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D 000	Initial Comments The Adult Care Licensure Section and the Johnston County Department of Social Services conducted an Annual Survey and Complaint Investigation on 1/11/17 and 1/12/17.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the adult care home was maintained in a clean, and free of hazards and obstructions as evidenced by the presence of numerous live bed bugs observed in two resident rooms with evidence of bed bugs in a two additional resident rooms; saturated and deteriorating ceilings in the dining room and hallways; dirt and debris on floors in the dining room, hallways, bathrooms and resident rooms; unclean bathrooms, showers and resident rooms and foul smelling standing water in a sink in the janitor's closet on the women's hall. The findings are: 1. Observations of an occupied resident room on	D 079		

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1/11/17 at 10:12am revealed:
-There were numerous live bed bugs and bed bug excrement on the bed frame; and numerous live bed bugs actively crawling on the floor and the walls in the last resident room on the left rear facing men's hall (there was no identifying room number).
-The mattress and box spring had been removed from the room.
-The Administrator was mopping the floor in the resident room.
-There was a pile of blankets, sheets and two pillows that had live bed bugs crawling on them and one of the pillows was covered in numerous old blood spots.
-The mattress and box spring were leaned against the outside rear of the building with innumerous live bed bugs on the surface, sides and seams with areas of heavy bed bug excrement.

Interview with a resident on 1/11/17 at 10:47am revealed:
-There were bed bugs in her room on the women's hall.
-She had been bitten by bed bugs on her arms and stomach as recently as 1/10/17.
-She had not seen a doctor for the bed bug bites.
-She told staff at the facility about the bed bugs "but they ain' t do nothing."

Observation on 1/11/17 at 10:51am revealed the 1st resident room on the right of the rear facing women's hall (there was no identifying room number) had black spots resembling pest excrement on the head board of the bed frame and old blood spots on the pillow.

Interview with a second resident on 1/11/17 at 11:00am revealed the facility had had a problem

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with bed bugs in the 1st resident room on the right of the rear facing women's hall.

Interview with a Medication Aide (MA) on 1/11/17 at 3:10pm revealed:
-There were two male residents with bed bug bites; one who had them "everywhere since he got here [June 2016]."
-The bites and bed bug issue had been reported to the Administrator "a while ago" but nothing was done about it.
-The Resident Care Coordinator (RCC) had bed bug bites on her arms and had to throw her furniture away [from the 2nd floor staff live in apartment in the facility.]
-The women's hall was treated for bed bugs in November 2016; she thought the pest control company came to "spray" the facility "a couple of times since then."

Observation on 1/11/17 at 3:50pm revealed a male resident had small red, raised bumps with scratch marks and dried blood on both hands and forearms.

Interview with the male resident on 1/11/17 at 3:50pm revealed:
-His hands and forearms itched and he scratched them.
-He had not seen a doctor for the itching bumps on his hands and forearms; he put antibiotic ointment on it himself.
-He had not seen any bugs in his room.

Interview with a second male resident on 1/11/17 at 11:45am revealed he did not have "any bug bites or things like that."

Interview with a second MA on 1/11/17 at 4:05pm revealed:

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-There was an infestation of bed bugs on the men's hall; she reported the bed bugs to the Administrator on 1/10/17.
-She did not know if there had been prior reports of bed bugs in any resident rooms.
-Staff checked the women's hall after finding the bed bugs on the men's hall; there were no bed bugs found on the women's hall.
-In the last resident room on the left rear facing men's hall the bed bugs were crawling up the wall.
-When she called the Administrator on 1/10/17 about the bed bugs, he told the MA he would deal with it tomorrow.

Interview with the RCC on 1/11/17 at 10:30am revealed:
-She had worked at the facility since April 2016; started as a MA and had been the RCC for a few weeks.
-The bed bugs in two resident rooms on the men's hall had been found by staff on 1/10/17 and reported to the Administrator on 1/10/17.

