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D 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted a complaint investigation on 05/23/16-05/25/16. The complaint investigation was initiated by the Robeson County Department of Social Services on 05/06/16.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to meet the health care needs of 2 of 7 residents sampled (#1, #6) by failing to seek medical evaluation for a resident who was prescribed Plavix on two different occasions after falls with reports of head injury (#1), and failing to seek medical evaluation for a resident with of changes in behavior and mental status after being prescribed Depakote (#6). The findings are: 1. Review of Resident #1's current FL-2 dated 12/30/15 revealed: -Diagnoses included dementia, hypertension, coronary artery disease (CAD), macular degeneration, degenerative joint disease (DJD), and anemia. -There was a medication order for Plavix 75mg daily. (Plavix is a medication used to prevent	D 273		

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blood clots from forming in the arteries. Plavix alters the ability of the blood to clot which can lead to a risk for bleeding).

Observation of Resident #1 on 05/23/16 between 11:42am and 11:50am revealed:
-Resident #1 was sitting in the dining room of the Special Care Unit (SCU).
-Resident #1 got up from the dining room table and walked across the hall to the Day Room of the SCU without staff assistance or an assistive device.
-Resident #1 sat down on a couch in the Day Room.
-Resident #1 was dressed in jeans, a long sleeved green shirt, socks, and shoes.
-Resident #1 was unshaved and wearing glasses.
-Staff was present to monitor and assist Resident #1 while in the dining room, hall, and Day Room.

Interview with a Personal Care Aide (PCA) on 05/23/16 at 11:52am revealed Resident #1 was a wanderer and had a history of falling.

Review of the "Care Notes" (CN) for Resident #1 dated 03/14/16 at 4:25pm revealed:
-Resident #1 "fell onto floor from standing position straight back hitting his head on wheelchair. "
-Resident #1's family member was notified at the time of the incident.
-The family requested that staff monitor Resident #1.

Review of the "Report of Accident/Incident" dated 03/14/16 revealed:
-Resident #1 fell in the Day Room of the facility at 4:25pm.
-The "area of injury" was documented as "head."
-Resident #1 "was standing and fell straight back

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hitting his head on wheelchair."
-Resident #1's family member was notified of the incident on 03/14/16 at 4:30pm.
-The box beside "Was the physician called?" was checked "no."
-The box beside "Was 911 called" was checked "no."
-The box beside "Was resident transported to ER?" was checked "no."
-The Report of Accident/Incident was signed by the staff completing the report and dated 03/14/16 and the previous Interim Administrator; there was no date for the previous Interim Administrator's signature.

Telephone interview with a Medication Aide/Supervisor (MA/S) on 05/25/16 at 1:26pm revealed:
-The MA/S completed the Accident/Incident Report when Resident #1 fell on 03/14/16.
-The facility had a fall policy.
-The facility fall policy for the SCU was different from the fall policy for the Assisted Living (AL) section of the facility.
-When a resident who resided in the SCU fell "we send them out (to the ER) because their mind is not there."
-The facility's fall policy required any resident who had a fall with a head injury, suspected head injury, or an unwitnessed fall, to be sent to the hospital ER for further medical evaluation.
-The facility procedure for falls with head injury or unwitnessed falls was: check the resident for bleeding or injury, call 911, stay with the resident until emergency medical services (EMS) arrived, tell EMS what happened, call the family, and complete the paperwork which consisted of completing and incident report and documentation in the resident's record.
-The facility usually called the physician after the

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resident returned from the hospital.
-If a resident refused to go to the hospital ER, the facility was supposed to notify their family.
-The MA/S did not know what the facility procedure was if a family member refused to send a resident to the ER.
-The facility did not call 911 or send Resident #1 to the hospital on 03/14/16.
-Resident #1's family member signed a "refusal."
-Resident #1's family member 'asked us to monitor him (Resident #1) and we did."
-The Nurse Practitioner (NP) was notified that Resident #1 had fallen and hit his head but did not go to the ER on 03/14/16.
-The MA/S did not know why the Accident/Incident Report dated 03/14/16 contained documentation that the NP was not notified.

Review of an untitled document in Resident #1's record revealed:
-Document that read "I, a resident of [facility name] refuse to go to the Emergency Room to be checked out after the staff has recommended me to go."
-The document was signed by Resident #1's family member, the "Community Supervisor", and a "Community Witness" and was dated 03/14/16.
-Below the three signatures was hand written documentation that read "*Staff says they will monitor him for the eight hours" and contained Resident #1's family member's initials and was dated 03/14/16.

Review of the CNs for Resident #1 dated 04/12/16 revealed:
-The time of the entry was not documented.
-Resident was found on the floor; "Stated when he tried (sic) to get up he fell down to floor and hit head.

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-Resident #1's responsible party signed a refusal form; Resident #1 was not sent to the hospital emergency room (ER).

Review of the "Report of Accident/Incident" dated 04/12/2016 revealed:
-Resident #1 was found on the floor of his bathroom at 9:45pm.
-Resident #1 fell on to the floor and hit his head.
-The "area of injury" was documented as "head" and "knee."
-Resident #1's family member was notified of the incident on 04/12/16 at 4:55pm.
-The box beside "Did incident involve first aid?" was checked "yes."
-"Bandage was put on knee."
-The box beside "Was the physician called?" was checked "no."
-The box beside "Was 911 called?" was checked "no."
-The box beside "Was resident transported to ER?" was checked "no."

Telephone interview with the MA/Supervisor (MA/S) on 05/25/16 at 3:50pm revealed:
-The MA/S completed the Accident/Incident report when Resident #1 fell on 04/12/16.
-It was facility procedure to send any resident to the hospital ER who hit their head during a fall or had an unwitnessed fall.
-The MA/S was notified by another staff member on 04/12/16 that Resident #1 fell and hit his head.
-"The normal procedure since he (Resident #2) hit his head was for him to go to the hospital emergency room."
-The MA/S did not call 911 or send Resident #1 to the hospital on 04/12/16.
-The MA/S called Resident #1's family member before calling 911.
-Resident #1's family came in to the facility the

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same night (04/12/16) and signed a refusal form.
-The MA/S did not notify Resident #1's physician that Resident #1 fell, hit his head, and was not sent to the hospital for evaluation.
-On the Accident/Incident Report dated 04/12/16, the MA/S documented "no" to indicate the physician was not notified.
-After Resident #1 fell on 04/12/16, staff watched him "more."

Review of an untitled document in Resident #1's record revealed:
documentation that read "I, a resident of [facility name] refuse to go to the Emergency Room to be checked out after the staff has recommended me to go."
-The document was signed by Resident #1's family member and the "Community Supervisor" and was dated 04/12/16.

Based on observations, record reviews, and interviews, Resident #1 was not interviewable.

Interview with Resident #1's family member of 05/24/16 at 9:50am revealed:
-The family member was happy with the care Resident #1 was receiving at the facility at the time of the interview.
-Resident #1 was "happy" at the facility.
-The facility had some staff changes; the new Administrator and Resident Care Coordinator (RCC) were "good" about working with him (the family member) in relation to Resident #1's care.

Confidential interview with three additional staff members revealed:
-3 of 3 staff interviewed reported it was facility procedure to send any resident who had an unwitnessed fall or fall with a head injury to the hospital.

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-If a resident hit their head they were supposed to be sent to the hospital "automatically."
-It was "better safe than sorry."
-If the resident refused to go to the hospital, 911 was still notified to "check them out."
-In the event of a fall or injury, 911 was always supposed to be called first.
-Any resident who had a fall resulting in head injury "must" be sent to the hospital.

Interview with the RCC on 05/25/16 at 12:55pm revealed:
-When a resident had a fall resulting in a "bump"on the head or was found on the floor (unwitnessed fall), it was facility procedure to send the resident to the hospital.
-The staff was supposed to call 911 first then call the family and physician.
-The facility could text the Nurse Practitioner (NP) or call the hospital after hours to notify the physician who was on call for the facility's contracted physician.
-Sometimes the facility notified the physician after the resident returned from the hospital because "usually" the physician gave orders to send the resident to the ER "because they cannot evaluate them over the phone."
-When a resident refused ER treatment the facility was supposed to notify the resident's family and physician.

Interview with the Administrator on 05/25/16 at 11:25am revealed:
-When a resident had a fall with a head injury or an unwitnessed fall, it was facility procedure to send the resident to the hospital ER for evaluation.
-It was "common knowledge" and all staff should know the fall policy/procedure.
-The Administrator reviewed all Accident/Incident

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D 273	Continued From page 7 Reports and expected the staff member completing the report to check the correct box to indicate if the physician was notified or not notified. -911 was supposed to be called first when a resident had an unwitnessed fall or a fall with a head injury. -The MA/S on duty was responsible for calling 911 in the event of a fall with injury or an unwitnessed fall. -The MA/S was supposed to notify the physician when a resident was sent to the ER at the time of the incident. -If it was the "middle of the night" the MA/S notified the physician the morning following the incident. -The Administrator expected the physician to be notified if a resident or family member refused hospital treatment but the Administrator was not sure if staff were aware of the expectation. -If a resident did not have a head injury, there were "certain" residents whose family wanted to be called first before sending the resident to the hospital because they were "private pay." -Staff knew "from experience" which families to call first. -When a resident hit their head, "it don't (sic) matter if the family wants them to go out (to ER) or not; they are sent (to the ER) regardless." -If a resident had a fall with a head injury whose family refused treatment, the facility would send the resident to the ER "anyway" because the facility had no way of knowing or determining if the resident was "bleeding inside." -It was facility procedure to obtain a resident or family signature for refusal of medical care. -The Administrator expected staff to notify her of any resident having a fall with a head injury and not being evaluated at the hospital due to family refusal.	D 273		

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-The Administrator recalled an incident during the first part of April (2016) when Resident #1's family member refused ER treatment for Resident #1; the Administrator notified the facility's Regional Director about the incident.
-After the Administrator notified the Regional Director in early April 2016, the facility was supposed to call 911 to send Resident #1 to the ER if he had a head injury and wait to notify Resident #1's family member after Resident #1 was transported out of the facility to the hospital.
-The Administrator thought she had written documentation from the Regional Director on the procedure to follow when/if Resident #1 had a fall with head injury or unwitnessed fall.

