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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, a follow-up survey and complaint investigation on 6/28/16 - 7/01/16.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure the walls, floors and floor coverings were cleaned in the residents' rooms and hallways. The findings are: Observation of the floor on the B hallway including the area of the floor in front of the nurse's station on 6/28/16 at 10:45 a.m. revealed the cream colored tiled floors on the entire hall were covered in black stains. Interview with a resident, who lived on the B hall, on 6/28/16 at 10:50 a.m. revealed the resident did not have a problem with the cleanliness of the facility. Observation of the cream colored tiled floor in Room B10 on 6/28/16 at 11:10 a.m. revealed two tiles in front of the couch had brown dried stains. Interview with a second resident, who lived on the B hall, on 6/28/16 at 11:00 a.m. revealed:	D 074		

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D 074	Continued From page 1 -The resident did not have a problem with the cleanliness of the facility. -She cleaned her room daily by choice. Observation made of C Hall (room 7) on 6/28/16 at 11:00am during tour of the facility revealed: - The floor in Room 7 beside hospital bed (near the door) had dark black scuff marks covering floor in front of the bed Interview with a resident in room 7 on 6/28/18 at 11:05am revealed: - The scuff marks have been on the floor (room 7) for a few weeks and even when the floor was mopped by the housekeeping staff, the marks remained. The needed to be stripped and waxed. - The room was not cleaned by housekeeping every day, maybe 1-3 days a week, sometimes less. Observation made of C Hall (Room 5) on 6/28/16 at 11:15am revealed the floor had a large area with black scuff marks in front of recliner between beds A and B. Resident interview (room 5) on 6/28/6 at 11:20am revealed. - The black scuff marks were made by his wheel chair, and the facility needed to clean the floors to remove the marks. - The resident did not recall when the floor was last cleaned. Interview with the facility's Regional Director of Operations on 6/28/16 at 12:15pm revealed: - She was aware the facility floors throughout the facility needed cleaning, stripping and rewaxing throughout. - The facility had hired a company to come in to start stripping the floors. They will start this	D 074		

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week.
- The facility planned to hire additional full-time housekeeping staff to assure the facility, including resident rooms were keep clean.

Observation of the floor on the D hallway in Room D4 on 6/28/16 at 11:47 a.m. revealed the entire viewing area of the cream colored tiled floor was covered in black stains (at the entrance of the room, in front of the recliner, the area between the bed and the recliner and the area in front of the side wall air condition vent).

Interview with a resident, who lived in Room D4, on 6/28/16 at 11:47 a.m. revealed:
-She could not remember the last time her room was cleaned or swept
-"It had been quite a while since someone has mopped" the resident's room.
-"My floors really need cleaning and waxing."

Observation of the hall where laundry services and the staff lounge were located on 6/28/16 at 5:30 p.m. revealed the entire cream colored tiled floor hallway was covered in black stains.

Observation of Room #13 on A hall during the facility tour on 6/28/16 at 11:10 a.m. revealed:
-There was a large dried orange and black stain with splattered borders, approximately 2 foot by 1.5 ft., located close to the entrance of the room.
-The floors throughout the room had a scattered buildup of rough, black, splotchy areas.

Interview with the resident in Room #13 on 06/28/16 at 11:15 a.m. revealed:
-The dried orange and black stain was a result of a wet spill that occurred about 2 days ago.
-The resident had reported the spill on the floor to

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D 074	Continued From page 3 a staff member when the spill was first seen. Observation of Room #13 on 06/28/16 at 11:45 a.m. revealed: -A staff member mopped the floor in Room #13 and placed a wet caution sign at the door way. -The orange and black stain had been removed. Observation of Room #8 on the A hall on 06/28/16 at 11:25 a.m. revealed: -The floors throughout the room had a scattered black buildup of rough splotches. - There was an area on the floor that was located next to the bed, positioned close to the window and bathroom of the room, that was heavily stained in a solid black color approximately 2 ft by 2 ft. Observation of Room #2 on the A hall during the facility tour on 06/28/16 at 11:30 a.m. revealed: -There were numerous black scuff marks scattered on the floor. -There was scattered brown and black stains beside the bed that was positioned close to the window of the room. -There was loose black dirt and dust debris scattered throughout the floor of the room. Based on record review and observation on 06/28/16 at 11:30 a.m. both residents assigned to Room #2 were not interviewable secondary to dementia. Observation of Room A18 on 06/28/16 at 10:34 a.m. revealed: -There were multiple patches of brownish black stains all over the bedroom floor. -The floor was sticky, causing shoes to stick to the floor in multiple areas.	D 074		

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D 074	Continued From page 4 Interview with a resident in Room A18 on 06/28/16 at 10:34 a.m. revealed: -The resident did not know how long the floor had been stained or sticky. -She did not recall seeing staff clean the floors often. Observation of Room A16 on 06/28/16 at 10:39 a.m. revealed: -There were multiple patches of brownish black stains all over the bedroom floor. -The floor was sticky, causing shoes to stick to the floor in multiple areas. -There were multiple areas of black streaks on the floor that appeared to have been caused by wheelchairs. Interview with a resident in Room A16 on 06/28/16 at 10:39 a.m. revealed the resident was unsure how long the floors had been stained. Observation of Room A14 on 06/28/16 at 10:50 a.m. revealed: -There were multiple patches brownish black stains all over the bedroom floor. -The floor was sticky, causing shoes to stick to the floor in multiple areas. -There were multiple areas of black streaks on the floor that appeared to have been caused by wheelchairs. Interview with a resident in Room A14 on 06/28/16 at 10:50 a.m. revealed: -The floors had always been that way. -The staff mopped everyday but it did not remove the stains from the floor. -The staff buffed the floors in the hallways, but not the floors in the residents' rooms. -He thought the stains were caused by the wheelchairs.	D 074		

