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
	HAL002003	A. BUILDING: _____ B. WING _____	07/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLORSVILLE HOUSE	350 SCHOOL DRIVE TAYLORSVILLE, NC 28681

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted an annual survey and complaint investigation on July 13, 2016 through July 15, 2016, and July 18, 2016. The county initiated the complaint investigation on May 16, 2016.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of truth of the facts alleged or conclussion set forth in the statement of deficiencies or corrective action report, The Plan of Correction is prepared solely as a matter of compliance with State Laws.	
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide adequate supervision for 2 of 6 (#1 and #16) sampled residents to prevent falls and limit aggressive behavior toward other residents. The findings are: A. Review of Resident #1's current FL2 dated 5/2/16 revealed: -Diagnoses included dementia, muscular weakness, a history of alcohol abuse, and atrial fibrillation. -An inappropriate behavior of wanderer was noted. -Psychoactive medications included clonazepam 0.5mg twice daily, donepezil 10mg at bedtime, memantine 10mg twice daily, and venlafaxine	D 270	10A NCAC 13F .0901 (b) Personal Care and Supervision (b) Staff shall provide supervision of each residents in accordance with each resident's assessed needs. care plan and current symptoms. 1.Facilty will implement a mood and behavior tracking system. 2.Staff will be trained on implementation documentation, and interventions of this tracking system. 3.Facility will implement the fall management program to include risk assessments, interventions, monthly meetings, and inservice staff. 4. The Memory Care Manager and the Executive Director will monitor and review the mood behavior tracking system for compliance and the fall management program	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna R Neal — TITLE: Executive Director — (X6) DATE: 8-26-16

10-28-16

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D 270	Continued From page 1 37.5mg ER daily in the morning. (Clonazepam is a medication used to treat anxiety disorders and agitation, donepezil and memantine are medications used to treat dementia, and venlafaxine is a medication used to treat depression and anxiety.) Review of Resident #1's Care Plan dated 6/14/16 revealed: -Behaviors of wandering and verbally abusive. -Resident injurious to others. Review of Resident #1's Resident Register revealed an admission date of 4/19/16. Review of Resident #1's record revealed: -A fax to a Nurse Practitioner (NP) dated 5/9/16 stated, "could we have prn (as needed) for him (Resident #1) please. Resident very physically/verbally abusive." -A subsequent medication order dated 5/9/16 for Depakote 125mg sprinkle twice daily for mood, and clonazepam 0.5mg twice daily and 1 every 4 hours as needed for anxiety and agitation, not to exceed 4 doses in 24 hours. (Depakote is a medication used to treat seizures, bipolar disorders, and to stabilize mood.) -A fax to Resident #1's NP dated 5/16/16 documented the resident had refused his 8am medications, -A return fax from the prescribing practitioner dated 5/16/16 documented "if (Resident #1) has outburst, threatening, or hitting at staff, call police, to (sic) magistrate for an involuntary commitment." -The fax on 5/16/16 also included a new medication order for trazodone 50mg, 1/2 tablet at bedtime for sleep. (Trazodone is a medication used to treat depression and insomnia.) -A fax to Resident #1's prescribing practitioner	D 270	5. The quality assuance team will review systems during site visits. The community will be in compliance by September 1, 2015.	

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dated 7/10/16 documented, "Resident has had outbursts today, threatening to hit staff with cane. Resident states he is not happy and will find a way to leave even if it means hurting someone. Family came and talked to resident. Trying to calm him down."
-Subsequent medication orders dated 7/11/16 changed Resident #1's clonazepam to 0.5mg three times a day and every 4 hours as needed for anxiety and agitation, not to exceed 3 doses in 24 hours, and increased his Depakote to (2) 125mg sprinkle twice daily.

Review of Resident #1's "Supervisor Notes" revealed:
-4/23/16 Resident had been calling the nursing assistants (NA) "bad curse words and hit and kicked them."
-4/23/16 Resident cursed kitchen staff today.
-4/26/16 Resident was very aggressive and hitting other residents.
-4/28/16 Resident slapped another resident on the arm because other resident tried to come into the front lobby.
-4/28/16 Resident stated he "peed on his roommate and would do it again if he don't (sic) shut up," and "I might even set fire to him."
-4/29/16 Resident sent out by emergency medical services to local hospital, resident telling NA he wanted to kill himself, family notified.
-4/29/16 Resident back from emergency room, no new orders, could not find anything wrong with resident.
-4/30/16 Resident had chair in front of door, wouldn't let staff in.
-4/30/16 "Resident was very combative, hit NA in face, family came in and talked to resident."
-5/5/16 "Resident very combative this morning, hit NA, called him a (racial slur)."
-5/9/16 "During morning med pass, heard

