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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL022005	A. BUILDING: _____ B. WING _____	R 07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYESVILLE HOUSE	480 OLD 64 WEST HAYESVILLE, NC 28904

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D 000	Initial Comments The Adult Care Licensure Section and the Clay County Department of Social Services conducted a follow-up survey and complaint investigations on July 12, 2016 and July 13, 2016. The complaint investigations were initiated by the Clay County Department of Social Services on May 24, 2016 and June 7, 2016.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the acts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is solely prepared as compliance with state law.	8/27/2016
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 review and interview, the facility failed to report allegations of sexual abuse against one staff member to the Health Care Personnel Registry (HCPR). The findings are: Review of Resident #7's current PL-2 dated 6/6/2016 revealed: -Diagnoses included Alzheimer's Dementia and psychotic behavior. -Resident #7 was semi-ambulatory, with constant disorientation, and was incontinent of both bowel and bladder. -Resident #7 used a wheel chair. -Resident #7 was admitted to the facility on	D 438	Hayesville House will comply with all rules addressed in 10A NCAC 13F .1205 Health Care Personnel Registry Facility will report all allegations of any mental or physical abuse according to 10A NCAC 13F.1205. Allegations will be reported to the Health Care Personnel Registry within 24 hours by Administrator. An internal investigation will be completed by the facility Administrator and or the RCC of any allegation made. The Administrator/RCC will then complete a 5 day working report and include findings. The Administrator/RCC will then assure the 5 day working report is then sent into the Health Care Personnel Registry within the alloted time of 5 days.	
		D 914	Refer to response to D 438 A Mandatory Residents' Rights training for all facility staff is scheduled September 22, 2016 with the Ombudsman. All facility staff will review and sign the Residents Right Agreement. Facility Mangement will continue to monitor staff and resident interaction to assure appropriate care is given.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William D Beale — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: Aug 19/16

STATE FORM 6899 8P8O11 If continuation sheet 1 of 9

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D 438	Continued From page 1 3/3/11. Review of Resident #7's current Assessment and Care Plan dated 3/14/16 revealed Resident #7 required total assistance with eating, toileting, ambulation, bathing, dressing, grooming and transfers. Review of Resident #7's current Licensed Health Profession Support (LHPS) Review revealed LHPS tasks of transferring/ambulation with one person assist and feeding assistance as needed. Review of the Personnal Record for Staff J, Personal Care Aide (PCA), revealed a date of hire at the facility of 6/16/2015. Review of a facility form for employee corrective action dated 5/26/16 revealed: -Documentation of an allegation of inappropriate touching by Staff J during incontinence care. -Action taken was re-training of Staff J on proper steps taken to check for resident incontinence. -Documentation of Staff J receiving counseling and a warning the any further reports might result in termination of employment. -The form was signed by the staff member, the Resident Care Coordinator and the Administrator on 5/27/16. Interview on 6/7/16 at 3:48PM with a Medication Aide (MA) revealed: -She witnessed Staff J check Resident #7 by sticking his fingers down the resident's adult brief. -"Most of the time" other PCAs were in the resident's rooms with Staff J. Interview on 6/7/16 at 4:34PM with a PCA revealed: -On rounds Staff J would take his hand, palm	D 438		

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D 438	Continued From page 2 facing up, inside the female resident's adult brief to check for incontinence, spending at least a minute doing this. -Other PCAs felt on the outside of the adult brief or pads for wetness. -Staff J was "very rough" with the residents in providing personal care. -She witnessed Staff J grab Resident #7 by the wrist. -Staff J spent "too much time" feeling Resident #7's adult brief for wetness. -These observations were reported to "higher up" staff. -She spoke to the prior Administrator and two MAs about this. -When this was spoken about to one of the MAs, she was instructed not to allow Staff J to care for female residents, which she had complied with. Based on observation and record review, Resident #7 was determined to be uninterviewable. Interview on 7/12/16 at 10:02AM with a second PCA revealed Staff J "maybe" was inappropriately touching the residents because Staff J was only allowed to provide incontinence care to female residents. Interview on 7/12/16 at 11:05AM with a third PCA revealed: -Staff J stuck his hand in front of the incontinence brief facing the private area and would not pull it out until it was wet. -Staff J would only change one particular resident, Resident # 7. -The facility did not have a protocol for changing residents for incontinence care. Interview on 7/12/16 at 4:46PM with a fourth PCA	D 438		

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D 489	Continued From page 3 revealed: -There were no staff members inappropriately touching the residents. -Staff J only provided care to male residents. Interview on 7/13/16 at 11:19AM with a MA revealed: -It was brought to her attention over the past two to three months that a staff member had been inappropriately touching a resident. -Staff J was alleged to have been inappropriately touching residents. -Five PCAs brought this allegation to her attention. -She handled the situation by going to the Administrator and then the Resident Care Coordinator. -The Administrator and Resident Care Coordinator provided Staff J with re-training on incontinence care. -Staff J is now only changing and bathing male residents. -She did not witness Staff J inappropriately changing residents. -No more complaints had been made since Staff J was changed to providing incontinence care and bathing male residents. -Staff J did his job and was appropriate with residents. -Staff J's duties at the facility included making rounds, providing personal care and providing eating/meal assistance to residents. Interview on 7/13/16 at 11:52AM with a fifth PCA revealed: -She had witnessed Staff J inappropriately touching a resident. -She witnessed Staff J sticking his hand down an incontinence brief and then removing his hand. -Staff J had his hand facing palm up to do	D 438		

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D 438	Continued From page 4	D 438		

checking for incontinence care.
-Staff J every time would put his hand to his face to smell after checking for incontinence care.
-Staff J was doing inappropriate incontinence care to Resident # 7.
-Staff J would only check female residents when doing rounds.
-A note was posted in the front office that Staff J was only allowed to bath and change male residents.
-Since the last complaint she had not witnessed Staff J performing inappropriate changing.
-Staff J's interactions with residents were "awkward."
-Staff # J had made the comment to residents, "Oh, you are nice and juicy and wet aren't you."
-Staff J's duties included showering, getting residents up for dinner and putting residents to bed.