Telephone interview with Resident #1's NP on 05/25/16 at 1:12pm revealed:
-The NP was not Resident #1's medical provider at this time.
-The NP recalled being previously notified by the facility by telephone or text that Resident #1 was being transferred to the hospital ER and then the facility called the NP the same day to notify her that Resident #1's family member had refused the hospital ER treatment and Resident #1 did not go to the ER.

2.Review of the current FL-2 for Resident #6 dated 4/14/16 revealed:
-Diagnoses included Alzheimer's, muscle weakness and hypothyroidism.
-Resident #6 was intermittently disoriented.

Review of the Resident Register for Resident #6 revealed she was admitted to the facility on 4/18/16.

Review of a "Report of Health Services to Residents" form dated 5/6/16 revealed:

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D 273	Continued From page 9 -The facility contacted the physician and reported Resident #6 had been combative when staff tried to redirect her. -Resident #6 had been taking belongings from other residents; she tried to hit, kick or push staff on several occasions. -Staff requested an order for agitation. -The physician ordered Depakote 250mg three times a day. (Depakote is a medication used to treat mood disorders). Observation of the Special Care Unit (SCU) dining room on 5/23/16 from 4:55pm-5:04pm revealed: -Resident #6 was sitting in a chair at the dining table with her head lying on the table. -Resident #6 was served her dinner tray and prompted by a staff member to eat her meal. -Resident #6 appeared drowsy, and laid her head down onto the dining room table on the right side of the soup bowl, and closed her eyes. -A family member of another resident told staff "hey, she needs help." -A staff member prompted Resident #6 to "eat your soup." -Resident #6 did not raise her head or respond to the staff's prompts. Interview with a staff member on 5/23/16 at 5:02pm revealed this was not Resident #6's usual behavior. Interview with a Medication Aide (MA) on 5/23/16 at 5:04pm revealed: -Resident #6 wandered. -"Last week" Resident #6 exhibited behaviors such as trying to get out of the SCU door, opening windows, and pulling the fire alarm. -Resident #6 was started on a new medication the previous week and had been sleepy since	D 273		

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starting the new medication.
-The MA thought Resident #6's medication may be making her drowsy.

Interview with the Administrator on 5/23/16 at 5:08pm revealed:
-Resident #6 had started exhibited behaviors beginning Thursday, 5/19/16, that were "not like her" such as removing her pants in the hallway and urinating on the floor.
-Last Friday (5/20/16) morning, the Administrator instructed the Activity Director to contact Resident #6's Nurse Practitioner (NP) to obtain an order for a urinalysis (UA)because the Administrator suspected Resident #6 had a urinary tract infection (UTI).
-She thought the facility had obtained a verbal order for a urinalysis on Friday, 5/20/16 and obtained a urine sample from Resident #6 "late Friday" (5/20/16).
-The MAs were responsible for collecting the urine sample.
-The Administrator and MA on duty on Friday, 5/20/16 had a discussion about where to send Resident #6s urine sample.
-The Administrator told the MA, if the MA was unsure of where to send the UA, Resident #6 should be sent to the hospital emergency room (ER) for evaluation.
-When the Administrator reviewed the incident reports of Monday 5/23/16 from the previous week-end, she noticed documentation that Resident #6 was still exhibiting abnormal behaviors such as laying in another resident's bed.
-Upon review of the documentation on the incident reports on 5/23/16, the Administrator told the Resident Care Coordinator (RCC) to send Resident #6 to the ER at "around 8:00am or 8:30am at the latest" on 5/23/16.

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D 273	Continued From page 11 -The RCC asked the Administrator if a staff member needed to sit with Resident #6 while she was at the hospital ER; the Administrator told the RCC she "imagined so." -She did not know if Resident #6's family had been notified. -The Nurse Practitioner (NP) was notified about Resident #6's status on Friday, 5/20/16 when the verbal order was obtained for the urinalysis. -The Administrator did not know if the NP had been notified after Friday (05/20/16) that Resident #6 was still exhibiting behaviors that were unusual for Resident #6. -The RCC was responsible for sending Resident #6 to the ER on 5/23/16. -The Administrator did not know why Resident #6 was not sent to the ER that morning (5/23/16) upon her directive. -Resident #6 should have been sent to the ER that morning; the Administrator would assure Resident #6 was sent to the ER now (5/23/16 at 5:08pm). Observation on 5/23/16 at 5:15pm revealed: -The Administrator was standing outside of the entrance door to the SCU with the surveyor when the RCC entered the SCU. -The Administrator stopped the RCC and told the RCC to send Resident #6 to the ER. Observation on 5/23/16 at 5:30pm revealed EMS taking Resident #6 to the hospital. Observation on 5/24/16 at 9:24am revealed: -Resident #6 was lying on her right side on the floor of the Special Care Unit (SCU) day room. -Resident #6 was awake but did not respond to verbal prompts. -There was a Nurse Aide (NA) sitting in a chair behind Resident #6.	D 273		

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D 273	Continued From page 12 Interview with a NA on 5/24/16 at 9:24am revealed Resident #6 "tripped" and fell and the ambulance was "on the way." Interview with a family member of Resident #6 on 5/24/16 at 12:15pm revealed: -She just brought Resident #6 back to the facility from the hospital. -The hospital had released Resident #6 today. -They did not find anything wrong. -The hospital did a CAT scan on Resident #6 yesterday and today and said nothing was wrong. Observation of the SCU on 5/25/16 at 11:45am revealed: -Resident #6 was lying on the floor, on her left side. -Resident #6 was alert, but drowsy. -Staff told EMS Resident #6 was not usually quiet and lethargic; Resident #6 had been slumped on the sofa with her head in her chest. Interview with the MA on 5/25/16 at 11:45am revealed: -Resident #6 was sitting on the couch in the day room as the MA and a NA were taking the residents across the hall to the dining room for lunch. -Resident #6 was sleepy looking, but she was alert when the MA walked across the hallway to take another resident into the dining room. -There was another NA walking down the hallway toward the dining room to take Resident #6 into the dining room. -By the time the other NA got to the day room Resident #6 was lying on the floor; that was less than 2 minutes. -Resident #6 had not been acting like herself today.	D 273		

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D 273	Continued From page 13 -She would usually be walking up and down the hallways trying to get out the facility or taking things and stuffing them in her pockets. -This was the first time the MA saw Resident #6 like this; the MA had been off since Thursday of the previous week. Interview with a NA on 5/25/16 at 1:45pm revealed: -The NA had noticed on the past Sunday (5/22/16) that Resident #6 had a change in level of consciousness. -Resident #6 had been lethargic and just sleepy a lot. -Earlier in the day, the NA walked into the day room and found Resident #6 on the floor. -Resident #6 was on lying on the floor in front of the couch. -Resident #6 said she hit her head on the wheel of another resident's wheelchair. -Resident #6 was sent out to the hospital. -Resident #6 fell yesterday too; Resident #6 was also sent out yesterday (05/24/16). -She was aware Resident #6 had also been sent out on Monday (05/23/16). Interview with a Personal Care Aide (PCA) on 05/24/16 at 2:50pm revealed: -Resident #6 tried to throw a telephone at the PCA on Sunday, 05/23/16. -Beginning about a week ago, Resident #6 "wants to sleep all the time. " -The PCA heard another PCA talking to a MA about Resident #6's UA. -Resident #6 was supposed to have been send to the hospital ER for a UA on Friday, 05/20/16. -The PCA was not sure if Resident #6's UA was ever obtained or if Resident #6 was sent to the ER.	D 273		

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Interview with the RCC on 5/24/16 at 5:15pm revealed:
-The physician was notified of Resident #6 having a change in mental status on 5/24/16 at 1:00pm.
-The physician was informed Resident #6 went to the hospital on 5/23/16 and 5/24/16 and the hospital did not find anything wrong.

Review of the "Report of the Health Care to Residents" form for Resident #6 dated 5/24/16 revealed, the physician stopped Depakote 250mg three times a day and ordered Depakote 250mg two times a day via telephone order.

Interview with the RCC on 05/25/16 at 12:55pm revealed when a resident had a changed in mental status, it was facility procedure to call 911, send the resident to the hospital, call the family, and call the physician.

Interview with the RCC on 5/25/16 at 6:15pm revealed:
-She (the RCC) had never been told by the Administrator to send Resident #6 to the ER.
-The RCC found out Resident #6 was being sent to the ER on 5/23/16 by overhearing staff talking about it.
-The RCC heard a MA say she would send Resident #6 to the ER on 5/23/16; the RCC was unsure of the time she heard the MA make the statement, but it was the "earlier part of the morning."
-The MA assigned to the hall was "usually" responsible for sending residents to the ER.