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screaming, ran to 300 hall, saw Resident #16 come flying out of Resident #1's room, Resident #16 hit the floor flat on face."
-5/10/16 Resident "very ugly this morning, would not come to breakfast."
-5/15/15 During morning medication pass, Resident #1 stated he hated this place and was going to "have to start killing people here."
-7/9/16 Resident locked bedroom door and refused to let anyone in, refused all morning medications, threatening staff and residents, will continue to monitor.
-7/10/16 Resident refused to take morning medications, threatening to hit staff with cane, very agitated, family came in to try and calm him down.

Interview with Resident #1's family member and guardian on 7/14/16 at 12:20pm revealed:
-He visited Resident #1 every week or two.
-He was not sure if Resident #1 liked the facility or not, and was not really sure he needed to be in a locked unit.
-Resident #1 previously resided in another assisted living facility without a special care unit, and "he walked off from there."
-He did not think Resident #1 would bother anyone, "it hasn't happened before."

A second interview with Resident #1's family member and guardian on 7/15/16 at 9:55am revealed:
-He was not aware of the incident with Resident #16, but "I can believe it."
-Resident #1 "wants to be left alone."
-Resident #1 used to have a roommate, but they moved him out, "not sure why."
-He had never seen Resident #1 put his hands on anyone before, staff or resident.
-He liked to "pick at the staff, horseplay."

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D 270	Continued From page 4 Interview with a Medication Aide (MA) on 7/14/16 at 10:35am revealed: -Resident #1 had been "doing better lately" since his medication changes in May and was less agitated and aggressive. -Resident #1 "liked to keep to himself." -She had never seen Resident #1 be aggressive or abusive to other residents. -Resident #1 got mad at staff sometimes when he was in a "bad mood." -Resident #1 was "mostly just talk." Interview with a second MA on 7/18/16 at 10:50am revealed: -"We (staff) try to check on (Resident #1) every 15 to 20 minutes." -Resident #1 usually stayed in his room by himself. -Resident #1 did not like for anyone to come into his room. -"He usually just yells, and the other resident leaves (Resident #1's room), or we go get them out." -Resident #1 did not currently have a roommate and had not had one since he was first admitted to the facility. -The reason Resident #1's roommate moved out was due to the room temperature, i.e. Resident #1 liked his room hot. -She witnessed the incident with Resident #16 just after it occurred. -Resident #1 had never been aggressive with other residents before or since the incident with Resident #16, i.e. pushing Resident #16 out of his room causing her to fall. -Most of Resident #1's aggression was directed toward staff. An attempt to interview Resident #1's former	D 270		

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D 270	Continued From page 5 roommate on 7/18/16 at 1:30pm was unsuccessful. Interview with Resident #1's NP on 7/18/16 at 9:45am revealed: -She was not sure if Resident #1 was safe to be around other residents, but when she had seen him, most of his threatening behaviors had been toward staff. -She was aware of the incident with Resident #1 pushing Resident #16 down and had adjusted his medications. -The involuntary commitment order dated 5/16/16 was due to increased behavior from Resident #1, e.g. not taking his medications, threatening to leave and break down the doors. -She felt his behavior had improved, but lately he had been threatening staff with his cane. -Resident #1 knew which staff he could manipulate and not take his medications. Review of encounter notes from the NP dated 4/25/16 and 6/27/16 revealed no documented concerns about Resident #1's behaviors. Review of Resident #1's Medication Administration Records for June and July 2016 revealed 2 days each month when the resident refused all of his morning medications. Interviews with 5 of 5 staff at various times during the survey revealed: -None were afraid of Resident #1 or any other residents. -Resident #1 could get loud at times. During an initial tour of the facility, no interviewable residents stated they were afraid of Resident #1.	D 270		

