -After Staff A left, Resident #1 made threatening remarks to Resident #3 one day while standing in the doorway of their bedroom. -The SIC reported this incident to the Administrator and staff took Resident #1 to the physician because of his mental health. -A few days later, Resident #1 again threatened Resident #3 in the middle of the night with his cane and the facility discharged Resident #1 to a sister facility while waiting on a permanent placement, but at the other facility he had a private room. -Resident #1's family member wanted him to move to a facility in the state where she lived. Review of the electronic Medication Administration Record (e-MAR) chart notes from 10/2/15 through 2/21/16 (while Staff A worked at the facility) revealed no documented incident of Resident #1 threatening Resident #3 with a knife and no documentation that he took the knife away from Resident #1. Interview with Resident #3's guardian on 4/5/16 at 10:00am revealed: -She did not find out about the knife incident until March 2016 when Resident #3 texted her about the incident. -She was not aware Resident #1 had threatened Resident #3 until March. B. Review of Resident #3's current FL-2 dated 6/17/15 revealed: -Diagnoses included bipolar disorder, polysubstance abuse, post-traumatic stress disorder (PTSD) and anxiety. -The comment "see physician orders" in the	C 246		

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medication order section of the form.
-Attached medication orders, dated 6/17/15, included disulfiram (a medication used in the treatment of alcoholism and equivalent to the generic brand antabuse) 250mg tablet take 2 tablets every day and vitamin B-12 1,000mcg tablet take 2 tablets every day (a vitamin used for pernicious anemia).

Review of Resident #3's current assessment and care plan dated 7/9/15 revealed:
-A check in the box for history of substance abuse.
-The comment that the resident's placement in the facility was by his guardian, he was limited to when and where he could visit with family, and he had established mental health and substance abuse care.

Review of Resident #3' s Resident Register revealed:
-An admission date of 12/4/15.
-In the personal information section the "other" block is checked with comments "supervision to avoid relapse (substance abuse)."
-In the known allergies/substances not to be administered was "no alcohol ... "

Review of physician orders for Resident #3 dated 12/17/15 revealed continuation of the medication disulfiram 250mg take 2 tablets every day and vitamin B-12 1,000mcg tablet take 2 tablets every day.

Review of Resident #3's Medication Administration Record (MAR) (e-M MAR) for March, 2016 revealed:
-The order for disulfiram 250mg take 2 tablets by mouth every day at 8:00AM.
-Documentation that the medications were

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administered at every opportunity as ordered except during the period of 3/20/16 through 3/30/16 (these dates had circles around the medication aide's initials).
-Documented comments for not administering the disulfiram on 3/20/16 and 3/21/16 were "given to resident to take later " while he was out of the facility.
-Documented comments for not administering the disulfiram for the period of 3/22/16 through 3/30/16 were "resident refused."

Review of Resident #3's eMAR for March, 2016 revealed:
-The order for vitamin B-12 1,000mcg tablet take 2 tablets every day at 8:00AM.
-Documentation that the medications were administered at every opportunity as ordered except during the period of 3/20/16 through 3/31/16 (these dates had circles around the medication aide's initials).
-Documented comments for not administering the disulfiram on 3/20/16 and 3/21/16 were "given to resident to take later" (when Resident #3 was out of the facility).
-Documented comments for not administering the disulfiram for the period of 3/22/16 through 3/31/16 were "resident refused."
Review of Charting Notes for Resident #3 on 3/18/16 at 12:17pm revealed:
-The "resident took it upon himself to set up appt. [appointment] with his primary care doctor to see about discontinuing some meds he doesn't feel like he needs."
- "SIC [Supervisor-in-Charge] gave the doctors phone number to guardian so she coupld [sic] follow up with it herself and she feels he is stable."