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D 074	Continued From page 5 Observation of Room A12 on 06/28/16 at 11:00 a.m. revealed: -There were multiple patches brownish black stains all over the bedroom floor. -The floor was sticky, causing shoes to stick to the floor in multiple areas. -There were multiple areas of black streaks on the floor that appeared to have been caused by wheelchairs. Interview with a resident in Room A12 on 06/28/16 at 11:00 a.m. revealed: -The floors got mopped everyday but the black coating did not come up. -Staff had to use special cleaners to get it cleaned. -Staff buffed the floors in the hallway. -Staff just cleaned another resident's floor recently and it was shiny now. Interview with a second resident in Room A12 on 06/28/16 at 11:13 a.m. revealed: -She had noticed the floors had black stains all over the tiles. -The staff mopped the floors everyday but it did not get the sticky film or stains up. -The black marks were caused by the wheelchairs. Observation of the hallway floor on the A hall during the tour on 06/28/16 at 10:00 a.m. revealed: -There were multiple patches brownish black stains all over the hallway floor. -There were multiple areas of black streaks on the floor that appeared to have been caused by wheelchairs. Observation of the television/sitting room at the	D 074		

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D 074	Continued From page 6 end of the B hall on 06/28/16 at 11:50 a.m. revealed: -There were multiple patches brownish black stains all over the floor in front of the couch and chairs. -There was some small pieces of trash, dirt, and debris on the floor in front of the couch and chairs. Observation of Room B14 on 06/28/16 at 12:03 p.m. revealed: -There were multiple patches brownish black stains all over the bedroom floor. -There were multiple areas of black streaks on the floor near the entrance that appeared to have been caused by wheelchairs. Interview with the Assistant Director of Clinical Services on 06/28/16 at 12:14 p.m. revealed: -She thought housekeeping staff had used chemicals when mopping that had caused the wax to make the floor sticky and stained. -The facility staff mopped everyday but it was not removing the stains. -The Regional Maintenance Director (RMD) had been at the facility for 2 weeks and had started stripping and waxing the floors. -The RMD started in the unoccupied residents' rooms. -The facility had a floor company coming on 06/29/16 to start the process of stripping and waxing the floors. -The floor company would start with the hallways and common areas. -The facility had recently hired a full time floor technician who would be maintaining the floors, including spot waxing and buffing the floors. Interview with the Regional Director of Operations on 07/01/16 at 11:59 a.m. revealed:	D 074		

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D 074	Continued From page 7 -The chemicals used to mop the floors had interacted with the wax on the floors. -The change in the floors began in March 2016. -They initiated getting quotes from flooring companies around the first of June 2016. -They received a quote to strip and wax the floors on 06/10/16. -The quote was approved on 06/15/16. -The earliest appointment that could be scheduled with the flooring company was 06/29/16. -They were working on getting a second flooring company to come in and help get the floors done in the residents' rooms since the facility was so large. -The housekeepers had been in-serviced on the proper chemicals to use to clean the floors. -The facility had a new floor technician position to maintain the floors and they had a buffer for the floors. Observation of the hallway floor on the A hall on 06/30/16 at 8:30 a.m. revealed the stains on the floor had been removed and the floor was shiny.	D 074		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by:	D 269		

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D 269	Continued From page 8 Rule area continued out of compliance. Based on interview, and record review, the facility failed to assure personal care, including assisting to the bathroom, was provided in accordance to the resident's assessed needs for 1 of 7 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 5/23/16 revealed: - Diagnoses included arthritis, gout, bicuspid aortic valve, and traumatic brain injury. - The resident was semi-ambulatory and used a wheelchair to ambulate. - The resident was continent of bowels and bladder. - Ordered medications included Senokot-S, 2 tablets, once daily; Senna-Lax, 8.6mg. 1 tablet prn for constipation; Miralax Powder, mix 17 grams into 8 ounces of fluid and drink daily as needed for constipation; Bisacodyl EC, 5mg, 2 tablets, as needed for constipation and Imodium AD 2mg, 1 tablet every 8 hours as needed for diarrhea. Interview with Resident #1 on 6/28/16 at 10:30pm revealed: - The resident required 1 person assistance with transfers, assistance on and off commode, and assistance with bathing and dressing. - The resident was not incontinent but wore adult briefs and used a urinal when in bed. - The staff only checked on him every 2 hours, which included assistance to the bathroom. - When he asked staff to assist him to bathroom before 2 hour check, they (the nursing assistants and medication aides) refused. - The resident had urine "accidents" because the staff would not assist him to the bathroom. - The staff told the resident they were busy passing snacks, cleaning dining room after	D 269		

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meals, or caring for other residents.
- After meals, the resident has had to wait up to 45 minutes to go to the bathroom due to the staff (nursing assistants) cleaning the dining room after meals and assisting other residents out of the dining room.
- "It's a miracle I have not had an accident, such as a bowel movement, on myself because of having to wait so long to go to the bathroom".
- The facility's Administrator had assisted the resident to the bathroom multiple times because other staff was doing "other things".
- The resident stated his medications included stool softeners and laxatives.

Review of Resident #1's medication administration records for May 2016 and June 2016 revealed:
- Senokot-S, 2 tablets were documented as administered every day at 8:00am.
- Senna-Lax, Miralax and Bisacodyl were documented as administered several times for constipation throughout the 2 months.
- Imodium AD was administered 2 - 3 times each month for diarrhea.

Review of the resident's care plan dated 5/13/16 revealed:
- The resident was ambulatory with aide or device.
- The resident had limited range of motion/limited strength of left upper extremity.
- The resident's bowel and bladder were normal/ no incontinence.
- The resident was oriented.
- The resident required extensive assistance with transferring and toileting.

Interview with a 1st shift Nursing Assistant (NA) on 6/29/16 at 1:10pm revealed:

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D 269	Continued From page 10 - The NA provided personal care for Resident #1 which included transfers/assistance with transfers on and off commode. - Resident #1 pressed the call light 6 to 7 times per shift and "always" requested assistance to the bathroom. - "In his mind he has to go to the bathroom, but I know he does not have to go". - The NA assisted the resident to the bathroom every 2 hours and the resident stayed on the commode for long periods (40 minutes at times). - The resident "always" requested to go to the bathroom just before or just after meals, but sometimes he had to wait because the staff had to assist some residents to and from the dining room. - The resident was incontinent of urine at times, but did not know how many or when he had the last incontinent episode. - The resident wore adult briefs every day in case he was incontinent and the staff changed the brief if needed. Interview with a 2nd shift NA on 6/29/16 at 3:40pm revealed: - Resident #1 had right-sided paralysis and required 1 person assistance with all transfers. - The resident asked the staff to assist him to the bathroom "a lot". - The resident had "bowel issues and thought he had to go to the bathroom a lot". - The resident used a urinal when he was in bed. - The resident pulled the call light when he needed to go to the bathroom, but always complained the staff took a long time to answer the light or would not answer the light. - The resident complained of having "accidents" because he had to wait too long (urine not bowels). - The staff checked on the resident every 2 hours	D 269		