Interview with the Administrator on 1/11/17 at 10:18am revealed:
-The pest control company treated the facility every month.
-There had been bed bugs found in three resident rooms on the women's hall which had been treated in November 2016.
-The furniture was treated in the resident rooms on the women's hall and the mattresses were placed inside plastic covers.
-There were no bed bugs on the men's hall in November 2016.

Interview with the RCC on 1/11/17 at 11:15am revealed:
-There were 2 rooms on the women's hall which

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were infested with bedbugs (Resident #1 and Resident #6's rooms).
-The rooms were never treated by the exterminator.
-Staff members, including the RCC were bitten by bed bugs.
-The Administrator was aware of active bed bug infestation in the facility; the RCC took pictures and gave the Administrator viewed the pictures.
-The bed bugs have been in facility since beginning of 2016.
-In May, 2016, the Administrator instructed the RCC and 2 other staff to use green rubbing alcohol and bleach to treat the bed bugs in the residents' rooms 2 times a week until the end of May.
-Plastic mattress covers were purchased in July and placed on mattresses, but bed bugs got through the covers.
-An exterminator sprayed for bed bugs on the Men's Hall in November or December 2016, but the bed bugs had gotten worse since, not better.
-Resident #3's room had the worse infestation on his bed, mattress and walls. Even though he never reported any bites, he probably had bed bug bites.

Review of a pest control receipt dated 12/27/16 revealed the facility was treated for "fly management sanitation and service."

Review of a pest control receipt dated 11/1/13 revealed there were five resident rooms treated for bed bugs.

There were no further pest control receipts for the treatment of bed bugs available for review.

Interview with the Administrator on 1/11/17 at 12:51pm revealed:

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-The bed linens and clothing in residents' rooms affected by bed bugs were placed in the dryer for 30 minutes, then washed and dried.
-The pest control person had provided an instruction sheet for the facility in November 2016 and that was what the facility followed.
-Staff had informed him the morning of 1/11/17 that there were bed bugs in two resident rooms; he immediately called the pest control company and removed the mattress and box spring.
-He did not use any cleaning agents or store bought extermination supplies to treat bed bugs.
-The pest control company would treat the affected resident rooms on 1/13/17.

Interview with the pest control person on 1/11/17 at 12:51pm revealed:
-The normal process was to inspect the "problem area" the pest control company was called for; they did not inspect the whole building or common areas as part of their routine process.
-He recommended inspecting and treating the whole building because bed bugs would just relocate from the problem area to another area.
-The pest control company was called 1/11/17; he came to the facility and inspected the "problem area" and did find evidence of bed bugs.

Review of the County Environmental Health report dated 1/11/17 revealed:
-Evidence of bed bugs and live bed bugs were found in four resident rooms.
-The affected rooms and common areas needed to be professionally treated.
-The treatment schedule was to be forwarded to the Inspectors office.
-The form was signed by the Administrator and the inspector.

Interview with a former staff on 1/12/17 at 9:50am

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revealed:
-A few weeks ago (in December 2016) a resident had bed bugs bites on her arms and face.
-The resident showed bites to the MA, but was told to go back to bed because there was nothing she could do.
-About 2 weeks ago, the former employee observed a bed bug crawling on a resident while he was sitting on a couch in the facility's living room.
-The former employee worked as a cook and was not aware of recent bed bug treatments by an exterminator.

2. Observations on 1/11/17 at 10:03am revealed:
-The ceiling tiles, on approximately ¼ of the area of the ceiling, were saturated.
-A ceiling fan was hanging nearby the saturated area.
-There was standing water in a ceiling light tile.
-There was a large puddle of water on the entire dining room floor.
-There was a mop bucket, a basin and a garbage can on the floor under areas dripping from the ceiling.

Interview with the Administrator on 1/11/17 at 9:50am revealed:
-The dining room area was closed off.
-There was a leak in the dining room coming from the ceiling.
-The tub in the 2nd floor apartment was overflowing.
-Staff had notified him of the water leaking from the dining room ceiling the morning of 1/11/17.
-He had contacted a plumber who was coming to the facility later on 1/11/17.