Review of Charting Notes for Resident #3 on

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C 246	Continued From page 7 3/20/16 at 12:11PM revealed the resident was out of the facility at home with a family member and due to return to the facility the following evening. Review of Charting Notes for Resident #3 on 3/21/16 at 9:13PM revealed: -The resident had signed back into the facility. -"He chose not to go to his appt. to meet with his previous primary care physician but came to supervisor and said he was going to be refusing his [vitamin] B-12 meds and his anti-buse [sic] meds." Review of Charting Notes for Resident #3 on 3/29/16 at 5:23pm revealed "Resident and SIC has called primary care to try and get meds being refused discontinued haven't herd [sic] response answering [sic] machine said give 24 hours for response back." Review of Charting Notes for Resident #3 on 3/30/16 at 3:30pm revealed "Guardian stated she did not feel comfortable with him going home off of his anti-buse meds because of previous conditions...Resident then started calling his family and asking could they pay for this med which is costly..." Interview with the SIC on 3/30/16 at 3:45pm revealed: -The SIC returned the disulfiram to the pharmacy because Resident #3 was refusing it, but the physician had not discontinued it. -After Resident #3's guardian found out Resident #3 was refusing the disulfiram, the guardian was not going to allow Resident #3 to go for his home visit on 4/2/16 for the week-end. -Now Resident #3 was very upset that he was not going to be allowed his home visit and wanted to resume the disulfiram so he would be allowed to	C 246		

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go home.
-The SIC had returned the disulfiram back to the pharmacy and was not aware there were any funds to pay for the disulfiram.

Interview with the Administrator/Owner on 3/3/0/16 at 4:00pm revealed:
-Resident #3 had not been paying for the disulfiram because the facility paid for it or made other arrangements for payment.
-The Administrator said she would contact the pharmacy to dispense the disulfiram for Resident #3.

Review of Charting Notes for Resident #3 on 3/30/16 at 9:13pm revealed "Meds came in 9pm was relieved he got them and can continue back on them."

Interview with the Property Manager on 4/1/16 at 9:20am revealed:
-She became aware of Resident #3's medication refusal on 3/29/16 when Resident #3 told her.
-The SIC was supposed to have called Resident #3's physician to inform him of the refusal.

Interview with the Administrator/Owner on 3/31/16 at 2:36pm revealed:
-Resident #3's medication refusal of Antabuse was a "planned" and she thought Resident #3's physician was aware of the refusal.
-Resident #3 told her his family member was planning on taking him to the physician on 3/21/16 and the physican knew he was going to refuse the medication.
-Resident #3 told the Adminstrator the physican would discontinue the medication after he refused it.
-Payment for the medication was never an issue and did not know why Resident #3 thought it was.

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C 246	Continued From page 9 -If a resident refused a medication, the physician was to be notified after 2 or 3 refusals, but this could also depend on the type of medication. -A discontinuation order was required from a physician for a medication that was refused for it to be returned to the pharmacy. -The SIC should not have sent the medication back to the pharmacy. -Staff should look at the reason why a medication was being refused and to seek guidance from the Property Manager or Administrator. -A staff member in the corporate office checked the computerized MAR "every day" for refusals and to make the appropriate referrals. Telephone interview with the Triage Nurse at Resident #3's physician's office on 4/1/15 at 10:40AM revealed: -The resident had an appointment on 3/21/16 but was a "no-show." -The office received a voice mail message by an unidentified person on 3/29/16 concerning the discontinuation of Antabuse that the resident refused to take and the physician's reply was for the resident to first have an appointment scheduled. -The physician had not written a discontinuation order for the Antabuse. -The physician's plan was for the resident to continue his medication. Telephone interview with the Contract Pharmacy pharmacist on 3/31/16 at 1:55pm revealed: -The Pharmacy had no discontinuation order on file for Resident #3's disulfiram. -An automatic refill occurred on 3/18/16 with the delivery of 6 tablets on 3/19/16 (probably due to low stock) and of 54 tablets on 3/21/16. -The tablets were sent back to the Pharmacy on 3/23/16 for which the resident's account was	C 246		

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given credit and there were no billing issues.
-The tablets were re-dispensed and delivered on 3/30/16.
-Facilities sent medications back to the pharmacy either due to a discontinuation order or a refusal.
-The Pharmacy needed a physician's order to discontinue a medication.