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D 269	Continued From page 11 to assist him to bathroom, but she checked on him more often because she knew he requested to go to bathroom more than every 2 hours. Interview with the Administrator and Resident Care Coordinator (RCC) on 7/01/16 at 2:00pm revealed: - They were aware Resident #1 required assistance with all transfers and was wheelchair bound. - They were not aware the staff was refusing to take the resident to the bathroom at times. - They were not aware the resident was having incontinent episodes. - The RCC was aware the resident had orders for scheduled stool softeners and laxatives as needed. - The staff should not be waiting for the resident to press call light and the resident should not be on a 2 hour bathroom schedule, but the staff should be checking on the resident frequently (at least every 30 to 45 minutes) throughout the shift which may decrease use of call light. - The Administrator had assisted the resident to the bathroom if he asked her for assistance. - The Administrator would follow-up with the staff today regarding providing appropriate personal care to the residents, including assistance to the bathroom.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 2 sampled Residents (#9, #8) known to be disoriented, who eloped from the facility, in accordance with each resident's assessed needs.

The findings are:

1. Review of Resident #9's current FL-2 dated 12/10/15 revealed:
-Diagnoses included stage 2 chronic kidney disease, hyperlipidemia and hypothyroidism.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #9's Care Plan dated 7/23/15 revealed she was forgetful, always disoriented and had an unsteady gait.

Review of Resident #9's Resident Register revealed she was admitted to the facility on 5/22/15.

Review of Resident #9's progress note dated 4/22/16 at 11:45 p.m. revealed:
-The resident walked out to the side door (B hall) into parking lot.
-The resident was beating on cars.
-When the resident got back into the building, the resident was fighting.

Review of Resident #9's incident report dated 6/1/16 revealed:
-The time of the incident was 11:04 p.m.
-Around 11:00 p.m., the resident walked up to the

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nurse's station and asked when was church.
-The Medication Aide (MA) told the resident that church was not scheduled for today (6/1/16).
-The resident sat in the living room.
-The resident was found outside in the front by the parking lot at 11:04 p.m. by a staff.
-The resident was very agitated.
-The resident was found "outside the building on grounds."
-The resident was willing to come back inside of the building at 11:27 p.m., but the resident was still agitated.
-The resident's temperature was 97.1 degrees Fahrenheit, the pulse was 89 and the blood pressure was 141/79.
-The resident's primary care physician was notified on 6/1/16 at 11:47 p.m.
-The resident's responsible party and another named person were contacted.
-The resident did not go to the hospital.

Review of Resident #9's physician order dated 6/3/16 revealed an order for the resident to be evaluated and treated by psychiatry due to the elopement on 6/1/16.

Review of Resident #9's record revealed the resident was seen by psychiatry on 6/13/16.

Review of Resident #9's psychiatric evaluation encounter notes dated 6/13/16 revealed:
-The resident's chronic active diagnoses were dementia, unspecified, in conditions classified elsewhere with behavior disturbance, bipolar disorder, agitation and organic psychosis.
-The resident was last seen for a psychiatric exam on 11/13/15.
-The resident had obsessive thoughts, delusions, hallucinations, short term and long term memory loss and the resident was irritable.

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-For the resident's attention concentration, the resident was alert, distracted and guarded.
-For the resident's thought process included, the resident was disorganized perseverative and slowed.
-For speech, the resident was spontaneous, slow and had a flight of ideas.
-The resident had poor judgement.
-The plan of order was to discontinue Risperdal 0.5 milligrams (mg) by mouth in the a.m. and 1 mg at bedtime. Start Risperdal 1 mg by mouth in the a.m. and 1 mg by mouth in the p.m. for control of psychosis.

Interview with a Nurse Aide (NA) on 6/29/16 at 10:30 a.m. revealed:
-Resident #9 was acting abnormal.
-In February 2016, when Resident #9 lived on the back hall, the resident ran out to the cars in the parking lot.
-Staff heard the alarms and ran out to the car to get Resident #9.
-It had taken staff between one to three minutes to get to Resident #9.
-Resident #9 had moments when she wanted to run outside.
-The doors in the building do not lock, they just alarm.
-Resident #9 had worn a wander guard and it beeped when the resident got close to the door.
-Resident #9 has had the wander guard at least for one year.
-Four to five months ago, Resident #9 had gotten out the front door.
-When the resident had gotten out of the door, the resident had not gotten far.
-When Resident #9 lived on the back hall, the staff person checked on the resident every 30 minutes.
-When she checked on Resident #9, she made

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sure she saw the resident.
-When the resident moved to the front hall, she checked on the resident each hour.

Interview with a second NA on 6/29/16 at 11:04 a.m. revealed:
-She did not monitor Resident #9.
-The resident did not have a wander guard.
-Resident #9 may go out the front door and walk on the sidewalk.
-Resident #9 had never walked towards the road.
-Two weeks ago, Resident #9 had gone out the front door and walked up and down the sidewalk.
-Resident #9 did not have to be supervised by staff.
-The NA had never known Resident #9 to leave out of the building without staff knowing.
-Many times the resident walked around the facility looking for a family member, after the family member had left from visiting her. Staff explained to the resident the family member was gone.
-She checked on Resident #9 every two hours which was when she checked on the other residents.

Observation of Resident #9 on 6/29/16 at 11:26 a.m. revealed the resident was sitting in her room on the edge of her bed and on 6/29/16 at 4:31 p.m. revealed the resident was sitting on her bed.

Observation of Resident #9 on 6/30/16 at 12:40 p.m. revealed the resident was in the dining room eating the lunch meal.

Observation of Resident #9 on 6/30/16 at 5:50 p.m. in the dining room revealed Resident #9 was not wearing a wander guard.