Interview with the Administrator on 5/24/16 at 12:00pm revealed:
-Resident #6 was not sent to the hospital on 05/20/16 for her changes in behavior.
-The Administrator did not know if Resident #6's

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D 273	Continued From page 15 UA was obtained. -The MA on duty on Friday 05/20/16 "misunderstood" the Administrator's directive to send Resident #6 to the hospital on Friday, 05/20/16 -The NP had ordered Depakote for Resident #6 for her combative behaviors. -The Administrator was not sure if staff had communicated that Resident #6 had been drowsy and lethargic after starting Depakote to the NP. -The Administrator did not know if the NP was notified before 05/23/16 except when staff requested the order for the UA on 05/20/16. -The Administrator had not asked the RCC why she had not Resident #6 to the hospital yesterday (05/23/16) morning. -"I think she (the RCC) just forgot." -The Administrator expected staff to be alert to changes in residents' conditions or behaviors. Attempts to contact the PA by telephone for interview were unsuccessful. Review of the Plan of Protection dated 05/25/16 revealed: -The Medication Aides and Supervisors would be responsible for contacting the primary care provider (PCP) in order to assure residents acute health care needs are met or will send the resident to the hospital if the need is indicated. -The Medication Aides and Supervisors would be responsible for documenting contact with the PCP or sending the resident to the hospital. -The Administrator, Resident Care Coordinator, or Designee would complete random record audits weekly for 4 weeks, then monthly for 4 months, and randomly thereafter to assure that the referral and follow-up needs of all residents have been met.	D 273		

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D 273	Continued From page 16 CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 9, 2016.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to assure documentation of physician treatment orders for 1 of 7 sampled residents (#2) for the use of oxygen as needed and to keep the right ankle padded at all times. The findings are: Review of Resident #2's current FL-2 dated 08/20/15 revealed a diagnoses included dementia Alzheimer's, coronary obstructive pulmonary disease, anemia, small bowel obstruction, cervical spinal stenosis, hypertension, tardive dyskinesia, degenerative joint disease, above the knee amputation, peripheral vascular disease, schizophrenia, diabetes type 2. Review of Resident #2's March 2016 Medication Administration Record (MAR) revealed: -There was a computerized entry to keep the right	D 276		

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ankle padded at all times.
-There was no documentation that the right ankle was padded.
-There was a computerized entry for oxygen at 2 liters by nasal cannula as needed for shortness of breath.
-There was no documentation that oxygen was administered.

Review of Resident #2's April 2016 MAR revealed:
-There was a computerized entry to keep right ankle padded at all times.
-The MAs documented that the right ankle was padded on the 6am to 2 pm shift from 04/01/16 through 04/04/16, on 04/06/16 and 04/07/16, 04/09/16 through 04/15/16, and 04/17/16 through 04/30/16.
-The MAs documented that the right ankle was padded on the 2pm to 10pm from 04/01/16 through 04/07/16 and 04/11/16 through 04/30/16, 10pm to 6am shift from 04/01/16 through 04/26/16.
-There was a computerized entry for oxygen at 2 liters by nasal cannula as needed for SOB.
-There was no documentation that oxygen was administered.

Review of Resident #2's May 2016 MAR revealed:
-There was a computerized entry to keep right ankle padded at all times.
-The MAs documented that the right ankle was padded on the 6am to 2 pm shift from 05/01/16 through 05/11/16, and 05/13/16 through 05/24/16.
-The MAs documented that the right ankle was padded on the 2pm to 10pm shift from 05/01/16 through 05/15/16, and 05/17/16 through 05/23/14.
-The MAs documented that the right ankle was padded on the 10pm to 6am shift on the 2nd, 3rd,

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D 276	Continued From page 18 5th, 7th, 8th, 9th, 11th, 12th, 14th, 15th 16th and 18th. -There was a computerized entry for oxygen at 2 liters by nasal cannula as needed for shortness of breath. -There was no documentation that oxygen was administered. Review of physician orders and Care Notes for Resident #2 revealed there were no subsequent treatment orders to keep the right ankle padded or for oxygen as needed. Based on observations, record reviews, and interviews, Resident #2 was not interviewable. Interview with the Resident Care Coordinator (RCC) on 05/24/16 at 5:20pm revealed: -The RCC had been in her current position since May 3rd or 4th, 2016. -She was in the process of reviewing and organizing records. -The subsequent orders for Resident #2 should be filed in the record. -She would attempt to locate the missing orders. A follow up interview with the RCC on 05/24/16 at 6:00pm revealed: -There were no orders found after the FL-2 date of 08/20/15 to continue oxygen as needed or to keep the right ankle padded in Resident #2's thinned record. -The only order found for the use of oxygen was prior to the current FL-2 date of 08/20/15. Interview with the Administrator on 05/25/15 at 11:22am: -Staff were expected to notify the physician for clarification of any orders. -The MA or SCC placed new orders on the	D 276		

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D 276	Continued From page 19 residents MAR. -Clarification should be done immediately and prior to that order being placed on the MAR. Interview with the RCC at 7:20pm on 05/25/16 revealed: -There were no subsequent orders found for padding the right ankle for Resident #2. -A clarification request had been written on 05/25/16 that questioned if the facility could continue to keep the right ankle padded at all times and to continue oxygen at 2 liters by nasal cannula as needed for shortness of breath. Review of a clarification request dated 05/25/16 revealed: -A handwritten entry that questioned if the facility could continue to keep the right ankle padded at all times, and to continue oxygen at 2 liters by nasal cannula as needed for shortness of breath. -The clarification was not signed by the PCP. A call was attempted on 05/25/16 at 7:30pm to the PCP, however there was no answer.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 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: Based on observations, interviews, and record reviews, the facility failed to assure residents' rights were maintained in accordance with G.S.	D 338		

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D 338	Continued From page 20 131 D-21. The findings are: 1. Based on observation, record reviews, and interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as evidenced by staff treating 1 of 7 residents sampled (#7) in a disrespectful manner by tapping on the resident's wrist and removing an eating utensil from the resident's hand during meal time and failing to provide residents residing in the Special Care Unit (SCU) with non-disposable eating utensils during meals. [Refer to Tag D911, G.S.131D-21(1) Declaration of Residents' Rights (Type B Violation)]. 2. Based on observations and interviews the facility failed to assure 1of 7 residents sampled (#7) was free of abuse as evidenced by Staff A handling Resident #7 too roughly during transfer from a chair. [Refer to Tag D917, G.S.131D-21(4) Declaration of Residents' Rights (Type B Violation)]. 3. Based on record reviews and interviews the facility failed to respond to resident and family requests related to the missing property of 6 of 12 residents sampled (#3, #5, #7, #10, #11, and #12). [Refer to Tag D917, G.S.131D-21(7) Declaration of Residents' Rights].	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358		

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

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observation, interview, and record review, the facility failed to administer medications as ordered for 2 of 6 residents (#7, #8) observed during the medication passes, including errors with a phosphorus binder (#8), and insulin (#9) and 1 of 7 residents sampled for record review (#2) including an error with a medication used to treat mood disorders.

The findings are:

1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 3:30pm-4:00pm.medication pass on 05/23/16 and the 8:30am-9:00am medication pass on 05/24/16.

A. Observation of a medication pass in the Special Care Unit (SCU) on 05/23/16 at 3:44pm revealed:
-The Medication Aide (MA) administered 2 calcium acetate capsules to Resident #8 at 3:44pm on 05/23/16. (Calcium acetate is a medication used to reduce high levels of phosphorus in the blood of individuals with kidney failure and/or on dialysis. Calcium acetate works by preventing phosphorus from being absorbed in the body).
-The MA observed Resident #8 swallow the medications and initialed Resident #8's

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D 358	Continued From page 22 Medication Administration Record (MAR) after Resident #8 swallowed the pills. Interview with the MA on 05/23/16 at 3:45 revealed Resident #8 had just returned to the facility from her scheduled dialysis treatment. Review of Resident #8's current FL-2 dated 03/23/16 revealed: -Diagnoses included end stage renal disease (ESRD) "on dialysis", dementia, asthma, and hypertension. -There was a medication order for calcium acetate 667mg take two capsules (1334mg) three times daily with meals. Observation of Resident #8 on 05/23/16 from 4:45pm-4:55pm revealed: -Resident #8 was sitting at a dining table in the SCU dining room. -Resident #8 was served her supper meal at 4:55pm. Review of Resident #8's May 2016 MARs revealed: -There was a preprinted entry for calcium acetate 667mg "Take (2) capsules by mouth three times daily with meals. " -The administration times for calcium acetate were handwritten as 08:00am, 11:00am, and 5:00pm. -Calcium acetate was documented as administered to Resident #8 three times daily from 05/01/16-05/23/16 with the exception of the 5:00pm dose on 05/09/16. -Calcium acetate was not documented as administered on 05/09/16 at 5:00pm. Telephone interview with a Medication Aide/Supervisor (MA/S) on 05/25/16 at 1:25pm	D 358		

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revealed:
-When a medication was ordered with meals, it was not administered with the meal.
-"We give them to the resident before they eat. "
-Medication ordered with meals was given "30 minutes to 1 hour" before meals.
-The MA/S recalled and named four specific residents who had medications ordered with meals.
-Resident #8 had "blue and white capsules" (calcium acetate is a blue and white capsule) ordered with meals.
-Resident #8 got her blue and white capsule 30 minutes to 1 hour before her meals.

Telephone interview with the Registered Nurse (RN) at Resident #8's dialysis facility on 05/25/16 at 1:46pm revealed:
-Resident #8 required dialysis three times weekly.
-The calcium acetate medication would not lower Resident #8's phosphorus if she did not take the medication with her meals.
-Calcium acetate was expected to be administered to Resident #8 when she was eating her meal or the medication would not be effective.

Based on observation, record reviews, and interviews, Resident #8 was not interviewable.

Interview with the Administrator on 05/24/16 at 12:00pm revealed:
-The Administrator could recall one resident with orders for oral medications to be administrated with meals.
-The Administrator had spoken with a dialysis clinic about medications ordered with meals so the order would indicate to give the medication with the meal.
-The MAs were aware that medications ordered with meals should be given with the meal

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because the MARs indicated to give with the meal.