Observation of Resident #3's medications on hand on 4/1/16 at 9:45am revealed disulfiram 250 mg available for administration and the Vitamin B-12, 1000mcg tab available for administration.

Review of the April 2016 MAR on 4/1/16 at 9:45am revealed:
-Documentation of the administration of disulfiram 250 mg at 8:00am on 4/1/16.
-Documentation the Vitamin B-12 1,000 mcg had been refused at 8:00am on 4/1/16.

Review of the facility's medication refusal policy revealed "If the resident is refusing medications related to blood pressure, diabetes and other serious medical conditions encourage the resident to take the medication and to discuss their wishes to discontinue or change the medication with their primary care physician or the prescribing doctor. If the resident still refuses, document the refusal in [name of electronic medication administration record system] and notify the physician."

Interview with Resident #3 on 4/1/16 at 9:35am revealed:
-He refused the disulfiram because it was so expensive.
-He refused the multivitamin because he was taking another vitamin with vitamin B 12 in it but he would start taking it again.
-He was not aware that his family had not been

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C 246	Continued From page 11 charged for his medication. -He did not keep his physician appointment on 3/21/16 because he forgot to bring a copy of his Medication Administration Record. Interview with Resident #3's guardian on 4/5/16 at 10:00am revealed the facility did not call her about the medication refusals, but she would have expected them to do so. _____ The Plan of Protection provided by the facility on 4/5/16 revealed: -The facility staff will report all incidents/accidents by telephone call to Administrator designee immediately. -Staff will notify the primary care mental health and all appropriate parties of accidents/ incidents and medcations refusals. -The Administrator/designee will follow-up on all incidents/accidents and document in residents' charts. -All referrals will be documented and refusals documented according to facility policy. -Staff will receive additional training on reporting accidents/incidents and refusals. -The Administrator will review weekly and follow-up with staff. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED May 20, 2016	C 246		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family 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.	C 311		

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C 311	Continued From page 12 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure residents were free of abuse as evidenced by the former Supervisor-in-Charge (Staff A) verbally and mentally abusing two of six residents (#1 and #2), exposing the other 4 of the 6 residents (#3, #4, #5, and #6) to the verbal and mental abuse, and allowing one Resident (#1) to maintain a knife for 3 days after threatening his roommate (Resident #3) with the knife. The findings are: A. Interview with the current Supervisor-in-Charge (SIC) on 3/30/16 at 8:45am revealed: -He just started working there about "three weeks ago." -He lived at the facility and was on duty 7 days and nights weekly except from 9:00am to 7:00pm on Thursday when a Relief Staff person came in. -The other SIC, Staff A, left before he was hired. -Resident #1 was transferred to another facility on 3/14/16. Review of Staff A's personnel records revealed: -He was hired June, 2007 as a Supervisor-in-Charge. -A criminal record check was completed on 6/5/07. -A health care personnel registry check was completed on 6/5/07 with no findings substantiated. -Staff A signed the receipt of the Resident Bill of Rights on 6/1/07.	C 311		

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C 311	Continued From page 13 -He last received training on Resident Rights on 3/5/15. Interview with the Administrator/Owner on 3/30/16 at 10:15am revealed: -The former SIC, Staff A, no longer worked at the facility, as of 2/27/16. -She discharged Resident #1 to a sister facility where a private room was available because of his threatening behaviors. -The current census was 5 since Resident #1 left. -Staff were supposed to chart any unusual behaviors in the Chart notes on the electronic Medication Administration Records (e-MARs) and were supposed to call her because she did not always read the Chart notes. -Staff A used to work in a sister facility in another town but came to work in that facility in 2012 when they needed a SIC for that facility. -Resident #1 shared a bedroom with Resident #3 while he lived at this facility. Confidential interviews with with 4 residents during the survey revealed: -Staff A would yell at residents "all the time" especially Residents #1 and #2. -Staff A would "rant and rave for 1 and 1/2 hour and go on and on like a tyrant." -Staff A "was hard to deal with." -Staff A "did not know how to treat people with mental illness." -Staff A would say, "Any problems here, we keep it here." -Staff A would make loud insulting remarks about Resident #1 and #2 when there were no other staff around. -Staff A "was argumentative." -Staff A made all the residents launder their own clothes and linens and would unlock the laundry room for them.	C 311		