Interview with the Area Director of Operations on

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D 270	Continued From page 16 6/30/16 at 6:00 p.m. revealed she reviewed Resident #9's record on 6/29/16 and the resident never had a wander guard. Interview with a third NA on 6/30/16 at 6:25 p.m. revealed: -Three weeks ago Resident #9 had gotten out of the front door during second shift. -The NA came to the facility to pick up another staff person. She pulled up to the facility and Resident #9 had come out the front door when she saw the NA. The alarm did not come on. -She asked Resident #9 where she was going. The resident told her she was going to a party. She told the resident "the party was over, " because she wanted the resident to go back inside. -The NA called inside the facility and told a Medication Aide (MA) Resident #9 was trying to leave the facility. -Three staff came outside of the building and tried to talk Resident #9 into coming back inside of the building. -After the other staff had come outside of the building and talked the resident back into the facility, the NA left the facility. -Resident #9 had worn a wander guard. -The wander guard had not worked in the past two months. -The wander guard was on Resident #9's leg then it was removed from the leg and placed on her wrist. -About two months ago, between 6:30 p.m. and 6:45 p.m., Resident #9 had went out the side door and had come to the front door without staff knowing. After the incident, the facility realized Resident #9's wander guard was not working. The staff person was not assigned to the resident on that day. -Since then, the resident had not gone out of the	D 270		

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building without staff knowing.
-She monitored Resident #9 every 1 ½ to 2 hours to see where the resident was located.
-She had always monitored the resident every 1 ½ to 2 hours.
-Staff did not document the monitoring.
-She had never been told to monitor Resident #9 more frequently.
-She did not know if management was aware of the attempted elopement.
-The prior Resident Care Coordinator (RCC) was working at the facility at the time of the elopement.
-If a resident had worn a wander guard, it would beep once the resident had gotten close to the door.
-Only the NAs wore a beeper.
-Only 1 person has the beeper on each hall.
-The aides tell each other verbally if the beeper alarms.
-The front door was locked at night, between 10:20 p.m. and 10:30 p.m., whenever the third shift MA came on duty.
-When the front door was locked, it only alarmed when someone who was wearing a wander guard was near the door and when someone was trying to come inside the facility. The front door did not alarm when someone was leaving the facility who was not wearing a wander guard.

Observation of Resident #9 on 7/1/16 at 9:12 a.m. revealed she was eating breakfast in the dining room.

Interview with a MA/NA on 7/1/16 at 4:04 p.m. revealed:
-Resident #9 was confused.
-Resident #9 had dementia, but the resident had never worn a wander guard.
-Sometimes Resident #9 may try to go out of the

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side door, but the alarm comes on and staff "catches her."
-About one month ago round 11:00 p.m., a staff person was coming to the facility to pick her up from work.
-Resident #9 had gotten out of the facility through the front door and had gotten to the facility's sign, which was located in front of the facility by the street.
-Resident #9 was agitated and was determined she was going home.
-The resident had an umbrella, a purse and an arm full of clothes.
-Resident #9 was sweating and wearing a dark blue shirt and jeans.
-The resident was standing by the road waiting for someone to pick her up.
-The MA and some other staff tried to get the resident to come back inside the facility. It took about an hour before they could convince the resident to come back inside of the building.
-She was not assigned to Resident #9 on that day and the staff person did not know when the last time Resident #9 was seen on that day.
-The street in front of the facility got really dark at night.
-The traffic in front of the street was very busy at night. Some people sped while driving on the road.
-One time around 6:00 p.m. to 6:30 p.m., which was after dinner, Resident #9 was found sitting in a gazebo near someone's back porch in an apartment complex, which was located behind the facility.
-A resident who was outside smoking in the back of the facility saw Resident #9 at the apartment complex and told staff.
-The NA and another staff person, who no longer worked at the facility, went and got Resident #9.
-It took staff about 20 minutes to convince the

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resident to come back inside the facility.
-Resident #9 looked tired.
-The temperature on that day was hot.
-Staff monitored Resident #9 every two hours.
-The resident needed to be monitored more often.
-Staff documented the monitoring in a book.
-Staff have always monitored Resident #9 every two hours.
-If a resident eloped, the facility called the resident's physician, family member and completed an incident report.
-The staff person did not know if Resident #9's physician and family member was called and if an incident report was completed.
-Resident #9 took Ativan twice daily as needed for anxiety.
-The times the doors are locked at night by the Supervisor varies.
-The doors are locked at night at least by third shift.
-When the front door is locked and someone goes out the front door, the front door does not alarm unless someone has a wander guard.
-The side doors alarm at all times when someone was trying to leaving the building.

Interview with a second MA on 7/1/16 at 6:32 p.m. revealed:
-Resident #9 was "very confused." The resident did not wear a wander guard.
-One night after 11:00 p.m. while she was checking her assigned resident medications during shift change, a NA, who was not working on that day, had come to the facility to pick up another staff person.
-The NA called the facility and reported Resident #9 was outside and someone needed to come and get the resident.
-The MA went outside to check on Resident #9.

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-The resident looked very confused.
-Resident #9 had her umbrella in her hand.
-The same MA convinced Resident #9 to give her the umbrella.
-The MA does not know who was assigned to Resident #9 on that day, because she worked the back hall.
-The MA does not normally work with Resident #9.
-There had been no other times the she staff person had known Resident #9 to get out of the facility.
-The doors are locked at night around 9:00 p.m.
-The only times the door alarm came on was when someone with the wander guard was close to the door.

Interview with a third MA on 7/1/16 at 6:47 p.m. revealed:
-"Sometimes" Resident #9 was confused. "Sometimes" the resident missed her family and wanted to go home.
-One night, two months ago, during shift change (2nd to 3rd), a staff person reported Resident #9 walked out the front door.
-The MA went and got the 3rd shift MA to go outside and help get Resident #9 back into the facility.
-The resident was under the carport at the facility when she saw her.
-She had last seen Resident #9 one hour before it was reported the resident was outside.
-The MA had worked second shift that night and was getting ready to end get off work.
-She had worked as the Supervisor on that night.
-Resident #9 never had a wander guard.
-If a resident eloped, staff always completed an incident report.
-The third shift MA took the resident's vital signs.
-The third shift MA gave the resident Ativan.

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-The resident had a psychiatric evaluation completed a couple of months ago.
-When staff monitored Resident #9 every two hours, they monitored the resident's location.
-If a resident had a wander guard, the door beeped when the resident had gotten close to the door and the NAs' pagers alarmed. The pager told the NA the door the resident was located.
-The side doors always alarmed.
-She was unsure if the back door alarmed with a resident who had a wander guard.
-The front door and patio doors are locked, it does not alarm.