Observations on 1/12/17 at 7:29am revealed:
-The Medication Aide (MA) asked a resident to

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assist her with cleaning up the ceiling tile from the floor.
-There was an open space in the ceiling above the dining room entrance with brown water marks on pieces of the remaining tile.
-A saturated ceiling tile was on the dining room floor in the entrance area.
-There were five additional ceiling tiles that had brown water marks and were sagging down.

Interview with the MA on 1/12/17 at 7:30am revealed the ceiling tile had "just fallen on the floor this morning;" there was no one in the dining room when it happened.

Interview with the Administrator on 1/12/17 at 11:45am revealed:
-The maintenance man inspected everything in the 2nd floor apartment and the ceiling for water damage from the leak; the facility dining room ceiling tiles were going to be removed and replaced on 1/12/17.
-There was no evidence of mold and a fan had been put in the dining room to help everything dry.

Observations on 1/12/17 at 3:05pm revealed six ceiling tiles in the dining room appeared to be new, without brown water marks or sagging, in the area of the damage from the leak on 1/11/17.

Review of the facility's "Food Establishment Inspection Report" dated 12/2/16 revealed:
-There was documentation of four "Risk Factor/Intervention Violations" and one "Repeat Risk Factor/Intervention Violations."
-There was documentation for corrective actions "Priority: Drain piping from kitchen area is leaking from below the floor onto the floor in the basement."

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D 079	Continued From page 8 Observations on 1/11/17 at 3:48pm revealed: -There was a black substance covering the inside of the basement door just off the kitchen near the walk in refrigerator. -There were beads of water on the ceiling and walls of the hallway leading down to the basement. -There was water on the entirety of the basement floor with a vertical pipe in the center of floor actively leaking a steady stream of water. 3. Observation of the women's hall on 1/11/17 at 10:09am and 1/12/17 at 11:06am revealed: -There was an electrical outlet located in the sitting area that was loose and had a gap of approximately one inch from the wall. -There was a yellowish stain at the corner of the ceiling with an approximate one foot square area of cracked plaster on the wall just below the ceiling above the medication cart area in the sitting area. Observations of the women's hall on 1/11/17 from 10:47am until 11:30am revealed: -There was a strong foul odor coming from a janitor's closet on the women's hall. -The janitor's closet had a garbage can without a garbage bag that was half full with soiled incontinence briefs. -The deep sink inside the janitor's closet was 2/3 full with dark water and a hose was attached to the faucet. Interview with a resident on 1/11/17 at 11:00am revealed: -The hole in the corner behind her bed had been there for a year and half; she put aluminum foil in it to seal it up. -Staff did not move her bed to clean behind or	D 079		

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under it.

Confidential resident interview revealed:
-The sink in the janitor's closet had been stopped up for 2-3 days.
-Staff knew about the stopped up sink.

Confidential interview with a staff revealed:
-The sink in the janitor's closet on the women's hall had been "like that [with standing foul smelling water]" for a week.
-There was no cleaning done on 1/10/17 for 3rd shift in the facility.
-These things happened frequently at the facility and nothing was done about it.

Observations of the women's hall on 1/11/17 from 10:47am until 11:30am revealed:
-There was a fire alarm box near the rear exit door with exposed wires from an unmatched sized cover.
-There was a hole where the base board met the floor in the corner behind the resident bed in the last resident room on the left of the rear hall.
-The window in the shower/bathroom had a towel stuffed in an approximate two inch gap between the top and bottom window panes.
-The 2nd resident room on the right side of the front facing hall had missing blinds in one window and broken blinds in a second window.
-The walls in the hallway had numerous areas of smudges, hand prints, chips and dings.
-There was trim molding approximately waist high in the hallway with a heavy dust build up.
-The linen closet had linens and loose, unused incontinence briefs on the floor.
-The 2nd resident room on the right of the rear facing hall had a male resident sleeping in the bed, a large cup of dark yellow liquid resembling urine on the floor beside the bed, several dead