Refer to the interview with the MA/S on 05/23/16 at 4:00pm.

Refer to the interview with the Administrator on 05/25/16 at 11:25am.

B. Observation of medication pass in the Assisted Living (AL) section of the facility on 05/23/16 at 4:15pm revealed:
-The MA obtained Resident #9's finger stick blood sugar (FSBS) using aseptic technique with a glucometer labeled with Resident #9's name and removed from a drawer labeled with Resident #9's name.
-Resident #9's FSBS was 86 at 4:17pm.
-The MA administered 18 units of Novolin R insulin subcutaneously (SQ) in Resident #9's right upper arm at 4:20pm using aseptic technique. (Novolin R insulin is a fast/short acting form of insulin used to lower blood sugar. After SQ administration, Novolin R insulin starts lowering blood sugar within about 30 minutes).

Review of Resident #9's current FL-2 dated 01/20/16 revealed:
-Diagnoses included type 2 diabetes, atypical psychosis, gastroesophageal reflux disease (GERD), mild dementia, anxiety, and hypertension.
-There was a medication order for Novolin R insulin 12 units SQ three times daily.

Review of the "Report of Health Care Services to Residents" form for Resident #8 dated 02/16/16 revealed:
-There was a verbal order received from the Nurse Practitioner (NP) to increase Resident #9's

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Novolin R insulin to 18 units SQ three times daily with meals.
-The Report of Health Care Services to Residents contained the NP's signature on the verbal order and was dated 02/17/16.

Review of Resident #9's May 2016 MARs revealed:
-There was preprinted entry for Novolin R insulin "inject 18 units three times daily with meals" with administation times preprinted as 08:00am, 12:00pm, and 5:00pm.
-Novolin R insulin was documented as administered to Resident #9 three times daily from 05/01/16-05/23/16.

Interview with Resident #9 on 05/23/16 at 4:20pm revealed:
-Resident #9 always received both her scheduled and sliding scale insulins before meals.
-Staff usually gave Resident #9 her insulin between 4:00-4:30pm daily before supper.
-"They know what they're doing. "

Interview with Resident #9 on 05/23/16 at 5:05pm revealed:
-Resident #9 had not eaten supper at the first seating in the AL dining room.
-Resident #9's hall ate supper at 6:00pm.

Review of the "Snack/Meal Serving Times" schedule provided by the facility revealed:
-Each of the three wings of the facility had different meal times for breakfast, lunch, and dinner.
-The wing that Resident #9 resided on was scheduled for supper at 5:50pm.

Observation on 05/23/16 at 5:30pm as the survey team exited the facility revealed Resident #9 had

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(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 358	Continued From page 26 not been served supper yet and was sitting in the front lounge located across the hall from the AL dining room. Telephone interview with a Medication Aide/Supervisor (MA/S) on 05/25/16 at 1:25pm revealed: -Residents who had medications ordered with meals received the medications 30 minutes to 1 hour before their meal. -Insulin was given before meals even if the MAR said to give with meals. -"Usually we are giving the insulin and the resident is going in to the dining room to eat within 30 minutes to 1 hour. " Interview with the Administrator on 05/24/16 at 12:00pm revealed: -The Administrator was "sure" the facility had a medication administration policy. -There was a "universal policy" that medication was supposed to be administered between 1 hour before and 1 hour after the time the medication was due. -Insulin was supposed to be given within 15 minutes of a meal unless otherwise ordered. -Insulin administration should not "go 1 hour before or after" the time ordered; "any Med Tech would know that. " -There was an "issue" with the way meals were served at the facility but the Administrator had no control over it. -The Administrator had not been at the facility long enough to know which residents were diabetic. -When asked if the facility's dining schedule took into consideration the time diabetic residents were served meals, the Administrator replied "probably not."	D 358		

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D 358	Continued From page 27 Refer to the interview with the MA/S on 05/23/16 at 4:00pm. Refer to the interview with the Administrator on 05/25/16 at 11:25am. _____ Interview with the MA/Supervisor (MA/S) on 05/23/16 at 4:00pm revealed: -When a medication was ordered with meals, the medication was supposed to be administered to the resident while the resident was eating; "not necessarily with first bite of food but before they finished the meal. " -There was only one resident that the MA/S was aware of that had medications ordered to be administered with meals. Interview with the Administrator on 05/25/16 at 11:25am revealed: -The MAs were supposed to follow the licensure rules regarding medication administration. -The Administrator expected medications ordered with meals to be administered with the meal. 2. A. Review of Resident #2's current FL-2 dated 08/20/15 revealed: -Diagnoses included dementia Alzheimer's type, coronary obstructive pulmonary disease, anemia, small bowel obstruction, cervical spinal stenosis, hypertension, tardive dyskinesia, degenerative joint disease, above the knee amputation, peripheral vascular disease, schizophrenia, diabetes type 2. -There was a medication order for Depakote (a medication used to treat mood disorders) 250mg one daily. Review of Resident #2's March 2016 Medication Administration Record (MAR) revealed: -There was a computerized entry for Depakote	D 358		

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250mg take 1 every morning.
-The Medication Aides (MA) documented the administration of Depakote 250mg from 03/01/16 through 03/31/16.
-There was a computerized entry for Depakote 500 mg take at bedtime.
-The MAs documented the administration of Depakote 500mg from 03/01/16 through 03/31/16.
-There was a computerized entry for Baza Antifungal cream apply under both breast twice daily.
-The MAs documented the administration of Baza Antifungal cream on the 6am to 2pm shift daily from 03/01/16 through 03/31/16.
--The MAs documented the administration of Baza antifungal cream on the 2pm to 10pm shift daily from 03/01/16 through 03/28/16
-There was a computerized entry for Tylenol 325mg, 2 tabs three times a day as needed with Ultram as needed for headache.
-The MAs did not document any administration of Tylenol with Ultram.

Review of Resident #2's April 2016 MAR revealed:
-There was a computerized entry for Depakote 250mg take 1 every morning.
-The MAs documented the administration of Depakote 250mg from 04/01/16 through 04/30/16.
-There was a computerized entry for Depakote 500 mg take at bedtime.
-The MAs documented the administration of Depakote 500mg from 04/01/16 through 04/30/16.
-There was a computerized entry for Baza Antifungal cream apply under both breast twice daily.
-The MAs documented the administration of Baza

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antifungal cream twice daily from 04/01/16 through 04/30/16 with the exception of 04/27/16 on the 2pm to 10pm shift.
-There was a computerized entry for Tylenol 325mg, 2 tabs three times a day with Ultram as needed for headache.
-The MAs documented the administration of Tylenol with Ultram on 04/15/16.

Review of Resident #2's May 2016 MAR revealed:
-There was a computerized entry for Depakote 250mg take 1 every morning.
-The MAs documented the administration of Depakote 250mg from 05/01/16 through 05/24/16
-There was a computerized entry for Depakote 500 mg take at bedtime.
-The MAs documented the administration of Depakote 500mg from 05/01/16 through 05/23/16.
-There was a computerized entry for Baza Antifungal cream apply under both breast twice daily.
-The MAs documented the administration of Baza antifungal cream twice daily from 05/01/16 through 05/24/16 with the exception of 05/12/16 on the 6am to 2 pm shift.
-There was a computerized entry for Tylenol 325mg, 2 tabs three times a day as needed with Ultram for headache.
-The MAs did not document any administration of Tylenol with Ultram.

Review of physician orders and Care Notes for Resident #2 did not reveal any subsequent orders for Depakote 500mg at bedtime, Baza antifungal cream twice a day, and Tylenol to be given with Ultram as needed for headaches.

Based on observations, record reviews, and

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interviews, Resident #2 was not interview-able.

Interview with the Resident Care Coordinator (RCC) on 05/24/16 at 5:20pm revealed:
-The RCC had been in her current position since May 3rd or 4th, 2016.
-She was in the process of reviewing and organizing records.
-The subsequent orders for Resident #2 should be filed in the record.
-She would attempt to locate the missing orders.

A follow up interview with the RCC on 05/24/16 at 6:00pm revealed:
-There were no orders found after the FL2 date of 08/20/15 for Depakote 500mg at bedtime or Baza antifungal cream bid in Resident #2's thinned record.
-The only order the Baza antifungal cream found was prior to the current FL2 date of 08/20/15.
-A call had been made to Resident #2's Primary Care Provider (PCP) regarding the Depakote dosage who then referred the dosage question of this medication to the Mental Health Provider.
-A call had been made to the Mental Health Provider who clarified that Resident #2 should be on Depakote 250mg in the morning and Depakote 500mg at bedtime; a clarification order would be written.

Review of the Policy and Procedure Manual for the facility revealed:
-All resident orders would be maintained in the resident's record.
-Medication orders would be verified by staff with a physician or prescribing practitioner when orders were received which were not clear or incomplete.
-Verification or clarification of medications would be documented in the resident's records.