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C 311	Continued From page 14 -Staff A treated residents differently depending on "who they were." Attempted telephone interview with Staff A on 4/5/16 at 2:21pm was not successful. B. Review of Resident #1's last FL2 while residing in this facility, dated 9/9/15, revealed he had diagnoses of dementia, chronic kidney disease, hypertension, and diabetes mellitus. Review of the Resident Register revealed Resident #1 was admitted to the facility on 9/11/15, was his own guardian, and was discharged on 3/14/16. Review of a physician note, dated 2/22/16, revealed: -Staff A wrote "reason for visit," "Resident have problem remembering. He forgets things very easy like taken a shower" -The physician wrote diagnoses of "dementia/neurocognitive disorder" and "Recommend pursing guardianship procedures." Interview with the Administrator on 3/30/16 at 10:40am revealed: -Resident #1's family member recently got in touch with Resident #1 and became his Power of Attorney (POA). -Resident #1's POA previously lost contact with Resident #1 but has chosen to be involved in his care. -Resident #1's POA is trying to find a facility for him near his family. Review of Resident #1's Assessment and Care Plan, dated 2/19/16, and completed by Staff E, a Co-Administrator, revealed: -Resident #1 "need verbal cuing and supervision	C 311		

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C 311	Continued From page 15 only." -"No concerns at this time." -Bathing, dressing, and grooming were assessed as Resident #1 requiring limited assistance. Confidential interview with 4 residents revealed: -The former SIC, Staff A, would ask Resident #1 to take a shower and Resident #1 was resistant to taking showers. -Staff A "would ride him" [Resident #1] and try to embarrass Resident #1 into showering. -Staff A would make derogatory remarks to Resident #1 which included: "You stink," and "This room stinks." -Resident #1 would report to Staff A that he had already showered. -Staff A would have the other 5 residents go into the bathroom to observe the dry shower curtain and dry towel in front of Resident #1 to prove Resident #1 was not telling the truth. -On occasions, (the times not known and the dates not known) Staff A would not allow Resident #1 to eat at the table with the other residents because of Resident #1's body odor and required him sit at a desk in the dining room. -Resident #1 was required to sit at the desk to eat "mostly at breakfast," because the showers were supposed to be completed before breakfast. -Resident #1 would use his shampoo as body cream and smooth on his skin so Staff A would not "yell" at him to take a shower. -Staff A "did not treat [Resident #1] good." -"I saw Resident #1 get in the shower when he was hollered at." -Staff A would "holler" at Resident #1 and say "Get in the shower you nasty old man." -Staff A would "holler real loud" at Resident #1 if he was standing in the hall and say, "Why are you standing in the hall?" -Staff A would not wash Resident #1's clothes for	C 311		

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him and Resident #1 had dementia and did not realize his clothes needed washing.
-Staff A would not change Resident #1's sheets and wash his linens for him.
-Because of Resident #1's dementia, he would forget where he had placed things and accuse people of stealing them.
-Staff A did not speak much to residents but did some "yelling and screaming."
-"He was vulgar and abusive."

Observation of the dining room on 3/30/16 at 10:00am revealed:
-A dining room table with 6 chairs.
-There was no desk in the dining room.

Interview with the SIC on 3/30/16 at 3:15pm revealed after he came to work there, he moved the desk to the office and placed a display cabinet in it's place in the dining room.