Review of Resident #9's incident report dated 4/22/16 revealed:
-The time of the incident was 11:45 p.m.
-The resident walked out the side door (B-hall) into parking lot.
-The resident was found "outside the building on grounds."
-The resident was beating on cars.
-Staff got the resident back inside of the building.
-The resident was yelling and fighting.
-The resident finally went to her room.
-The resident refused to allow staff to take her vital signs.
-The resident's Responsible Party was called on 4/23/16 at 12:00 a.m.
-The resident's primary care physician was called on 4/22/16 at 12:45 a.m.
-The resident was sent to the local emergency room (ER) by the Emergency Medical Services (EMS) on 4/23/16 in the a.m.
-The time the resident was transported to the local ER was not documented on the incident report.

Review of Resident #9's progress note dated 4/18/16 revealed:

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-Consider moving the resident to a new room.
-The patient is paranoid about what is outside the window.
-The resident does not get along with her roommate.

Confidential interview with a third staff person revealed:
-Resident #9 was very independent.
-The resident was very agitated and emotional.
-Around the middle to end of May 2016, Resident #9 wanted to leave the facility.
-Staff had to calm the resident down.
-When staff see Resident #9 walking the halls with bags, they know to watch her.
-One time she walked out of the door around 11:00 p.m. and staff had to calm her down.
-Resident #9 received medications to try to help calm her down.
-Staff monitored Resident #9 every two hours and as much as they could.
-Resident #9 did not wear a wander guard.
-The staff person was told Resident #9 was waiting on approval for a wander guard from the resident's physician.
-She did not know if Resident #9's primary care physician was aware of her behaviors.

Observation of the back patio on 7/1/16 at 6:44 p.m. revealed:
-The back door which led to the patio did not alarm when opened.
-The patio was on the back of the facility.
-The top of the patio had a patio cover which covered the whole patio.
-The patio was 25 feet wide and 25 to 50 feet long.
-The patio had a picnic table with 2 benches and a table with patio chairs.
-There was a 60 foot walkway from the patio

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which led to the apartment complexes located behind the facility.
-Fifty feet between the facility and the apartments was a gazebo with a picnic table and 2 benches.
-The lawn between the facility and apartments was low cut.
-The low cut lawn on the left side of the patio was 100 feet and led to a side road.
-The low cut lawn on the right side of the patio was 100 feet long and led to a large 1/2 acre of a garden.

Observation of the lawn in the front of the facility on 7/1/16 at 8:30 p.m. revealed:
-There was a 25 by 25 foot drive through carport at the entrance of the facility with a covering.
-At the end of both sides of the car port was a walkway which led to a parking lot.
-There was a 10 ft. wide driveway on the side of the car port.
-Beside the driveway was a 25 to 50 foot low cut lawn which led to the road.
-The facility's sign was on the lawn and was 10 feet from the road.

Telephone interview with Resident #9's friend on 7/1/16 at 6:00 p.m. revealed:
-The resident had often gotten confused.
-One or two months ago, the staff at the facility had to get the resident back into the facility, because the resident had gotten out of the facility.
-He could not provide any other information about the resident leaving the facility.

Interview with the Administrator on 6/28/16 at 9:15 a.m. revealed:
-She had just started working at the facility at the end of May 2016.
-The Resident Care Coordinator started working at the facility 6/2/16.

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D 270	Continued From page 24 Interview with the Administrator on 7/1/16 at 7:10 p.m. revealed: -If a resident was an "exit seeker," staff should check on the resident at least every 30 minutes and know the resident's location. -If a resident had exited the facility, staff should bring the resident back inside of the facility, try to engage the resident in activities and monitor the resident every 15 to 30 minutes. -Staff does not document when monitoring residents. -When residents had eloped from the facility, she was not aware staff had not monitored residents more often. -If she would have known, she would have checked documentation and spoke with staff. -Since she had been at the facility, she had not communicated to staff her expectation of supervision when a resident had eloped from the facility. -She was not aware Resident #9 had exited the back door to the patio. Resident #9's POA was not available for interview. Resident #9's primary care physician was not available for interview. 2. Review of Resident #8's current FL-2 dated 3/30/16 revealed: - Diagnoses included peripheral vascular disease, hypertension, depression, anemia, and dysphagia. - The resident was intermittently disoriented and was semi-ambulatory. Review of the Resident Register revealed	D 270		

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D 270	Continued From page 25 Resident #8 was admitted to the facility on 04/01/16. Review of the resident's Care Plan with an assessment date of 5/18/16 revealed: - Resident #8 was forgetful and needed daily reminders. - The resident had limited range of motion, limited strength of upper extremities and ambulated with the use of a walker. Review of an incident report revealed: - On 5/20/16 at 5:10pm, Resident #8 was outside the building/on grounds. - The resident went outside of the building toward the road. - The resident wanted to go home. - The resident was brought back to safety into the building. - The "Wander guard" was put on left ankle. - The resident sustained no injury. - The incident was described as an "elopement". An order dated 5/23/16 revealed: - A request by the facility to place "Roam Alert" band on Resident #8. - Physician comments: "Ok for above". Interview with a 2nd shift medication aide (MA) on 6/29/16 at 3:40pm revealed: - On May 20, 2016 (2nd shift) Resident #8 was agitated, was more confused than usual and repeatedly asked for her family. - The medication aide working on the resident's hall called a family member but recieved no answer. - The resident walked to the front exit door and opened it several times before supper (which was served at 5:00pm) but the Resident Care Coordinator assisted the resident back from the	D 270		

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front door at least one time.
- Around 5:00pm, at the beginning of supper, a man from the community walked in the facility and informed the MA a resident with a walker was walking toward the road.
- The MA walked outside and observed the resident at the end of the facility's semi-circular drive (which connected to the highway in front of the facility). The resident was less than 5 feet away from the highway.
- Another MA walked outside, called the resident's name, and walked across the grass to her.
- The resident was "resistant" in coming back inside, but another staff member came out and got her back inside of the facility.
- Resident #8 continued to ambulate up and down the hallways with a walker and at times tried to open the front door, but when the alarm sounded, the staff knew to check their beeper and go to the door.
- The MA did not know if the resident was on 30 minute or 15 minute supervisory checks, but all residents were to have 2 hour checks to make sure they were safe and provide personal care if needed.