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D 358	Continued From page 31 Interview with the Administrator on 05/25/15 at 11:22am: -Staff were expected to notify the physician for clarification of any orders. -The MA or the SCC sent all medication orders to the pharmacy. -The MA or SCC placed the new orders on the residents MAR. -Clarification should be done immediately and prior to that order being placed on the MAR. Telephone interview with the Mental Health Provider's nurse on 05/25/16 at 5:05pm revealed: -Resident #2's current dose of Depakote should be 250 mg in the morning and 500 mg at bedtime. -Review of Resident #2's notes reflect that Depakote was increased by 250 mgs to equal 750 mg total dose daily on 07/02/15. -Resident #2's Depakote levels had been stable within the last year. Interview with the RCC at 7:20pm on 05/25/16 revealed: -A clarification request had been written on 05/25/16 to continue Baza cream antifungal 2 percent under breast twice daily, and to continue Tylenol 325mg, 2 tabs three times a day as needed with Ultram for headache. Review of a clarification request written on 05/25/16 revealed: -There was handwritten entry that questioned if the facility could continue the Baza cream antifungal 2 percent under breast twice daily, and to continue Tylenol 325mg, 2 tabs three times a day as needed with Ultram for headache. -There was a note at the bottom of the order that	D 358		

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D 358	Continued From page 32 the medications were not listed on the FL-2 but were still being given. -The primary care provider had not signed the form. A call was attempted on 05/25/16 at 7:30pm to the PCP, however there was no answer. Review of the Plan of Protection dated 05/25/16 revealed: -The Administrator, Resident Care Coordinator (RCC), or Designee would immediately begin to review MARs to ensure orders were being carried out appropriately. -Medications to be given with food would be high-lighted on the MARs for easier recognition by staff. -The MAs and Supervisors would be provided with additional training on medication administration. -The Administrator, RCC, or Designee would review all diabetic orders to ensure clarification of the orders. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 9, 2016.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior	D 366		

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D 366	Continued From page 33 to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record review and interviews, the facility failed to assure staff observed 1 of 7 residents (Resident #5) swallowed medications before signing off on the Medication Administration Record (MAR) resulting in medications being left in cups in the chest of drawers of Resident # 5's room. The findings are: Review of Resident # 5's current FL-2 dated 12/3/15 revealed: -Diagnoses included hypertension, osteoporosis and insomnia. -There was a medication order for Fosamax 70 mg weekly. -There was a medication order for Docusate Sodium 100 mg twice daily. -There was a medication order for Ranitadine 150 mg daily. Observation of an open chest of drawers in Resident # 5's room on 5/25/16 at 11:30am revealed: - There was a medication cup with two white oblong tablets with markings which were later identified as Fosomax tablets. -There was a medication cup with eight white round tablets with markings which were later identified as Docusate Sodium tablets. -There was a medication cup with 10 orange round tablets with markings which were later identified as Ranitidine tablets.	D 366		

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D 366	Continued From page 34 -There were nine additional empty medication cups Interview with Resident #5 on 5/25/16 at 11:30 am revealed: -Has been having "a problem in her vaginal area"and went to see her Primary Care Physician (PCP). -The PCP told her that some of her medications might be causing the problem that she was experiencing. -Resident #5 decided not to take some of her medications to see if the "problem" would go away. -Two of the Medication Aides (MAs) would leave the cup with the medications and would walk away because she had been there a long time and they felt comfortable that the medication would be taken. -Some of the MAs would watch the medication being swallowed. -Resident #5 was unable to identify the medications in two of the cups but was able to identify the two Fosamax tablets in one cup. -Resident #5 was unaware that the tablets in one of the cups was Docusate Sodium for constipation. -Resident #5 reported being constipated for the last couple of days. Interview with a MA on 5/25/16 at 12:30 pm revealed: -Resident # 5 would tell her that her PCP didn't want her to take the medications because the medications might be causing her "dryness" and she would give the medications back. -The MA disposed of the returned medications in the medication room trash can. -The MA did not know how the medications got into the chest of drawers in Resident #5's room	D 366		

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D 366	Continued From page 35 unless Resident # 5 spit the medications out after she left the room. Interview with a second MA on 5/25/16 at 4:00 pm revealed: -Resident # 5 had never refused her medications on her shift. -The MA always stood in Resident # 5's room and observed Resident #5 taking her medications. -The MA denied leaving a medication cup in Resident # 5's room. -The MA always took the cup with her after the resident had taken her medication. -The MA could not explain how medication would be in cups in the chest of drawers in Resident # 5's room. Interview with the Administrator on 5/25/16 at 1:30 pm revealed: -The Administrator could not explain how or why the medications were in Resident # 5's chest of drawers. -The MAs were expected to follow facility policy and observe residents take their medications. Review of the facility's "Policy and Procedure Manual" regarding Medication Administration revealed staff would provide documentation on the MAR after observing the residents taking the medications and before administration to another resident. --- Review of the Plan of Protection dated 05/25/16 revealed: -Staff would receive additional training on medication administration policies and procedures beginning 05/25/16. -The Administrator, Resident Care Coordinator (RCC), or Designee would conduct routine	D 366		

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D 366	Continued From page 36 interviews with residents to ensure medications were being administered per policy. -Any staff not following the medication administration policies will receive additonal training and disciplinary action up to and including termination. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 9, 2016.	D 366		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to report allegations of abuse against 1 of 6 staff sampled (Staff A) to the North Carolina Health Care Personnel Registry (NCHCPR) within 24 hours and provide documentation the alleged acts were investigated and reported to NCHCPR within 5 days. The findings are: Review of Resident #7's current FL-2 revealed diagnoses included Alzheimer's disease and essential hypertension. Confidential interview with a resident's family	D 438		

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member revealed:
-"Last Friday" (05/20/16) at breakfast, Staff A "jerked" Resident #7 out of a chair "inappropriately."
-The family member would not want "[her family member] handled like that."
-The family member reported the incident to the Supervisor of the Special Care Unit (SCU) on the same day of the incident (05/20/16).
-The Supervisor told the family member she would talk to staff A about the incident.
-Staff A approached the family member during lunch and said "I understand you think you saw me jerk [Resident #7's name] but her family knows how we have to handle her."
-Staff A told the family member "You have no idea how hard our job is."
-Staff A also told the family member "If you have anything to say to me, don't tell my co-workers, tell it to my face."

Confidential telephone interview with a staff member revealed:
-On 05/19/16 or 05/20/16, a family member told the staff that Staff A "jerked a lady out of the chair" after breakfast in the SCU dining room.
-The family member asked the staff if anyone had been treating her family member that way.
-The staff "explained" to the family member to report the incident to the "SIC" (Supervisor in Charge) on duty that day.
-It was against the rules to discuss a resident with any other resident's family member.
-When the staff went to report the family member's allegation against Staff A to the MA/SIC, the MA/SIC already knew about the incident because the family member had already notified the MA/SIC.
-The family member told the staff she (the family member) was going to report the allegation to the

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facility Administrator.
-Staff A told the staff that she (Staff A) had reported the family member's allegation to the Administrator that day.
-The Administrator never contacted the staff about the incident after Staff A told that staff she had talked to the Administrator about the incident.

Confidential interview with a second staff revealed:
-The staff recalled being notified about the family member's allegation that Staff A removed Resident #7 from a chair in an inappropriate manner.
-The staff was not sure of the date she was notified of the allegation but recalled it was last Wednesday or Friday (05/18/16 or 05/20/16).
-That same day (05/18/16 or 05/20/16) Staff A told the staff that she (Staff A) was going to talk to the Administrator about the alleged incident.
-That same day, (05/18/16 or 05/2016), the staff observed Staff A with a piece of paper and Staff A told the staff member that the Administrator had instructed Staff A to write a statement.

Confidential interview with a third staff member revealed:
-"After Breakfast" on 05/20/16 at "7:30 or 8:00'" (am) a family member told the staff member that Staff A was rude and jerked Resident #7 out of her chair.
-The staff talked to Staff A about the allegation on 05/20/16.
-Staff A told the staff member she was not rude to the family member and had not "jerked" Resident #7 out of the chair.
-The family member also told another staff member about the incident, and that staff member told her to report the incident to the Supervisor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(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
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-Staff A told the staff she was going to talk to the Administrator about the incident.
-The staff observed Staff A in the Administrator's office about 9:00am on 05/20/16; "they had closed the door."
-Staff A was off the floor "like 30 minutes."
-The staff did not report the allegation to the Administrator because Staff A said she reported it to the Administrator and Staff A was in the Administrators office.
-The Administrator had not asked the staff anything about the allegation.

Based on observations, record reviews, and interviews, Resident #7 was not interviewable.

Telephone interview with Resident #7's family member on 05/25/16 at 12;44pm revealed the family member denied concerns or complaints related to how staff members treated Resident #7, but Resident #7 was scheduled to move out of the facility because the family was not satisfied with the overall level of care provided to Resident #7.

Interview with the Administrator on 05/24/16 at 12:00pm revealed:
-It was facility procedure for the Supervisor to be notified of allegations of violations of residents' rights and the Supervisor was supposed to notify the Administrator.
-No staff or family member had ever complained about Staff A to the Administrator.
-The Administrator had never observed Staff A be disrespectful to any resident.
-The Administrator had no knowledge of the allegation against Staff A and had not investigated or reported the allegation to NCHCPR.

Interview with Staff A on 05/25/16 at 1:00pm

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revealed:
-Staff A worked as a Personal Care Aide (PCA) on first shift in the SCU.
-Staff A recalled an incident on Friday or Saturday (05/20/16 or 05/21/16) when a family complained to another staff that she (Staff A) "snatched" Resident #7 out of her dining room chair.
-Staff A denied removing Resident #7 from the chair in an inappropriate manner.
-Staff A "got upset about it" and reported the incident to the the Administrator on the same day of the incident.
-The Administrator told Staff A she would talk to the family about the incident.

Interview with the Administrator on 05/24/16 at 1:26pm revealed:
-Staff A had just been terminated.
-The Administrator would report the allegations against Staff A to NCHCPR.