Interview with Resident #1 on 3/31/16 at 8:15am at the facility where he was residing revealed:
-Staff A "acted like he was running a prison."
-"Don't treat me like a kid, I been through too much."
-"I sat at the desk when I ate, and it tee' d me off."
-He did not know why he had to sit at the desk to eat.
-"I'm paying a lot of money and he had no business treating me that way."
-Staff A would not talk to him directly, but would talk to others about him.
-"He was louder than anyone else."
-"I don't think they're supposed to run a place like that."
-"I've been a man a long time."
-"I kept to myself so things would not lead to something else."
-"Some people figure when they are in charge,

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C 311	Continued From page 17 they can say anything to me." -"Some people get a little authority and run away with it." -"I don't know why they made me move over here." -Sometimes it was not what Staff A said, but "the way he said it." -Resident #1 reported he did not know anything about taking showers. -Resident #1 did not remember if Staff A washed his clothes or his linens. -Resident #1 never told Staff A of any pain and said, "Some people you can't talk to because it might lead to something else." -"I never mentioned to anyone how he [Staff A] treated me." Interview with Resident #3 on 3/30/16 at 8:50am revealed: -He was Resident #1's roommate in this facility and Resident #1 was resistant to taking showers. -The room always had an odor because Resident #1 would not take showers, Staff A would not wash Resident #1's clothes, and would not change Resident #1's sheets. -Staff A came into the room daily and sprayed an air freshener real heavily while Resident # 1 and Resident #3 were in the room. -There continued to be an odor in the the room after Resident #1 moved out and when the Relief Staff was cleaning, she found a "messy pair of underwear" under the bed which was "growing stuff." -Staff A always made Resident #1 and #3 keep their bedroom door closed because of the stench. -Resident #3 said he slept with the window open all winter because of the odor and kept a cold all winter. -After Staff A left, the Relief Staff and the new SIC "started to clean the place up."	C 311		

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C 311	Continued From page 18 Review of Chart notes on the electronic Medication Administration Records (eMARs) from 10/2/15 through 2/26/16 revealed: -Notes were written daily by Staff on duty. -The first documentation of Resident refusing showers was on 12/22/15 by Staff A who wrote, "Resident has refused to take a shower for the last 5 days." -Other days that Staff A documented Resident #1's shower refusal was 1/4/16, 1/10/16, 1/13/16, 1/15/16, 1/16/16, 1/29/16, 1/30/16,2/1/16, 2/2/16, 2/16/16. -After Staff A was no longer working at the facility, a relief staff documented on 2/26/16 that Resident #1 "took a shower this afternoon and we changed his bed sheets, cleaned all the dirty laundry from his dresser and started washing everything." Telephone interview with Resident #1 Power of Attorney (POA) on 3/31/16 at 5:50pm revealed: -She lived in another state and had lost contact with Resident #1 until recently and now is his POA. -The facility did not have her contact information until recently. -She did not visit the facility where Resident #1 did live but had visited his current facility. -She had no knowledge how Resident #1 was treated while he was in the "other" facility. -Resident #1 had told her that someone at this facility had spoken to him "roughly." Telephone interview with the transportation staff, Staff C, on 4/4/16 at 6:10pm revealed: -Residents had never told her that Staff A was inappropriate to the residents. -She never heard Staff A talk inappropriate to the residents.	C 311		

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C 311	Continued From page 19 -Staff A normally talked loud because that was his personality. Refer to interview with the Administrator on 3/31/16 at 12:25pm. Refer to interview with the Property Manager on 4/4/16 at 9:20am. C. Review of Resident #2's current FL2 revealed diagnoses which included morbid obesity, hypertension, tobacco dependence, schizoaffective disorder, and anxiety disorder. Review of Resident Register revealed Resident #2 was admitted to the facility on 10/1/06 and that he was his own guardian. Interview with Resident #2 on 3/30/16 at 10:15am revealed: --Staff A insulted me "quite a few times." -Staff A called me "useless," and that "I was a waste." -Staff A said "I smoke too many [cigarettes] in a row." -Staff A was older and more aggressive and always "very angry." -Management said "If they got rid of him [Staff A], they would have to shut down." -"I never told anyone, I wanted things to work out." -Staff A would argue "morning and night, fire and ice." -"We have a better SIC now." Confidential interview with 3 residents revealed: -Staff A called Resident #2 "fat and overweight." -Staff A "was argumentative" with Resident #2 "about his hygiene and smoking." -Resident #2 would not respond to Staff A's	C 311		