Interview with the facility's Administrator on 6/30/16 revealed:
- Resident #8 had not exited the facility since May 20, 2016.
- The resident had a Roam Alert band on her leg/ankle since the incident.
- The staff provided 2 hour supervisory checks and retrieved the resident from exit doors when she attempted to open the door and alarm was activated.
- The administrator was aware the resident was confused/disoriented.
- The staff was not required to document supervisory checks.

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D 270	Continued From page 27 - The Administrator was not aware the staff were not implementing 15 - 30 minute supervisory checks for residents who exited the facility. - Training on supervision had not been provided for the staffsince the Administrator started working at the facility last year. Interview with a family member on 7/01/16 at 4:15pm revealed: - The resident had lived at the facility since 2011, but was hospitalized earlier this year and was admitted to a skilled nursing facility. The resident was re-admitted to the facility the 1st of April. - Since the resident had been back to the facility, she was more confused (recognized close family members only) withdrawn and less social with other residents and staff. - The resident liked to go to the exit doors and look out. - The facility contacted the family member on 5/20/16 and reported the resident had walked out of the facility and a passerby saw her at the highway (in front of the facility) and went into the facility and reported to the staff. - The facility placed an alarm bracelet on the resident's leg, but the staff need to watch her closer to keep her away from the exit doors. - The family member talked to staff about watching the resident closer but did not recall the name of staff. - The facility has "a lot" of staff turnover. Interview with another 2nd shift MA on 7/01/16 at 4:00pm revealed: - Resident #8 was confused and roamed back and forth in hallways, in the front TV room and in other resident rooms. - The resident did not remember names or recognize familiar faces other than her family member.	D 270		

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D 270	Continued From page 28 - The staff checked on the resident every 2 hours unless wandering in the hallway. - The resident's supervision had never changed, no 15 minute or 30 minute checks by staff. - The resident currently had a wander guard (Roam Alert band) on leg. - The MA was not aware of the incident which the resident wandered outside of the facility last month. Interview with a 2nd shift nursing assistant (NA) on 7/01/16 at 5:00pm revealed: - Resident #8 was confused and at times she was more confused and asked repeatedly to go home. - The resident walked out of the facility one time last month and staff had to go get her away from the road. - The resident continued to walk to the front exit door and look out. Her wander guard beeped and staff walked the resident away from the door. - The resident continued to be checked every 2 hours by the staff. Random observations made of highway in front of the facility during the survey during the mornings, afternoons, and early evenings revealed the traffic was steady throughout the day everyday. _____ Review of the facility's Plan of Protection dated 6/30/16 revealed: - All staff will be in-serviced on those residents identified as at risk for exit-seeking. - A list will be placed for accessibility to all staff as a reminder for increased monitoring frequency. -Inservice conducted with immediate staff by the Administrator, the RCD or designee. - Monitoring by Administrator, RCD or designee monthly and with significate change.	D 270		

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D 270	Continued From page 29 - Identified residents at risk for exit seeking; notifications to primary care provider for evaluations and referrals; roam alert bands place; staff trained on immediate response to roam alert system (Wander Guard). - Staff made aware of those residents with roam alert bands. - Increased staff on each shift, increased laundry staff to eliminate aides from all laundry duties. - Increased housekeeping which increased hall supervision. THE CORRECTION DATE FOR A TYPE A2 VIOLATION SHALL NOT EXCEED JULY 31, 2016.	D 270		
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: Follow-up to Type B Violation. The Type B Violation was abated. Non-compliance continues. Based on observations interviews and record reviews, the facility failed to assure residents were spoken to in a respectful manner by Staff (A, B, NA's, MA's) and a resident (#10) was toileted when requested. The findings are: Observation on 6/28/16 at 11:50 a.m. revealed:	D 338		

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D 338	Continued From page 30 -Staff B, Nurse Aide (NA), came to a resident's room to get the resident to go to lunch. -The resident told Staff B she did not want to go to the dining room for lunch, because she was not feeling well. -The resident asked Staff B if she could eat in her room? -Staff B told the resident in a harsh manner she could not eat in her room and she needed to come to the dining room to eat. -Staff B assisted the resident to the dining room for lunch. Observation on 6/28/16 at 11:55 a.m. revealed: -Staff B had come to another resident's room to get the resident to go to lunch. -The resident asked staff B if he could come to lunch a little later. -Staff B told the resident he had to come to the dining room now. -Staff B had spoken very harsh to the resident. Interview with the same resident on 6/28/16 at 11:55 a.m. revealed: -He did not have any problems with the treatment by Staff B. -Staff B was nice to him. -He said he would go ahead and go to the dining room. Observation on 6/30/16 at 8:21 a.m. revealed: -A resident asked for assistance from the surveyor. -The surveyor asked Staff B to assist the resident. -Staff B responded in a harsh manner, "I just helped him; what does he want?" -The surveyor advised her to go and ask the resident. -She asked the resident what he needed.	D 338		

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D 338	Continued From page 31 -The resident wanted her to pick up his personal cereal box off the floor. -She picked up the resident's cereal box and went to assist other residents. Observation on 06/28/16 at 12:03 p.m. revealed: -Staff B came down the hallway and told a resident to go to lunch in a firm voice. -The resident explained to Staff B he was not ready to go to lunch because he wanted to talk to the surveyor first. -Staff B came back a second time in less than 5 minutes, and in a firm tone, told the resident he had to go to the dining room. -The resident told Staff B he just had a tomato sandwich and he did not want to go to the dining room at that time and he would be there soon. -Staff B kept standing in the hallway looking at the resident. -The resident appeared uncomfortable with Staff B standing and looking at him. Confidential interview with a resident revealed: -A couple of weeks ago, Staff A yelled at the resident. -The resident was dizzy and asked for help to the bathroom. -Staff A told the resident that the resident was not sick and the resident could go to the bathroom by the resident's self. -Staff A helped the resident go to the bathroom but complained about helping the resident. -Staff A told the resident that the resident needed to be in a wheelchair. -Staff A hurt the resident's feelings by talking to the resident that way. Interview with Resident #10's family member on 6/29/16 at 8:30am revealed:	D 338		

