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D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a follow-up survey and complaint investigation on November 2 - 3, 20916 with an exit conference via telephone on November 9, 2016.	D 000		
D 233	10A NCAC 13F .0702 (i) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow regulatory rules and facility policy to discharge 1 of 2 residents (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 05/02/2016 revealed: -Diagnoses which included Alzheimer's dementia and Paranoid Schizophrenia. -Medications included aripiprazole (an antipsychotic) 400mg injection 1 vial every month by home health and 5mg tablet each day, lorazepam (an antianxiety medication) 0.5mg tablet each day and one tablet every six hours as	D 233		

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needed (PRN) for anxiety/agitation, and trazodone (an antidepressant) 50mg tablet each day.

Review of the Resident #1's Resident Register revealed an admisstion date to the facility on 11/12/14.

Review of Resident #1's August 2016 Medication Administration Record revealed:
-No scheduled medications were administered on 08/31/16 due to hospitalization.
-Resident #1 refused clonidine (an antihypertensive medication) 11 days and nystatin (an antifungal medication) on 1 day of the month.
-These types of medications do not effect behaviors.
-Aripiprazole injection and oral tablet, lorazepam and trazodone were all documented as administered from 08/01/16 through 08/30/16.
-On 08/23/16 and 08/31/16 it was documented the resident received PRN lorazepam which was effective.

Review of Resident #1's record revealed:
-Resident #1 was seen by a psychiatrist at the facility for her behaviors.
-Nursing note entries did not document any behaviors that would be considered dangerous or result in an immediate discharge.
-No copies of or documentation concerning discharge notice forms.
-No documentation from a Physician or Provider regarding the need for discharge from the facility.

Telephone interview on 11/02/16 at 9:45PM with Staff B, Medication Aide (MA), revealed:
-If a resident refused medication, she would reapproach them at a later time and it might take another staff member to convince the resident to

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take their medication.
-She would report all medication refusals at change of shift report with the on-coming MA and Supervisor.
-Resident #1 left the facility recently.
-She had noticed a total change of behavior from when she had last worked at the facility.
-Resident #1 had hallucinations and got easily aggressive with residents and staff.
-She did at times try to calm the resident down.
-Resident #1 scared residents and staff.

Interview on 11/03/16 at 9:00AM with the Memory Care Manager, Nurse Consultant and Executive Director revealed:
-The facility's policy for discharge process was to "follow state regulations."
-Resident #1 went to the hospital for psychotropic medication management and to address behavioral problems.
-Resident #1 was verbally abusive and physically aggressive, hitting residents and staff.
-Resident #1's primary diagnosis changed from dementia to schizoaffective disorder with violent tendencies.
-The facility had no contract with a mental health service, with referrals made by contacting a provider or family.

Interview on 11/03/16 at 9:50AM with Staff C, MA, revealed:
-Resident #1 was known to have a history of refusing medications.
-Resident #1 was more "verbal than physical."
-Resident had been checked for a urinary tract infection and a "psych doctor" had been consulted.
-"I feel like she needed to be sent out" and needed a medication adjustment.
-She was not aware of any details regarding

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Resident #1's medication management while hospitalized.

Interview on 11/03/16 at 11:00AM with Staff D, MA, revealed:
-Care staff were instructed to tell her if residents became agitated as with some, a "change of face" was needed to approach agitated residents.
-Taking a resident to a different area, redirection and use of a PRN medication sometimes helped.
-Leadership had told staff to document on residents and report issues.
-Physicians were good to check on medications.
-Resident #1 "had her days."
-Resident #1 experienced hallucinations which were reported to the Provider (no dates were provided).
-Prior to the Summer of 2016, Resident #1's medications were changed.
-Resident #1 would verbally "jump on" certain staff.
-One resident had reported that Resident #1 had slapped her.
-If Resident #1's medications came under control, she did not see why she could not come back to the facility.
-Resident #1 knew her medications and was known to refuse her PRN medications and blood pressure medication.
-She did not recall Resident #1 complaining about medication side effects.
-The Nurse Practitioner was notified about Resident #1 and the Memory Care Manager would know if mental health services were arranged.