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roaches on the floor, a paint can in the corner of the room, clothing on the floor inside and outside the closet, dirt and debris on the floor with a heavy build up in the corners; and clutter on the dresser including a dirty coffee maker, coffee stains on the dresser and on plastic containers, and numerous containers in a disorganized manor.
-There was a heavy buildup of dirt and debris on the floor and under the bed in the last resident room on the left of the rear facing hall.
-The shower/bathroom had dirt and debris on the floor; a heavy buildup of dirt, dust and debris in corners and at the rear of both toilet bases; used pieces of tissue, empty toilet paper roles, and a dirty toilet brush on the floor; urine stains at the bases of the two toilets and on the walls behind the toilets; and heavy soap scum build up in the shower with a wet towel on the shower floor.
-The 1st resident room on the right side of the front facing hall had dirt and debris on the floor with an increased amount underneath the bed.
-The 2nd resident room on the right side of the front facing hall had dirt and debris on the floor; a white powder on the floor covering the entire surface under the bed; and clothing on the floor in the closet and in front of the closet.

Interview with the maintenance man on 1/11/17 at 3:05pm revealed:
-He worked at the facility on an irregular part time basis.
-He had been at the facility making repairs last week.
-He would be at the facility every day for the next week "doing a lot of work getting ready for a big inspection" over the coming week.
-He was unable to give details on how long he had worked at the facility, what kind of repairs he had done and what repairs were going to be

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done.
-He was unable to respond to specific repair concerns observed in the facility.

Interview with a resident on 1/11/7 at 10:47am revealed the resident did not like living in the facility because "it's nasty and they don't clean up."

Interview with a second resident on 1/11/17 at 11:00am revealed the Medication Aides (MAs) were responsible for cleaning the facility including resident rooms every day.

Interview with a MA on 1/11/17 at 3:10pm revealed:
-"It's hard to do all these jobs, I am just one person."
-MAs were responsible for administering medications, assisting residents with activities of daily living, serving residents for each meal, sitting with residents in the dining room for each meal; cleaning resident rooms, bathrooms and hallways; making residents' beds, sweeping and mopping; and sweeping outside of the facility.
-There were two MAs on duty when the Resident Care Coordinator (RCC) was a MA; the RCC had become the RCC about three weeks ago and there was just one MA since then.
-There was no Personal Care Aide (PCA), Dietary Aide or Housekeeper.

Interview with a second MA on 1/11/17 at 4:05pm revealed:
-There was only one staff person on duty for all shifts on the weekends.
-The 2nd shift MAs were responsible for cleaning the bathrooms and starting resident laundry if there was time.
-The 3rd shift staff was responsible for doing

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resident laundry and cleaning the bathrooms.

Interview with the Administrator on 1/12/17 at 11:45am revealed:
-There was no housekeeping staff, "just a PCA to do housekeeping."
-He did not have a response for who was the PCA duty for 1/11/17.
-Sometimes there would be an MA and a PCA and sometimes there would be two MAs.
-On 1/11/17 for 1st shift, there were four staff on duty including himself, the RCC, the MA and the cook.

Interview with the Administrator on 1/12/17 at 6:12pm revealed:
-The Administrator planned to have someone come and clean the floors in the building the weekend of 1/14/17.
-He planned to do "a lot of cleaning," repairs and replacing furniture at the facility over the next few weeks.
-The Administrator was going to hold himself responsible for making sure "everything was getting done."

The facility failed to ensure the adult care home environment was safe and free of hazards for residents as evidenced by the presence of numerous live bed bugs observed in two resident rooms with evidence of bed bugs in a two additional resident rooms; and saturated and deteriorating ceilings in the dining room and hallways which affected all 18 residents. The failure of the facility to assure an environment free of bed bugs and which had ceilings in good repair was detrimental to the health and safety of the residents which constitutes a Type B violation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 13 Review of the facility's Plan of Protection dated 1/12/17 revealed: -The Administrator will develop a cleaning schedule for the cleaning of the facility. -The Administrator and the Resident Care Coordinator (RCC) will inspect the rooms and the facility to ensure the cleaning schedule is being followed by employees. -The facility will replace damaged and old furniture. -The Administrator and the RCC will inspect rooms daily to ensure rooms and floors are clean. -The Administrator or RCC will notify the pest control company if bed bugs are found in the facility for immediate treatment. -Staff will pack affected resident clothing; dry and wash the clothing before returning the clothing to the resident. -The facility and pest control company will continuously monitor the facility for any signs of bed bugs and treat any affected areas. -Damaged ceiling tiles have been replaced and the room will be monitored for any mold infestation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 2/26/17.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION	D 105		