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- The family member came to the facility every day, usually before 3rd shift staff left.
- The nursing assistants were very disrespectful to the residents.
- Two weeks ago, the family member walked into the facility and heard Staff A (NA) yelling at the resident in the front TV room.
- Two weeks ago, a resident asked Staff A to assist her to the bathroom and help put on shoes.
- Staff A yelled at the resident to go to the bathroom by herself and put her shoes on by herself.
- Last weekend (Saturday or Sunday) Resident #10 needed a nitroglycerin tablet to relieve mild chest pain and the family member informed the medication aide (MA), who was administering medication on the hall.The MA administered the nitroglycerin about 10 minutes later.
- About 25 minutes later the family member asked the MA to check the resident's blood pressure. The MA yelled at her "I'm the only one working 2 halls and I got 2 more residents to pass medications; you got to wait".
- I through my hands up, but she came in 5 minutes later and checked the resident's blood pressure".
- Last week the family member purchased a new outfit and left the outfit hanging on Resident #10's closet door. When the family member arrived the next day, the resident had on a long sleeved shirt and a pair of "thick weather pants". The family member asked the resident why she was not wearing the new outfit hanging on the door, the resident stated Staff A told her you will wear this outfit, I'm going to put this on you.
- A few weeks ago (less than 2 months), when the family member walked into the resident's room, a 1st shift NA (Staff B) was in Resident #10's room trying to put a sweat shirt on the resident, but the resident was already dressed. The resident was

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telling the NA "I'm not going to put this on, it's too hot and I'm already dressed. When the family member walked in and asked what's going on, the NA stated "she is being difficult" and walked out. The family member reported the incident to the former Administrator and requested the NA not come back to the resident's room.

Interview with Resident #1 on 6/28/16 at 10:30am revealed:
- The resident required assistance with transfers, bathroom use, bathing and dressing.
- The resident was not incontinent but wore adult briefs and used a urinal when in bed.
- The staff only checked on him every 2 hours.
- When he asked staff to assist him to bathroom before 2 hour check, they (the nursing assistances and medication aides) refused.
- The resident had urine "accidents" because the staff would not assist him to the bathroom.
- The staff told the resident they were busy (passing snacks, cleaning dining room after meals, or caring for other residents).
- After meals, the resident had to wait up to 45 minutes to go to the bathroom due to the staff (nursing assistants) cleaning the dining room after meals and assisting other residents out of the dining room.
- "It's a miracle I have not had an accident on myself because of having to wait so long to go to the bathroom".
- The facility's Administrator has assisted the resident to the bathroom multiple times because other staff was doing "other things".
- The resident's medications included stool softeners and laxatives.

Interview with a 1st shift Nursing Assistant (NA) on 6/29/16 at 1:10pm revealed:
- The NA provided personal care for Resident #1

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which included transfers/assistance with transfers on and off commode.
- Resident #1 pressed call light 6 to 7 times per shift (about every half hour to 1 hour) and always requested assistance to the bathroom because he liked to go to the bathroom.
- In his mind he has to go to the bathroom, but I know he does not have to go.
- The NA assisted the resident to the bathroom every 2 hours and the resident stayed on the commode for long periods (30 - 40 minutes at times).
- The resident always requested to go to the bathroom just before or just after meals, but sometimes he had to wait because the staff had to assist some residents to and from the dining room.
- The NA stated the resident had incontinent (urine) episodes at times, but did not know how many or when he had the last incontinent episode.
- The resident wore adult briefs every day in case he was incontinent and the staff changed the brief if needed.

Interview with a 2nd shift NA on 6/29/16 at 3:40pm revealed:
- Resident #1 had right-sided paralysis and required 1 person assistance with all transfers.
- The resident asked the staff to assist him to the bathroom "a lot".
- The resident had "bowel issues" and thought he had to go to the bathroom a lot.
- The resident used a urinal when he was in bed.
- The resident pulled the call light when he needed to go to the bathroom, but always complained the staff took a long time to answer the light or would not answer the light.
- The resident complained of having "accidents" because he had to wait too long (urine not

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D 338	Continued From page 35 bowels). - The NA stated the staff checked on the resident every 2 hours to assist him to the bathroom, but she checked on him more often. Interview with the facility's Administrator and Resident Care Coordinator (RCC) on 7/01/16 at 2:00pm revealed: - The RCC and the Administrator were aware Resident #1 required assistance with all transfers and was wheelchair bound. - The RCC and the Administrator was not aware the staff was refusing to take the resident to the bathroom at times. - The RCC and the Administrator was not aware the resident was having incontinent episodes. - The RCC was aware the resident had orders for scheduled stool softeners and laxatives as needed. - The staff should not be waiting for the resident to press the call light, or waiting 2 hours to assisted the resident to the bathroom, but the staff should be checking on the resident frequently (at least every 30 to 45 minutes) throughout the shift which may decrease use of call light. - The Administrator had assisted the resident to the bathroom if he asked her for assistance. - The Administrator would follow-up with the staff today regarding providing appropriate personal care to the residents, including assistance to the bathroom.	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:
FOLLOW-UP TO TYPE B VIOLATION.

The Type B Violation was abated.
Non-compliance continues.

Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered for 3 of 6 residents (#11, #12, #13) observed during the medication passes, including errors with a medication for pancreatic enzyme replacement to help digest food (#11), a rapid-acting insulin (#12), and an inhaler for chronic lung disease (#13).

The findings are:

The medication error rate was 10% as evidenced by the observation of 3 errors out of 30 opportunities during the 4:30 p.m. / 5:00 p.m. medication pass on 06/28/16 and the 8:00 a.m./9:00 a.m. medication pass on 06/29/16.

1. Review of Resident #12's current FL-2 dated 04/25/16 revealed:
-The resident's diagnoses included diabetes mellitus, chronic renal insufficiency, history of kidney cancer, obesity, coronary artery disease, gastroesophageal reflux disease, chronic obstructive pulmonary disease, hyperlipidemia, atrial fibrillation, gout, and restless leg syndrome.
-There was an order for Novolog Flexpen inject 30 units 3 times a day with meals, hold if blood

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sugar is less than 100. (Novolog is rapid-acting insulin. According to the manufacturer, a meal should be eaten within 5 to 10 minutes of taking Novolog.)