Interview on 11/03/2016 at 11:30AM with Staff A, Personal Care Assistant (PCA), revealed:
-When a resident became agitated or aggressive towards another resident staff were expected to

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talk with them and get them busy so their mind was not constantly going back and forth.
-Staff were expected to take residents to their room to help calm them and figure out what the resident needed or wanted.
-If residents refused their medication then the Medication Aide would calm them down and reattempt to get them to take their medication.
-Resident #1 was very aggressive and was refusing her medication.
-She was scared of Resident #1.
-She did not think that Resident #1 should have been able to come back to the facility from the hospital.

Interview with Resident #1's Guardian on 11/03/2016 at 2:30PM revealed:
-The facility did not notify the Guardian or family that Resident #1 was not taking her medication or that Resident #1 was having behaviors while at the facility.
-Resident #1 could become combative and verbally abusive and could become mean to other residents.
-It was only after the Resident was admitted to the hospital that family was notified about medication refusals and behaviors resulting in the hospital admission.
-Resident #1 was sent to the hospital on 08/26/16, returned to the facility the same day and went back to the hospital on 08/31/16, again returning the same day.
-Family was called on 09/01/16 and told Resident #1 had been refusing her medications and was being sent out again that evening because of behaviors, at which time the resident was involuntarily committed by the Guardian.
-She received a phone call on 09/03/16 from the Executive Director stating the facility could no longer could meet Resident #1's needs and would

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not be taking Resident #1 back following her hospitalization.
-She did not have any clue that Resident #1 was going to be discharged.
-She was notified by the facility that they could appeal the discharge.
-She did not receive a hard copy of the pending discharge form.
-She was told the Executive Director was going to be at the facility on 09/05/16 so they could talk, but the Executive Director was not there.
-No one from the facility came to the hospital to do an assessment.
-Resident # 1 was in the hospital for a month.
-Resident #1's diagnosis did not change when she left the hospital for another facility.

Review of the facility's policy for discharge revealed that if a resident was hospitalized, the facility would re-evaluate the resident before hospital discharge, to assure continued services and that supervision could be provided for the resident.

Interview with the Executive Director on 11/03/2016 at 3:00PM revealed:
-Administrator stated that Resident #1 was walking around the facility angry and stomping around, glaring at the other residents and stating "she did not want them there."
-The Nurse Practitioner reviewed Resident #1's medications.
-Resident #1 got more physical with the staff and would not let people in the facility.
-Resident #1 refused her PRN medication and was sent to the emergency room.
-Resident #1 returned to the facility, refused her medication again and on 09/01/16 was threaten staff and mumbling about the residents.
-Staff called Resident #1's family member who

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did come out to the facility.
-Resident #1 was a safety concern for other residents and after talking with other staff she determined the facility could no longer meet the needs of Resident #1.
-She called the Guardian on 09/03/16 and reported that the facility could not meet Resident #1's needs.
-The facility probably would have taken Resident #1 back if medications were adjusted.
-Resident #1's diagnosis changed to "mental health."

Interview with the Nurse Practitioner on 11/04/2016 at 9:59AM revealed:
-Resident #1 would want to go home at times and would refuse medications.
-Resident #1 did not like some employees and would refuse to take medications, but if the staff would call the family they would be able to calm Resident #1 down and get her to take the medications.
-They were not sure if Resident #1 needed a medication adjustment or change.
-She did not change or adjust psychotropic medications for Resident #1.
-The facility never asked for a written doctor's note for discharge of Resident #1.
-She was not aware that facility was discharging Resident #1 until she came to the facility to visit residents.
-Resident #1 would frighten other residents because of her appearance, not because of behaviors.
-Resident #1 did need a locked unit and she was calmer at this facility than at other facilities where she had previously lived.
-Resident #1 did not have behaviors often.
-She felt that it would have been better if the facility would have gone back and done a