Interview with the Administrator on 05/25/16 at 11:25am revealed:
-No family member had ever came to the Administrator to report any allegations against Staff A.
-Staff A went to the Administrator on 05/20/16 and told her "she didn't want to lose her license because [family member's name] has a history of exaggeration."
-On 05/20/16, Staff A told the Administrator she had to "grab a hold of a resident" to keep her from falling'; the Administrator "cannot even remember" if Staff A told the Administrator the resident's name.
-The first time the Administrator received report of anyone being "jerked" was "yesterday"(05/24/16).
-"There were no red flags."
-Staff A told the Administrator on 05/20/16 that she told the family member "woman to woman

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D 438	Continued From page 41 that if she (the family member) had a problem with her to come to her and not to tell other staff." -"Staff felt like they reached a point to where they need to stand up to her" (the family member). -The Administrator had started an investigation and the allegations against Staff A were reported to NCHCPR. Review of the facility's "Policy and Procedure Manual" with a revision date of "July 7, 2014" revealed: -Documentation in the section entitled "Abuse Policy and Procedures" read "The facility reports alleged violations, conduct, and investigation of all alleged violations to the proper authorities and takes necessary corrective actions." -"As part of the administration process, residents and family are provided with information regarding how to report suspected abuse and their right to be free of abuse, neglect, and misappropriation of their property." -"Employees will be provided with the information regarding the process for reporting witnessed abuse." -"All reports whether from family, residents, or staff will be reported immediately to the Executive Director." -"When an incident or suspected incident of resident abuse, neglect, misappropriation of resident property or injury of unknown source is reported, the Executive Director/Designee will begin an investigation." -"the Executive Director/Designee will follow all regulatory requirements for reporting to the appropriate agencies to include the Health Care Personnel Registry. A 24 hour initial report is made to the Health Care Personnel Registry and a completed investigation report is submitted within 5 days of the initial report."	D 438		

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D 438	Continued From page 42 Review of the Plan of Protection dated 05/25/16 revealed: -Management staff will receive additional training on reporting accusations of abuse and/or neglect to the healthcare personnel registry-05/25/16. -All staff will receive additional training regarding policy and reporting procedures-06/03/16. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 9, 2016.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify the county department of social services of incidents requiring referral for emergency medical evaluation for 1 of 7 residents sampled (#1). The findings are: Review of Resident #1's current FL-2 dated 12/30/15 revealed diagnoses included dementia, hypertension, coronary artery disease (CAD), macular degeneration, degenerative joint disease (DJD), and anemia.	D 451		

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Review of the "Care Notes" for Resident #1 dated 04/26/16 revealed:
-There was no time documented on the entry.
-Resident #1 "was sent to hospital due to him falling."

Review of the "Care Notes" for Resident #1 dated 04/26/16 at 7:30pm revealed Resident #1 returned from the hospital with "no new orders, only to monitor for fall risk."

Review of the hospital "Physician's Note" for Resident #1 dated 04/26/16 revealed:
-The "history of present illness" contained documentation that Resident #1 was transferred from the facility to the hospital "after falling just prior to arrival."
-Resident #1 complained of "pain to the head" and had an "abrasion" on his right upper arm.
-"Diagnosis 1" was fall.
-"Diagnosis 2" was skin tear.
-The "Physician Note" was electronically signed by the physician and dated 04/28/16.

Review of the hospital "Emergency Department Chart" for Resident #1 dated 04/26/16 revealed:
-Resident #1 had an "abrasion" on back of his right upper arm.
-Resident #1 had an "abrasion located over the left elbow."
-Resident #1 was discharged from the hospital on 04/26/16.

Interview with a Medication Aide/Supervisor (MA/S) on 05/25/16 at 4:04pm revealed:
-The MA/S was on duty when Resident #1 fell on 04/26/16 and documented the fall in Resident #1's "Care Notes."
-Resident #1 hit his head on the wall on 04/26/16.
-The MA/S called 911 and Resident #1 was

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transported to the hospital emergency department (ED) by emergency medical services (EMS).
-The MA/S did not complete an Accident/Incident Report on 04/26/16.
-The MA/S had received training on completion of Accident/Incident Reports "about 4 months ago" but was "confused" and did not know an Accident/Incident Report was required.

Review of "Care Notes" for Resident #1 dated 05/13/16 at 12:30am revealed:
-Resident #1 "stumbled into/against bedroom door."
-Resident #1 had a "small bump/bruise on the right side of his forehead" and one skin tear on each arm.
-Resident #1 was transported to the hospital.

Review of "Care Notes" for Resident #1 dated 05/13/16 at 4:20am revealed Resident #1 returned to the facility from the hospital.

Review of the hospital "Physician's Note" for Resident #1 dated 05/13/16 at 01:38am revealed:
-The "history of present illness" was Resident #2 was transferred to the hospital "after falling tonight."
-Resident #1 reported "slipping and falling and hitting his head."

Review of the hospital "Emergency Department Chart" for Resident #1 dated 05/13/16 revealed:
-Resident #1 received a Tetanus immunization injection in the emergency department on 05/13/16.
-Resident #1 was discharged from the hospital on 05/13/16

The staff member who documented the two

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D 451	Continued From page 45 "Care Notes" in Resident #1's record dated 05/13/16 was not available for interview on 05/25/16. Interview with the Resident Care Coordinator (RCC) on 05/25/16 at 12:55pm revealed: -The MA/S on duty was responsible for completing an Accident/Incident Report at the time an incident occurred. -All Accident/Incident Reports were supposed to be sent to the county Department of Social Services (DSS). -The facility Administrator (ADM) reviewed the Accident/Incident Reports and faxed the reports to DSS. Interview with the county DSS Adult Home Specialist (AHS) on 05/25/16 at 9:33am revealed DSS had not received any reports from the facility for Resident #1 dated 04/26/16 or 05/13/16. Interview with the facility ADM on 05/25/16 at 11:25am revealed: -Accident/Incident Reports were supposed to be completed by the MA/S when a resident was injured requiring hospital evaluation. -The ADM reviewed the Accident/Incident Reports and then faxed the reports to DSS. -The ADM retained fax confirmation after the Accident/Incident Reports were faxed to DSS. -Sometimes the ADM gave the Accident/Incident Reports to the AHS during the AHS visits to the facility.	D 451		
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,	D911		

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D911	Continued From page 46 dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record reviews, and interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as evidenced by staff treating 1 of 7 residents sampled (#7) in a disrespectful manner by tapping on the resident's wrist and removing an eating utensil from the resident's hand during meal time and failing to provide residents residing in the Special Care Unit (SCU) with non-disposable eating utensils during meals. The findings are: 1. Observation of the SCU dining room during the lunch meal on 05/24/16 between 11:20am and 11:40am revealed: -Resident #7 was sitting at a dining table on the left side of the room near the cabinet. -Staff were serving residents lunch. -Staff A removed a plastic spoon out of Resident #7's hand. -Staff A tapped Resident #7's right wrist with her fingers. -Staff A told Resident #7, "Put it down. Don't eat the meat because you ain't chewing it." -Staff A removed the plastic spoon from Resident #7's hand a second time, emptied the food on the spoon onto Resident #7's plate, and then put potatoes on the spoon. -After removing the plastic spoon from Resident #7's hand the second time, Staff A told Resident #7 "Eat these vegetables. It's good for you."	D911		

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D911	Continued From page 47 -Resident #7 did not respond verbally to Staff A. Review of Resident #7's current FL-2 revealed diagnoses included Alzheimer's disease and essential hypertension. Confidential interview with a family member on 05/23/16 revealed: -A select few staff who worked at the facility "don't need to be here." -Staff A spoke to residents and families in a "rude" manner. Confidential interview with a second family member revealed: -Staff A "can be very hostile. " -"A week or so ago" during lunch, the family member observed that two female residents in the SCU dining room had been given metal eating utensils to eat with but the other residents in the SCU dining room had plastic eating utensils. -Staff A approached the two residents and took their metal eating utensils off of their table and replaced it with plastic eating utensils. -Staff A told the two residents "You ain' t no better than anybody else and you can use plastic (eating utensils) just like everybody else. " -The family member felt bad for the two residents; "there was no reason for [Staff A] to treat them like that." -The family member did not report the incident because he was afraid his family member would be mistreated if he reported the incident. - Around the end of April 2016, Staff A was observed using profanity during a discussion with another staff member in the SCU dining room during a meal, in the presence of several residents. -The family member observed Staff A saying	D911		

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D911	Continued From page 48 "There may be somebody new here, but that's all their gonna get dammit; we are going to continue dammit like we have been doing, or they can do it their damn self." -"In my opinion, she (Staff A) does not need to be here." Interview with a Staff A on 5/24/16 at 1:00pm revealed: -Staff A worked as a Personal Care Aide (PCA) on first shift in the SCU. -Staff A had not observed any resident being treated in a disrespectful manner. -Staff A denied treating any resident in a disrespectful manner. -Staff A was the only staff member that could handle Resident #7. -"[Resident #7's family] knows how I have to take care of her." -Staff A had training on residents' rights about every three months. Confidential interviews with 4 additional staff members revealed: -The 4 staff members denied observing any resident being treated in a disrespectful manner by any staff. -The 4 staff members denied receiving any reports from residents, family members, or other staff about residents being treated in a disrespectful manner. -Staff were not supposed to used profanity; profanity was "prohibited." Based on observations, record reviews, and interviews, Resident #7 was not interviewable. Interview with Resident #7's family member on 05/25/16 at 12:24pm on revealed: -The family member was not happy with the	D911		

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overall care Resident #7 received at the facility but the family member had not observed any staff members treat Resident #7 in a disrespectful manner.
-The family member's only concern regarding respect and dignity was that staff did not address the residents by "Mr. or Mrs."

Interview with the facility Administrator on 05/24/16 at 12:00pm revealed:
-The Administrator expected all residents to be treated with respect; "we work for them."
-No staff or family member had ever complained about Staff A to the Administrator.
-The Administrator had never observed Staff A being disrespectful to any resident.
-The Administrator was trying to get facility staff more customer service oriented.
-Staff were trained annually on residents' rights.