Review of the June 2016 medication administration record (MAR) revealed:
-There was an entry for Novolog Flexpen inject 30 units 3 times a day with meals, hold if blood sugar is less than 100.
-Novolog was scheduled to be administered at 7:30 a.m., 11:30 a.m., and 4:30 p.m.

Interview with the medication aide (MA) on 06/28/16 at 4:22 p.m. revealed:
-The residents usually went into the dining room between 4:30 p.m. and 4:45 p.m. for supper.
-Supper was usually served when the residents went into the dining room to her knowledge.

Observation during the 4:30 p.m. medication pass on 06/28/16 revealed:
-The MA checked Resident #12's blood sugar and it was 125 at 4:30 p.m.
-The MA administered 30 units of Humalog insulin to Resident #12 at 4:33 p.m.

Observation of the dining room on 06/28/16 revealed:
-There were some residents sitting in the back dining room at 5:00 p.m.
-Staff started serving supper to the residents at 5:08 p.m.
-Resident #12 was not in the dining room.

Observation and interview of Resident #12 on 06/28/16 at 5:20 p.m. revealed:
-The resident was in her room eating a piece of pizza.
-She had ordered out for lunch today and it took a

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while to get the pizza delivered.
-She just received and started eating the pizza about 45 minutes after she received the insulin.
-She usually got the insulin about 30 minutes before her meal.
-She denied any symptoms of low blood sugar prior to eating the pizza.

Interview with the MA on 06/28/16 at 6:18 p.m. revealed:
-If was insulin was ordered with meals, she would administer the insulin at the start of the resident's meal.
-She would take the resident from the dining room to a private area, administer the insulin, take the resident back to the dining room, and the resident would start eating.
-Resident #12 would sometimes eat in her room.
-The MA was aware Resident #12 was not eating in her room for supper today.
-When she went in the room to administer the resident's insulin, an aide was coming out of the room and had just ordered the pizza at that time.
-She did not realize it was going to take the pizza so long to be delivered.

Interview with the Administrator on 06/28/16 at 6:35 p.m. revealed:
-The facility's policy was to administer insulin ordered with meals within 15 minutes of the meal.
-They like for the resident to have the plate in front of them or the plate ready to be served when the resident's insulin was administered.

2. Review of Resident #11's current FL-2 dated 05/25/16 revealed:
-The resident's diagnoses included pancreatic insufficiency, gastroparesis, hyperlipidemia, hypothyroidism, hypertension, vertigo, and cervical spondylosis.

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-There was an order for Creon 24,000 units take 1 capsule 3 times a day with meals. (Creon is used to help digest food for those whose pancreas does not make enough enzymes. According to the manufacturer, Creon should be taken during each meal to help digest the food being eaten.)

Review of the June 2016 medication administration record (MAR) revealed:
-There was an entry for Creon 24,000 units with instructions to take 1 capsule 3 times a day with meals.
-Creon was scheduled to be administered at 8:00 a.m., 12:00 noon, and 5:00 p.m.

Observation during the 5:00 p.m. medication pass on 06/28/16 revealed the medication aide (MA) administered Creon to Resident #11 at 4:15 p.m.

Interview with the MA on 06/28/16 at 4:22 p.m. revealed:
-The residents usually went into the dining room between 4:30 p.m. and 4:45 p.m. for supper.
-Supper was usually served when the residents went into the dining room to her knowledge.

Interview with Resident #11 on 06/28/16 at 5:00 p.m. revealed:
-She usually got the Creon before she ate her meal.
-She had not received her supper meal yet.

Observation of Resident #11 on 06/28/16 revealed:
-Resident #11 was served supper at 5:08 p.m.
-Creon was administered 53 minutes before the meal instead of with the meal as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	R 07/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(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 40 Interview with the MA on 06/28/16 at 6:15 p.m. revealed: -She usually gave the medication to Resident #11 before the resident went to the dining room. -Most residents had food they could eat in their rooms if they wanted it. -She was not aware the Creon was used to help digest a meal. Interview with the Administrator on 06/28/16 at 6:35 p.m. revealed the facility's policy was to administer medications ordered with meals when the resident's meal was in front of them. 3. Review of Resident #13's current FL-2 dated 04/25/16 revealed: -The resident's diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, hypertension, anemia, anxiety, depression, and schizophrenia. -There was an order for Symbicort 160/4.5mcg inhale 1 puff twice daily. (Symbicort is used to treat lung disease.) Review of the June 2016 medication administration record (MAR) revealed: -There was an entry for Symbicort 160/4.5mcg inhale 1 puff twice daily. -Symbicort was scheduled to be administered at 8:00 a.m. and 8:00 p.m. Observation of the 8:00 a.m. medication pass on 06/29/16 revealed: -The medication aide (MA) handed Resident #13 the Symbicort inhaler. -The resident pressed the inhaler 2 quick puffs in a row at 9:05 a.m. without inhaling the medication. -The MA did not instruct the resident to take one puff.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 41 -The MA did not instruct the resident to inhale the medication when the inhaler was pressed down nor to hold breath in for approximately 10 seconds to allow the medication to reach the lungs. -The medication vapors came back out of the resident's mouth. Interview with Resident #13 on 06/29/16 at 11:19 a.m. revealed: -The MAs always handed the Symbicort inhaler to him to administer. -He was supposed to take 2 puffs to his knowledge. -He always administered 2 puffs in a row. -The inhaler helped his breathing at times. Interview with the MA on 06/29/16 at 11:28 a.m. revealed: -Resident #13 preferred to hold the inhaler himself. -The resident always took 2 puffs when she handed him the inhaler. -Resident #13 knew he was only supposed to take 1 puff. -She had not notified anyone that the resident was taking 2 puffs instead of 1 puff. Interview with the Resident Care Coordinator (RCC) on 06/29/16 at 11:48 a.m. revealed: -If the MA handed the inhaler to the resident, the MA should instruct the resident on how may puffs to take. -The MA should also instruct the resident on the proper technique for inhaling the medication.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 42 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 observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to supervision of residents. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 2 sampled Residents (#9, #8) known to be disoriented, who eloped from the facility, in accordance with each resident's assessed needs. [TAG 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (TYPE A2 Violation)].	D912		