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C 311	Continued From page 20 insults. Refer to interview with the Administrator on 3/31/16 at 12:25pm. Refer to interview with the Property Manager on 4/4/16 at 9:20am. D. Review of Resident #3's current FL-2 dated 6/17/15 revealed diagnoses which included bipolar disorder, polysubstance abuse, post-traumatic stress syndrome, and anxiety. Review of the Resident Register revealed he was admitted to the facility on 12/4/15. Interview with Resident #3 on 3/3/0/16 at 8:45am revealed: -He had a roommate, Resident #1, until recently. -Resident #1 had some dementia and could not remember things. -Resident #1 had a wrist watch that had quit working, so Resident #3 volunteered to take the watch to have it repaired/replace battery. -When Resident #3 brought the watch back to Resident #1, the watch was one hour off and Resident #1 could not get it to set correctly. -Resident #1 was very upset and accused the watch repair shop of taking out the mechanics of the watch. -Resident #1 was so upset that he came into the living room where Resident #3 was standing and where the Relief staff person, Staff D, was sitting on the couch, waved his open pocket knife around and kept saying to Resident #3, "I'm going to cut you, again and again." -Resident #1 was "mad and physically shaking" when he made the threats. -Resident #3 stated, "I backed up and sat down on the couch."	C 311		

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C 311	Continued From page 21 -Staff D went to the kitchen during the threats. - Resident #1 finally calmed down and put the knife in his pocket and Staff D did not take the knife away from Resident #1. -When the former SIC, Staff A, came back to the facility that evening, Resident #3 reported the knife incident to him. -Resident #3 did not know the date or time but the incident happened "around the holidays," in November or December, 2015. -Resident #3 remembered the incident happened around the holidays because when he reported the knife incident to Staff A, Staff A, said it was best to not ruin the holidays by reporting the incident and that he would get the knife away from Resident #1. -Staff A continued to ask Resident #1 for the knife, but it took 3 days for Staff A to retrieve the knife. -Resident #3 reported he was very afraid for the three days and nights he had to sleep in the same room with Resident #1 retaining a knife and he kept asking Staff A to get the knife. -He was not aware of management taking any actions related to Resident #1 threatening him with a knife and allowing him to keep it with him for three days. -After Staff A was "fired," Resident #3 woke up in the middle of the night with Resident #1 holding a cane in the air over him threatening to beat him up. -The new SIC reported the cane incident to management and soon afterwards, Resident #1 was transferred to another facility. Interview with the Administrator on 3/31/16 at 12:25pm revealed: -She was not aware of the knife incident until "today." -She had not seen any documentation of the knife	C 311		

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incident.
-She did not know Resident #1 had a knife and she did not know Staff A took it away from him.
-She became aware of Resident #1's threatening behaviors after Staff A was not longer working there.
-Staff were supposed to write incident/accidents/behavior issues on the eMAR under chart notes.
-She had not been reading all the chart notes, but expected Staff A to call her with all incidents/accidents/behaviors.
-After Staff A left, Resident #1 made threatening remarks to Resident #3 one day while standing in the doorway of their bedroom.
-The SIC reported this incident to the Administrator and staff took Resident #1 to the physician because of his mental health.
-A few days later, Resident #1 again threatened Resident #3 in the middle of the night with his cane and the facility discharged Resident #1 to a sister facility while waiting on a permanent placement, but at the other facility he had a private room.
-Resident #1's family member wanted him to move to a facility in the state where she lived.