2..Observation of the SCU dining room on 05/23/16 from 11:28-am11:50am revealed:
-There were twenty-seven residents in the dining room.
-Twenty three residents had a disposable plastic spoon and metal fork during the lunch meal service.
-Four residents had only a metal fork for the meal; the 4 residents were not provided a spoon.

Observation of the SCU dining room during the supper meal on 05/23/16 from 4:45pm-5:04pm revealed:
-There were twenty-seven residents in the dining room.
-All twenty-seven residents had a disposable plastic spoon and metal fork.
-The menu consisted of vegetable soup.

Observation of the SCU dining room on 05/24/16

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D911	Continued From page 50 at 11:50am revealed: -Twelve residents had only a disposable plastic spoon to eat the lunch meal. -Sixteen residents had a disposable plastic spoon and metal fork to eat the lunch meal. -None of the twenty-six residents were provided with a knife. -The menu served consisted of pork loin and mashed potatoes. Confidential interview with a family member revealed: Residents in the SCU had to eat with plastic eating utensils "sometimes." "Sometimes" both the spoon and fork were plastic. "Sometimes" the residents were not given forks during their mea -The last time residents did not receive forks at their meal was the previous evening, 05/22/16, at "dinner. " -The family member was told by staff that the facility did not have any forks. -Some residents had trouble manipulating the plastic eating utensils. -Some foods could not be cut with the plastic utensils. -The Administrator was aware of the use of plastic eating utensils. -Last Friday, 5/20/16, the Administrator observed that the residents in the SCU had plastic eating utensils and said "Why are they eating with plastic?" Confidential interview with a second family member revealed the facility had been using plastic eating utensils on and off for the last 3 to 4 weeks. Confidential interview with a third family member	D911		

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revealed:
-The family member had observed that the residents in the SCU had to use plastic eating utensils during meals on several occasions.
-The family member was very concerned about the use of plastic eating utensils being used in the SCU, especially the use of plastic forks with the risk of the fork tines breaking, being swallowed, and risking a possible internal injury.
-The family member had questioned the staff in the past why plastic eating utensils was used, and was told by staff that the residents would take the metal eating utensils.
-The family member had observed residents having a hard time using the plastic utensils due to the plastic being too pliable; "they have a hard enough time eating as it is."

Confidential interviews with two staff revealed:
-Two of two staff had observed plastic eating utensils being used in the SCU dining room during meals.
-Staff was unsure how long plastic utensils had been used in the SCU.
-One staff was not aware metal eating utensils were supposed to be used during meals.

Interview with the Administrator on 05/24/16 at 12:00pm revealed:
-It came to the Administrator's "attention" last Friday, 05/20/16, that plastic eating utensils was being used in the SCU during meals when the Administrator observed the plastic eating utensils in use.
-The Administrator called her Supervisor (the Regional Director) that same day (05/20/16) to report the use of the plastic eating utensils.
-The Dietary Manager (DM) told the Administrator that residents took the metal eating utensils to their room or the metal eating utensils got thrown

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D911	Continued From page 52 in the trash so the facility did not have enough metal eating utensils. -The Administrator had never been notified by dietary staff about the lack of eating utensils prior to her observation on 05/20/16. -The Administrator expected the DM to notify her about the lack of adequate eating utensils supply. -The facility would have an adequate supply of metal eating utensils that Friday, 05/27/16. Review of the Plan of Protection dated 05/25/16 revealed: -Staff A had been terminated. -New metal eating utensils would be purchased and staff will be informed plastic ware would not be used unless indicated by physician order. -Administrator or Designee would conduct random interviews with residents and staff weekly for four weeks then monthly thereafter. -Ombudsman would provide Resident Rights training to all staff on 06/01/16. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 9, 2016.	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. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents received care and	D912		

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D912	Continued From page 53	D912		

services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration.

The findings are:

1.Based on observations, interviews, and record reviews, the facility failed to meet the health care needs of 2 of 7 residents sampled (#1, #6) by failing to seek medical evaluation for a resident who was prescribed Plavix on two different occasions after falls with reports of head injury (#1), and failing to seek medical evaluation for a resident with of changes in behavior and mental status after being prescribed Depakote (#6). [Refer to Tag D273, 10A NCAC 13F.0902(b) Health Care (Type B Violation)].

2. Based on observation, interview, and record review, the facility failed to administer medications as ordered for 2 of 6 residents (#7, #8) observed during the medication passes, including errors with a phosphorus binder (#8), and insulin (#9) and 1 of 7 residents sampled for record review (#2) including an error with a medication used to treat mood disorders. [Refer to Tag D358, 10A NCAC 13F.1004 Medication Administration (Type B Violation)].

3. Based on observation, record review and interviews, the facility failed to assure staff observed 1 of 7 residents (Resident # 5) swallowed medications before signing off on the Medication Administration Record (MAR) resulting in medications being left in cups in the chest drawer of Resident # 5's room. [Refer to Tag D366, 10A NCAC 13F.1004 Medication Administration (Type B Violation)].

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D914	Continued From page 54	D914		
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: TYPE B VIOLATION Based on observations and interviews the facility failed to assure 1of 7 residents sampled (#7) was free of abuse as evidenced by Staff A handling Resident #7 too roughly during transfer from a chair. The finding are: 1. Review of Resident #7's current FL-2 revealed diagnoses included Alzheimer's disease and essential hypertension. Confidential interview with a family member on 05/23/16 revealed: -On 05/20/16 at breakfast, Staff A "jerked" Resident #7 out of a chair "inappropriately." -The family would not want her family member "handled like that." -The family member reported the incident to the Supervisor of the Special Care Unit (SCU) on the same day of the incident (05/20/16). -The Supervisor told the family member she would talk to staff A about the incident. -Later in the day on 05/20/16 during lunch, Staff A approached the family member and said "You have no idea how hard our job is." -Staff A told the family member "If you have anything to say to me, don't tell my co-workers, tell it to my face."	D914		

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-Staff A would not speak to the family member since the incident occurred on 05/20/16.
-The family member "keeps a close eye" on Staff A because of an incident that occurred in November 2015 when Staff A "popped" a resident on the head and told him to :"shut up when he was having an outburst."
-The family member had not actually observed the incident in November 2015 but was told by another member of her family who observed the incident so she would know to watch Staff A.
-The family did not report the November 2015 incident because the family was not sure what to do at that time.

Interview with a Staff A on 5/24/16 at 1:00pm revealed:
-Staff A worked as a Personal Care Aide (PCA) on first shift in the SCU.
-Staff A had not observed any resident being treated in a disrespectful manner.
-Staff A recalled an incident on Friday (05/20/16) with Resident #7.
-Another resident's family member was in the dining room when Staff A was getting Resident #7 out of a chair and holding her up.
-The resident's family member went to another staff member and reported that she (Staff A) pulled on Resident #7 and "snatched" her out of a chair.
-The family member who reported that she (Staff A) removed Resident #7 from the chair inappropriately did not know what she was talking about.
-Staff A did not remove Resident #7 from the chair in an inappropriate manner.
-The family member was upset about pull-ups because the facility was not able to use the pull-ups on the private pay residents.
-When the other staff member went to provide

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incontinent care to the resident of the family members , the family member asked the staff member why was she f .....g worried about her mom's pull-ups.
-Later that day when Staff A saw the family member again, Staff A told that family member she should have come to her (Staff A) if she had a problem with her.
-"I was not aggressive to her" (the family member).
"I just asked her why she didn't talk to me about it" and walked away.
-Staff A acknowledged she should not have gone to the family member about the incident.
-She had training on residents' rights about every three months.

Confidential telephone interview with a staff member revealed:
-On 05/20/16 at "7:30 or 8:00" (am) a family member reported that Staff A was rude and "jerked up" Resident #7 out of her chair.
-The staff member talked to Staff A about the allegation on 05/20/16.
-Staff A said she had not said anything rude and had not "jerked" Resident #7 out of the chair.
-The family member made the same allegation that Staff A "jerked" Resident #7 out of the chair to another staff member.

Confidential telephone interview with a second staff member revealed:
-At the end of last week on "Thursday or Friday," (05/19/16 or 05/20/16) a family member told the staff member that Staff A "jerked a lady out of the chair" after breakfast in the SCU dining room.
-The family member reported the incident between Staff A and Resident #7 to the staff member when she was changing a resident's pull-up and asked the staff member if anyone had

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D914	Continued From page 57	D914		

been treating her family member that way.
-Staff A did not "jerk her (Resident #7) out of the chair."

Based on observations, record reviews, and interviews, Resident #7 was not interviewable.

Interview with Resident #7's family member on 05/25/16 at 12:24pm on revealed the family member was not happy with the overall care Resident #7 received at the facility but the family member had not observed any staff members mistreat Resident #7.

Review of the facility's "Policy and Procedure Manual" with a revision date of "July 7, 2014" revealed:
-Documentation in the section entitled "Abuse Policy and Procedures" which read "Abuse is defined as: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical, emotional, or psychological harm, pain, or mental anguish.'
-"Types of abuse:...For example, rough handling of a resident ...."

Interview with the facility Administrator on 05/24/16 at 12:00pm revealed:
-'Nobody" had ever complained about Staff A to the Administrator.
-The Administrator had no knowledge of the family member's complaint about Staff A on 05/20/16.
-Staff were trained annually on residents' rights.