Confidential interview with one staff revealed if a resident was wet and she had to check, she would assist them to the bathroom and remove the incontinence brief there.

Telephone Interview on 7/13/16 at 11:32AM with a family member of Resident #7 revealed:
-Visits occurred 3 to 4 times a month.
-The resident did not verbally communicate nor did they walk.
-"Staff have been real good to her [Resident #7]."
-When she visited the resident was always clean, but when she had incontinence and staff were told, there was no delay in this care being provided.
-Staff were appropriate with the resident and there were no concerns.

Interview on 7/12/16 at 2:07PM with the RCC revealed:

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D 438	Continued From page 5 -Facility policy regarding a report of allegation of abuse required an investigation. -Investigations included interviews, a report and, if findings required, corrective action. -If an investigation was inconclusive, the alleged staff member would continue care activities but would still be counseled. -She and the Administrator were responsible for conducting investigations as they were responsible for keeping residents safe. -The Administrator would be the one to decide if the Health Care Personnel Registry (HCPR) required notification. -She was not aware of any HCPR notifications in the previous recent months, but if the Administrator submitted a report she would be notified. -If a resident was determined to be harmed an incident report was completed but "our report does not give you the specifics." -Reports of staff inappropriately touching residents would be a cause for an investigation and "I think it would be reported to [HCPR]." -There was a report of a staff member with questionable personal resident care practices who afterwards was only assigned to select residents and counseled on how to check for incontinence. -The investigation showed that Staff J was not correctly checking for incontinence as directly witness by other PCAs present during "walk through" checks at change of shifts, but it was her opinion that a staff member would not deliberately inappropriately touch a resident in front of another staff member. -There were inconsistencies in reports regarding how Staff J checked for incontinence, but Staff J explained how they were trained a description of this care. -There had been no previous complaints reported	D 438		

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D 438	Continued From page 6 about the manner in which Staff J cared for residents and there had been no complaints afterwards. -She did not recall HCPR notification coming up in conversation during the investigation with the Administrator, who is new in his role. Interview on 7/12/16 at 4:00PM with the Administrator revealed: -He had been in his role for 2 ½ months. -He was responsible for writing up investigations and forwarding them to his corporate office for review. -If required, reports were sent to the HCPR within 24 hours. -Reports of inappropriate touching would be considered events which triggered HCPR reporting. -He was aware of the investigation surrounding care delivered by Staff J which he had discussed with the RCC in depth. -The RCC completed the investigation after she had spoken to other staff. -The RCC provided him with information to assist him to arrive at his conclusion that Staff J did not have negative intent. -He received training from his corporate office on the HCPR, but he had not reported this incident and "that would be my error." Telephone interview on 7/13/16 at 3:15PM with Staff J, PCA, revealed: -He had been trained as a Nursing Assistant in another state and previously worked at a nursing home. -He had been employed by the facility for about a year. -He would check a resident for incontinence by asking the resident and removing the brief if saturated or soiled.	D 438		

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D 438	Continued From page 7 -If a resident was in bed he would slide his gloved finger down the outer side of the resident's leg and not down their groin. -There was one particular time when he thought a resident's incontinence brief was wet below the resident's navel which "had to be investigated more," but the resident was dry. -There was no recollection of any actions that resulted in his suspension from work. -The RCC and Administrator had spoken to him about a month prior regarding the manner in which he checked for incontinence for Resident #7 as appearing inappropriate. -No awareness of concerns about resident care had been expressed to him prior to this incident. -Challenges with checking Resident #7 for incontinence included the resident being curled up in a fetal position, but the resident did not have to lie down for them to check. -The resident would sometimes lean forward and "seem to fall" so staff were encouraged to use a wheelchair to take the resident to the bathroom. -When trained at the facility he was shown "shortcuts" to check for incontinence, which for Resident #7 included going inside the incontinence brief from the top as in most cases Resident #7 wet from the front, but he could not remember who showed him. -Since the allegation was made he had only been assigned to male residents. -There had been no other complaints, no administrative leave and no suspension. On 7/12/16, the facility Administrator submitted a Plan of Protection which included: -Staff J had been counseled and trained regarding appropriate personal care. -Investigation of any resident issues would be sent to the proper agency. -HCPR would be notified immediately of the	D 438		

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D 438	Continued From page 8 allegation (a copy of the 24 Hour Initial Report and a fax transmittal report dated 7/12/16 at 6:43PM was provided). -Staff J would provide personal care for male residents. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, AUGUST 27, 2016.	D 438		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to protect residents from mental and physical abuse due to a failure to report an allegation of sexual abuse to the Health Care Personnel Registry (HCPR). The findings are: Based on record review and interview, the facility failed to report allegations of sexual abuse against one staff member to the Health Care Personnel Registry (HCPR) [Refer to Tag 438, 10A NCAC .1205, Health Care Personnel Registry (Type B Violation)].	D914		