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D 270	Continued From page 6 Observation of Resident #1 on 7/18/16 at 2:15pm revealed: -A thin male with mild kyphosis and an unsteady gait. -Resident #1 appeared to be in a good mood and was joking with staff about a beverage he was carrying in a plastic cup. Review of the facility's policy on supervision of residents with difficult behaviors revealed: -Emphasis was on identifying residents with potential behaviors prior to admission to the facility. -Explanations of the various types of difficult behaviors such as agitation, aggression, assaultive behaviors and sexually inappropriate behaviors. -Staff were to report to management any of these observed behaviors in residents. B. Review of Resident #16's current FL2 dated 5/2/16 revealed: -Diagnoses included Alzheimer's Dementia, falls, hypothyroidism, and status post repair of left hip fracture. -Resident was semi-ambulatory with wheelchair. Review of Resident #16's record revealed: -From 1/1/15 through 12/31/15, Resident #16 had 7 documented falls. -Three of those 7 falls in 2015 required transportation to the local Emergency Room (ER) for evaluation. -5/6/16 Resident #16 was found on the floor outside of Resident #1's room in the 300 hall, laying on face, bleeding, was sent to the local ER. -A discharge summary from the local ER dated 5/6/16 noted fall with dementia, mild nose bleed, acute head injury, and thigh injury. -A fax to Resident #16's physician dated on	D 270		

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D 270	Continued From page 7 5/29/16 documented that resident fell out of her bed, no injuries at that time. -A fax to resident's physician dated 6/3/16 documented Resident #16 was found in the floor, no injures at that time. Interview with a Medication Aide (MA) on 7/18/16 at 10:50am revealed Resident #16's face had a lot of abrasions due to falling on the carpet face first on 5/6/16 and was sent to the emergency room for evaluation. Review of Resident #16 Care plan revealed: -Resident # 16's care plan was dated 8-24-14. -Resident # 16 used a walker for ambulation. -Resident # 16 required limited assistance with ADL's such as bathing, toileting, and dressing. The facility was unable to locate a Care Plan for Resident #16 for 2015. Interview with the Memory Care Manager (MCM) on 7/15/16 at 9:50am revealed: -Resident # 16 was in Resident #1's room on 5/6/16. -Resident #1 had asked Resident #16 to leave his room but Resident #16 would not leave. -Resident #1 then pushed Resident #16 causing her to fall in the 300 hall. -The steps taken for falls are: call the doctor, lower bed, floor mat, and alarm for wheelchair or Geri chair if needed. -Resident #16 was in a wheelchair and it is working for her", i.e. to reduce falls. -Resident #16 was a two person assist and staff walked with Resident #16 because she tried to walk on her own with no assistance. - Resident #16 had only two falls for this year (2016). -The primary care physician had ordered physical	D 270		

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D 270	Continued From page 8 therapy and physical therapy had assessed Resident #16 on 12/21/15 but the family member declined therapy. -She was not sure about any other interventions the facility had in place to prevent Resident #16's falls. Review of Resident #16's record revealed no documentation any of the above fall interventions had been attempted for Resident #16. Interview with a Medication Aide (MA) on 7/15/16 at 10:00am revealed: -Resident #16 "had fallen recently but not as often as she had in the past." i.e. twice in the past two months. -They (staff) kept Resident #16 "in their sight" and would pass by her room more often than the 2 hours required by the facility's policy. -She believed Resident #16 could remove a tab alarm if she had one. -She believed the facility had done everything they could to keep Resident #16 from falling. -Resident #16 had a walker prior to having a wheelchair and actively ambulated around the facility. Interview with Resident #16's family member on 7/12/16 at 1:42pm revealed: -The family member stated they were concerned about number of falls the resident was having. -The family member stated that they were aware another resident pushed Resident #16 and she fell. -The family member believed a few of the Personal Care Aides (PCAs) had heard Resident #16 hit the ground. Attempts to reach Resident #16's primary care physician on 7/15/16 at 10:46am, 1:50pm, and	D 270		

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D 270	Continued From page 9 1:52pm were unsuccessful. On 7/15/16 the facility provided the following plan of protection: -Facility will implement a mood and behavior tracking system. -Staff will be trained on implementation, documentation, and interventions of this tracking system. -Facility will implement the fall management program to include risk assessments, interventions, monthly meetings, and inservice staff. -The Memory Care Manager and Executive director will monitor and review the mood behavior tracking system for compliance and the fall management program. -The quality assurance team will review systems during site visits. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 1, 2016.	D 270		
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 observation, record reviews, and interviews, the facility failed to assure every	D912		

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D912	Continued From page 10 resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules an regulations in the area of supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide adequate supervision for 2 of 6 (#1 and #16) sampled residents to prevent falls and limiting aggressive behavior toward other residents. [Refer to Tag D 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation.)]	D912	Declaration of Resident Rights review will be provided toall staff and conducted by the Executive Director. Resident Rights training will be provided by the Ombudsman on Stepember 22, 2016, which is the first available date for the Ombudsman. Please refer to the Plan of Correction for Tad D 270, 10A NCAC 13F .0901(b)	9/1/16