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D 233	Continued From page 7 reevaluation. -She felt that there was no activities for Resident #1 to engage in.	D 233		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility staff failed to respond immediately, in the case of an accident involving a resident, to provide care and intervention according to the facility's policies and procedures for 1 of 5 sampled residents (Resident #3) who had fallen and sustained a head injury. The findings are: Review on 11/02/16 of Resident #3's current FL2 dated 05/02/16 revealed: -Diagnoses which included dementia and a cerebrovascular accident (CVA) with aphasia (a cardiovascular accident or stroke resulting in the loss of speech). -Medications including Aspirin 81mg every morning (used as a blood thinner) and Clopidogrel 75mg every morning (a blood thinner). -The Resident was constantly disorientated,	D 271		

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D 271	Continued From page 8 ambulatory, a wanderer and verbally limited in ability to communicate her needs . Review of Resident #3's Resident Register revealed an admission date of 06/02/15. Review on 11/02/16 of Supervisor Notes in Resident #3's record revealed: -On 10/28/16 at 6:00AM, a Personal Care Aide (PCA) had gone to the resident's room to get her dressed -Resident #3 told the PCA, "Fell...hurt", and the PCA noted a "knot on the resident's left eye". -A family member had been notified and told the Medication Aide (MA)/Supervisor "to keep watch of any other signs". -There was no documentation the physician had been informed of the fall. -There was no documentation first aide had been given, post-fall interventions had been put into place or monitoring of the resident's condition post-fall had occurred. Review of the facility Falls Management Program, provided by the Nurse Consultant as the facility's falls policy and procedure, revealed: -The staff will complete an Incident Report in it's entirety for any fall. -Staff will contact the resident's family/responsible party and their physician. -The Executive Director (ED) is required to review all incident reports for content, accuracy and completeness. -ED and/or Care Manager should determine any immediate interventions required, based on the circumstances of the fall. -Staff completes the "72 Hour Follow Up" on the resident fall to investigate possible circumstances contributing to the fall and document observations for the period of 72 hours after the fall.	D 271		

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-The 72 Hour documentation includes vital signs initially and on each shift for 72 hours (additionally as necessary) and assessment of possible risk/contribution factors for the fall.
-For any fall, the resident must be placed on "Hot Box/Alert Charting" for 72 hour follow-up and monitoring.

Interview on 11/03/16 at 2:20PM of the Medication Aide (MA) on duty revealed:
-If a resident falls and has a head injury, first aid would be administered if needed and the resident would automatically be sent to the Emergency Room (ER).
-Sometimes the family did not want the resident sent to the ER and then they would remain at the facility and be closely monitored.
-Staff would try to figure out what happened and to put some kind of intervention in place.
-The resident would be kept near a staff member, if possible, and monitored for sleepiness every hour after the fall.
-An incident report was completed and left for the Memory Care Manager to review and then it goes to the ED.

Interview on 11/03/16 at 3:10PM with the Memory Care Manager revealed:
-"If a resident falls and we see them hit their head, they [the resident] say they hit their head and/or are complaining of pain, EMS (Emergency Medical Service) is called and we send them to the hospital."
-"If a resident falls and they are on blood thinners, we would definitely send them to the hospital, especially if they have, or may have, a head injury."
-If the family or the Responsible Party did not want them sent out to the hospital, staff would explain to them why the resident needed to be

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D 271	Continued From page 10 seen. -Sometimes the family absolutely refused to give permission and the resident did not go even though staff felt they should. -She could not locate an incident report from 10/28/16 at 6:00AM for Resident #3 and stated "one probably wasn't made out". -She could not locate "Hot Box/Alert Charting" for the 72 hour period post fall and stated "it probably was not done". Interview on 11/03/16 at 3:25PM with the Executive Director revealed: -She had been in the position less than two months. -She expected the staff to send out residents to the hospital who had a change in condition or a fall with injury even if the family didn't agree. -She expected the staff to complete the required documentation. -She would expect the staff to send out residents with head injuries, most especially if the resident was taking blood thinners. -She would meet with the staff and go over the falls policy and sending residents by EMS to the hospital. Telephone interviews attempted on 11/04/16 and 11/05/16 with the MA/Supervisor on duty at the time of Resident #3's fall were not successful.	D 271		