Interview with the Administrator on 05/24/16 at 1:26pm revealed:
-Staff A had just been terminated.
-The Administrator would report the allegations against Staff A to the NC Health Care Personnel

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D914	Continued From page 58 Registry (HCPR). Interview with the Administrator on 05/25/16 at 11:25am revealed: -Staff A went to the Administrator on 05/20/16 and told her "she (Staff A) didn't want to lose her license because [family member's name] has a history of exaggeration." -On 05/20/16, Staff A told the Administrator she had to "grab a hold of a resident" to keep her from falling"; the Administrator "cannot even remember" if Staff A told the Administrator the resident's name. -The first time the Administrator received report of anyone being "jerked" was "yesterday" (05/24/16). -"There were no red flags." -Staff A told the Administrator that on 05/20/16 she told the family member "woman to woman" that if she (the family member) had a problem with her to come to her and not to tell other staff. -"Staff felt like they reached a point to where they need to stand up to her" (the family member). 2. Based on record reviews and interviews the facility failed to report allegations of abuse against 1 of 6 staff sampled (Staff A) to the North Carolina Health Care Personnel Registry (NCHCPR) within 24 hours and provide documentation the alleged acts were investigated and reported to NCHCPR within 5 days. [Refer to Tag D438, 10A NCAC 13F.1205 Health Care Personnel Registry (Type B Violation)]. Review of the Plan of Protection dated 05/25/16 revealed: -Staff A was terminated and reported to NCHCPR. -Administrator or Designee would conduct random interviews with residents and staff weekly	D914		

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D914	Continued From page 59 for four weeks then monthly thereafter. -Ombudsman would provide Resident Rights training to all staff on 06/01/16.	D914		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to respond to resident and family requests related to the missing property of 6 of 12 residents sampled (#3, #5, #7, #10, #11, and #12). The findings are: 1. A. Review of Resident #3's current FL-2 revealed diagnoses included Alzheimer's disease, hypertension, depression, anxiety, and non-insulin dependent diabetes. Review of the Resident Register revealed Resident #3 was admitted to the facility on 12/15/14. Based on observations, record reviews, and interviews, Resident #3 was not interviewable. Interview with Resident #3's family member on 05/23/16 between 12:00pm-12:30pm revealed: -Resident #3 had "many" clothes missing; the problem was ongoing since Resident #3's admission. -Resident #3's clothing was labeled with her name.	D917		

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D917	Continued From page 60 -Resident #3 recently had missing hangers and Resident #3 only had one pair of socks today, 05/23/16; all other socks were missing. -The family member found black hair in Resident #3's hairbrush that day (05/23/16) and her hair is white. -The family member had reported the missing items to the previous Interim Administrator. -The former Interim Administrator would tell the family member she would follow up but then would not follow up. -The family member was going to request a lockable space for Resident #3. Confidential staff interview revealed: -The facility did not have a lost and found policy. -Items reported missing were not documented in writing; missing items were verbally reported among staff. Refer to the interview with the Administrator on 05/24/16 at 12:02pm. B. Review of Resident #11's current FL-2 dated 11/12/15 revealed diagnoses included dementia, insomnia, seizure disorder, hypertension, and degenerative joint disease (DJD). Based on observation and interviews, Resident #11 was not interviewable. Interview with Resident #11's family member on 05/23/16 at 12:30pm revealed: -Resident #1 had missing clothing and other items since being admitted to the facility. -In November 2015, a pair of black pants with the tags still attached went missing and were never found. -Resident #11 had three pairs of pajama bottoms missing "recently."	D917		

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D917	Continued From page 61 -Resident #11 was also missing a pair of black bed room slippers, a "bone shaped bed pillow", and two flat sheets. -About three weeks ago Resident #11's door decoration (a grapevine basket) went missing. -The family member notified staff about each of the missing items; none of the items had been found or returned. -"They don't care." Refer to the interview with the Administrator on 05/24/16 at 12:02pm. C. Review of Resident #5's current FL-2 dated 12/3/15 revealed diagnoses included hypertension, osteoporosis, and Insomnia. Review of Resident #5's Resident Register revealed an admission date of 01/10/15. Interview with Resident #5 on 5/23/16 at 11:55 am revealed: -Resident #5 had a nice shirt and a pair of pants that matched to go missing from the laundry that were never located. -Within the past few months, Resident #5 hid $34.00 in her wallet one Saturday morning in the top chest drawer under some clothes and discovered the money was missing while out shopping later that day. -Resident #5 reported the missing money to the previous Interim Administrator and the money was never reimbursed. -The previous Interim Administrator arranged for a lock to be placed on her door. -Resident #5 did not have a lockable space in her room prior to the lock being placed on her door. -Resident #5 did not have any more items go missing after the lock was placed on her door.	D917		

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D917	Continued From page 62 Interview with a Supervisor on 5/25/16 at 1:50 pm revealed: -The Supervisor was aware that Resident # 5 reported some missing money to the previous Interim Administrator but was not aware of the amount. -When items were reported missing by residents, staff attempted to track down the item by checking the residents' rooms to see if the items were misplaced. -If items were found that do not have labels with resident names, they are left in the laundry room to see if anyone claimed the items. Refer to the interview with the Administrator on 05/24/16 at 12:02pm. D. Review of Resident #10's current FL-2 dated 12/22/15 revealed diagnoses included hyperglycemia, hypertension, bipolar disorder, diverticulitis, bronchitis and history of breast cancer. Interview with Resident #10 on 5/23/16 at 11:30 am revealed: -Resident #10 had a pair of expensive red slacks to go missing in the past two weeks. -Resident #10 had reported the stolen pants to the Administrator. -Resident #10 did not know if she would be reimbursed for the pants. -Resident #10 had heard other residents complain about stolen items but didn't remember their names. Refer to the interview with the Administrator on 05/24/16 at 12:02pm. E. Review of Resident #7's current FL-2 revealed diagnoses included Alzheimer's disease and	D917		

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D917	Continued From page 63 essential hypertension. Review of the Resident Register for Resident #7 revealed she was admitted to the facility on 03/07/16. Interview with a family member on 05/25/16 at 12:24pm revealed: -A staff member reported to her around the end of April 2016 that they had found Resident #7's upper dentures on the floor in the resident's room; the staff member picked them up, placed them in the bathroom sink, got distracted in another room, and when she returned the dentures were gone. -The upper plate had one gold overlay tooth. -The family member had spoken with the other staff members and the administrator about the missing plate, and was told that all staff had been informed to look for the resident's upper dentures. -The replacement of the upper dentures was expensive. -Resident #7 had not had any other missing items except "for a sock or two or underclothing, but she was not worried about that". Confidential interview with a housekeeping staff member revealed: -She was not aware of any missing dentures for Resident #7, "first she had heard of it ". -She was not always told about residents missing items unless she was there on the day an item was missing and could not recall ever being instructed to be on the lookout for a certain item. Confidential interviews with 3 other staff members revealed: -Some staff members were aware of the missing dentures, but they had not been found.	D917		

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D917	Continued From page 64 -A staff member did not know anything about the missing dentures. Interview with the RCC on 05/25/16 revealed: -The resident's family member had reported that Resident #7's upper dentures with one gold overlay were missing. -The staff member that placed the dentures in the resident's sink was supposed to be looking for the dentures. -A room to room search had been done to locate the dentures. -The family member had been looking for the dentures. -The dentures could have been accidentally thrown in the trash. Interview with Administrator on 05/25/16 at 4:30pm revealed: -She was aware of the missing upper denture and was afraid it may had been thrown in the trash. -She had reported to the Regional Director about the missing upper denture. Interview with the Regional Director on 05/25/16 at 4:50pm revealed she had been informed about the missing upper denture and knew staff had been looking for the denture. F.Review of Resident #12's current FL2 revealed diagnoses included dementia, diabetes type 2, chronic essential hypertension, acute myocardial infarction and carcinoma of the uterus. Interview with Resident #12's family member on 05/24/16 at 11:07am revealed: - The family member was recently asked by administration and the Regional Director to take a picture of the resident's items which made him feel that they did not believe him.	D917		

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D917	Continued From page 65 -The family member was told in the past by administration not to buy nice things for the resident, because the items would not last because other people would take them. -The family member did not want the resident to look "throwed away" . -The family member had been reimbursed $300.00 in the past for missing clothing items that belonged to the resident and was never recovered. Interview with the Administrator on 05/24/16 at 12:00pm reavealed: -There was a time that the washer in the SCU was not working; they had recently purchased a new washer, and this would decrease the chance of clothes getting misplaced out of the SCU. -The staff members had a general idea of what clothes belonged to the residents. -The Administrator was aware of several missing clothing items for Resident #12 that occurred prior to her start of employment. -The Administrator did take pictures of Resident #12's clothes and all of them were still there. -Family members were told to label resident clothes with the resident 's name on the clothing but she did not think to tell Resident #12's family to label the clothes that she took a picture of since those clothes were brought there prior to her start of employment. Interview with the Regional Director on 04/25/16 at 4:50pm revealed: -Resident #12's family was reimbursed $300.00 in the past for missing clothing. -There had been another complaint recently about more clothes missing, but pictures were taken and the items were all there. -The facility had replaced the washer on the SCU so their clothes would not have to be taken out of	D917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	C 05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D917	Continued From page 66 that side of the facility. _____ Interview with the Administrator on 5/24/16 at 12:02 pm revealed: -The Administrator had received general complaints about resident's clothes not being returned to them after they are laundered. -The Administrator had attempted to alleviate the problem by obtaining a new washing machine for the Special Care Unit (SCU) so that the laundry for the residents on the SCU unit will be done specifically for them. -Staff should report all resident issues to their supervisor, and the supervisor should report to her. -There had not been any other complaints of missing items in the SCU other than clothes and towels since she had started working at the facility; one family member did ask to bring a lockable file cabinet and was advised that they could. -The Administrator had one complaint of money missing on the Assisted Living (AL) side, and suggested a lockable space for valuables to that resident. -The Administrator had talked to staff about the importance of getting clothing back to the correct person. -Residents and their family members were encouraged to put names in their clothing. -The Administrator expected all staff members to treat all residents with respect and dignity and wanted staff to understand how they would feel if their clothes and belongings were missing.	D917		