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
D 000	Initial Comments	D 000		
	The Adult Care Licensure Section completed a Complaint Investigation from 04/05/16-04/08/16 and 04/11/16-04/12/16.			
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	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with state law.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ED — (X6) DATE: 5/13/16

STATE FORM 6899 TH9Z11 If continuation sheet 1 of 41

Plan of Correction Reviewed/accepted
Tamara Talbot, RN, BSN
5/16/2016

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D 270	Continued From page 6 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.	D 270	All staff have been notified of the requirement for meals to be supervised. A personal care aide/ med aide or a member of the management team will be assigned to monitor all meals. See attachment A	5/12/16

Date_____

Assignment Sheet

Effective immediately- all **MEAL TIMES** are to be supervised by a staff member.

7-3

100 Med Aide: _____ Aide: _____

Aide: _____

200 Med Aide: _____ Aide: _____

300 Med Aide: _____ Aide: _____

Breakfast Monitor: _____

Lunch Monitor: _____

3-11

100 Med Aide: _____ Aide: _____

Aide: _____

200 Med Aide: _____ Aide: _____

300 Med Aide: _____ Aide: _____

Dinner Monitor: _____

11-7

100 Med Aide: _____ Aide: _____

200/300 Med Aide: _____ Aide: _____

On call: _____

Employees get 1 hour lunch & 2 10 min breaks if working 6hrs or more.

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D 270	Continued From page 10 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	D 270	When behaviors are identified, the resident will immediately be removed from the area. An attempt to de-escalate or re-direct the resident will be performed. The physician and or mental health provider will be notified of behaviors exhibited. The resident will be placed on acute charting for 72 hours. The facility will implement the mood and behavior tracking log. We will implement a change of shift "stand up" meeting. During this meeting the med aides and personal care aides will discuss any significant changes in behaviors or interventions needed for any resident identified on the behavior log. Any concerns needing follow up will be noted on board in clinic for management to review. Change of shift reports will be signed off by the care managers. Primary Care physicians will be notified, in writing, of changes in behaviors.	5/12/16

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D 273	Continued From page 24 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.	D 273	Facility will demonstrate proper coordination of care by implementing a care plan meeting any time there is a recommendation for a change in level of care. The resident and or responsible party will be notified of said recommendation. If the recommendation does not generate from a primary care provider the facility will notify the primary care provider in writing. The primary care provider will have the opportunity to agree or disagree with the recommended level of care. The Level of Care Meeting Documentation will be filed in the resident's record. Attachment B	5/12/16

Level Of Care Meeting

The following provider has recommended a change in you level of care:

Provider name and credentials

Date

If provider is not this resident's primary care physician forward this notice to the primary care physician.

This recommended change in your level of care is due to:

I have been notified of this recommendation:

Resident and or Responsible Party Signature

Facility Representative

Primary Care Physician Signature and Recommendation:

I agree with change in level of care ☐

I do not agree with change in level of care ☐ Date:

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D 273	Continued From page 25 -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	D 273	The facility has implemented a tracking system to ensure all orders/recommendations from licensed providers have been followed through and documented in the resident's care notes. The care managers and administrator have monitored the system. An audit to verify that the referral and follow up of all healthcare needs of all residents has been completed.	5/12/16

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D 338	Continued From page 31 -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	D 338	Residents will only be awakened at night to utilize the bathroom if there is an order from the primary care physician recommending a bowel and bladder training program that specifies every two hour checks even during the nighttime hours. Staff will be notified of this new procedure. Care managers and administrator to monitor. All residents and family members will be notified of the facility grievance procedure. Multiple options as to how to notify management of any concern or dissatisfaction will be provided.	5/27/16 5/27/16

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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 failed 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	All staff have received Resident's Rights training with a focus on dignity and comapssionate care for residents. Training was provided by Brunswick County DSS Adult Services Supervisor.	5/12/16
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		