Review of the eMAR chart notes from 10/2/15 through 2/21/16 (while Staff A worked at the facility) revealed no documented incident of Resident #1 threatening Resident #3 with a knife and no documentation that he took the knife away from Resident #1.

Interview with Staff D, the Relief Staff person on 3/31/16 at 9:26am revealed:
-She was at the facility when Resident #1 pulled out his knife and threatened Resident #3 saying he would cut his "head off."
-She did get up and go in the kitchen when

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C 311	Continued From page 23 Resident #1 threatened Resident #3 with a knife. -She did not call any staff to come over to the facility. -She did not ask Resident #1 for the knife. -She did not tell any other staff about the incident since it blew over and no one was hurt. -She knew now that she was supposed to have reported the incident. -She did not document the incident in any records. Refer to interview with the Administrator on 3/31/16 at 12:25pm. Refer to interview with the Property Manager on 4/4/16 at 9:20am. _____ Interview with the Administrator on 3/31/16 at 12:25pm revealed: -When she found out about Resident #1 refusing showers, on 3/7/16, she scheduled a class to be taught on "Bathing Challenges." -She did not always read the Chart notes on the e-MAR, but Staff A should have called her about the shower refusals. -She was not aware until Staff A left that he had verbally abused the residents and then the residents told her when questioned about the abuse. -She was not aware until the surveyor told her that Staff A required Resident #1 to sometimes sit at the desk to eat. -She said she often talked to the residents and none of the residents mentioned the abuse while Staff A was employed there. -None of the Staff reported to her the verbal and mental abuse. -She reported Staff A to the Health Care Personnel Registry on 4/1/16 related to his verbal and mental abuse to residents.	C 311		

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C 311	Continued From page 24 Interview with the facility Property Manager on 4/4/16 at 9:20am revealed: -She knew Resident #3 had complained about the odor in his room. -She became aware recently Resident #1 was resistant to bathing, but the Administrator had scheduled a class on Bathing Basics. -She never heard anything about Resident #1 being dangerous. -She did not know about the knife incident until 3/31/16. -She never heard Staff A talk disrespectful to the residents. The Plan of Protection provided by the facility on 4/1/16 revealed: -All staff will immediately report any possible instances of abuse, neglect, and/or exploitation. -Residents will be encouraged to relate any concerns to management using confidential suggestion boxes, the Administrator cell phone, and regular interviews with administrative staff. -Visits and interviews with residents at least twice a week. -Additional training for staff on resident abuse, neglect, and exploitation. -The toll free complaint hotline number will be posted in the home and used for staff and residents. -The local ombudsman will be contacted to assist with routine visits to the home. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED May 5, 2016.	C 311		

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C 912	Continued From page 25	C 912		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to 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 health care referral and follow-up. The findings are: Based on observations, interview, and record review, the facility failed to assure referral and follow-up for 1 of 6 residents (#1) who exhibited threatening behaviors with a knife and for 1 of 6 residents (#3) who refused two medications without staff notifying the prescribing physician. [Refer to 10A NCAC 13G .0902(b) Resident Rights (Type B Violation).]	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's 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 all residents were free of mental and physical abuse, neglect,	C 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011235	A. BUILDING: _____ B. WING _____	04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUNDVIEW FAMILY CARE HOMES - UNIT H	134 CENTER AVENUE BLACK MOUNTAIN, NC 28711

(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
C 914	Continued From page 26 and exploitation as evidenced by the Supervisor-in-Charge verbally and mentally abusing residents. The findings are: Based on observations, interviews and record reviews, the facility failed to assure residents were free of abuse as evidenced by the former Supervisor-in-Charge (Staff A) verbally and mentally abusing two of six residents (#1 and #2), exposing the other 4 of the 6 residents (#3, #4, #5, and #6) to the verbal and mental abuse, and allowing one Resident (#1) to maintain a knife for 3 days after threatening his roommate (Resident #3) with the knife. [Refer to 10A NCAC 13G .0909 Resident Rights (Type A2 Violation).]	C 914		