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D 105	Continued From page 14 Based on observations, interviews and record reviews, the facility failed to assure prompt repair and adequate maintenance for long standing plumbing and sewer problems in the facility causing a significant leak in the facility dining room that presented potential hazards to residents from large amounts of water in the ceiling and on the floor, damaged ceiling tiles falling to the floor and potential bacterial growth in standing water left in a sink for up to a week. The findings are: Observations on 1/11/17 at 10:03am revealed: -There was a significant leak from three spots on the dining room ceiling; one spot with a steady heavy drip and two spots with a slower drip. -There was a garbage can, mop bucket and basin under the drip areas. -There was a large amount of standing water with a saturated blanket and several saturated towels on the floor. -The ceiling tiles, on approximately ¼ of the area of the ceiling, were saturated. -A ceiling fan was hanging nearby the saturated area. -There was standing water in a ceiling light tile. -There was a steady drip along the wall outside the entrance to the dining room. Interview with the Administrator on 1/11/17 at 9:50am revealed: -The dining room was not available for resident meals since approximately 7am on 1/11/17. -There was a leak from the ceiling in the dining room with a large amount of standing water on the dining room floor. -The tub in the 2nd floor apartment was overflowing.	D 105		

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D 105	Continued From page 15 -Staff had notified him of the water leaking from the dining room ceiling the morning of 1/11/17. -He had contacted a plumber and expected the plumber to address the leak on 1/11/17. Interview with a Medication Aide (MA) on 1/11/17 at 10:03am revealed: -The leak in the dining room was present when she came in for work at 7am on 1/11/17. -There were no plumbing issues on 1/10/17. -The residents had to eat breakfast in the common areas which included the living room and seated hallways. Interview with the Resident Care Coordinator (RCC) on 1/11/17 at 10:30am revealed: -She had worked at the facility since April 2016; started as a Medication Aide (MA) and had been the RCC for a few weeks. -There had been problems with the plumbing in the facility "for a while." -The toilets on the women's hall had been "backing up" approximately two weeks ago. -The residents on the women's hall had to go to the men's hall to use the bathroom. -The toilets on the women's hall were backed up for about 2-3 days. Interview with a resident on 1/11/17 at 11:00am revealed: -The facility had plumbing issues all the time. -The dining room ceiling had started leaking this morning (1/11/17). -Residents had to eat one piece of sausage and one piece of toast for breakfast in the living room this morning (1/11/17). Interview with the RCC on 1/11/17 at 11:30am revealed: -The RCC lived in the 2nd floor apartment; there	D 105		

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were no problems with the tub the night of 1/10/17.
-There was a problem with the toilet being backed up; she plunged it but "it just wouldn't go down."
-She woke up the morning of 1/11/17 to find the tub filled with water and overflowing.
-The 3rd shift MA reported to the RCC that she noticed the leak in the dining room early in the morning on 1/11/17 and called the Administrator.

Observation on 1/11/17 at 10:51am revealed:
-There was a strong foul odor coming from a janitor's closet on the women's hall.
-The deep sink inside the janitor's closet was 2/3 full with dark water and a hose was attached to the faucet.

Confidential resident interview revealed:
-The sink in the janitor's closet had been stopped up for 2-3 days.
-Staff knew about the stopped up sink.

Confidential interview with a staff revealed:
-The sink in the janitor's closet on the women's hall had been "like that [with standing foul smelling water]" for a week.
-These things happened frequently at the facility and nothing was done about it.

Interview with a second MA on 1/11/17 at 4:05pm revealed:
-The sink in the janitor's closet on the women's hall had "been like that" for four to five days.
-As far as the MA knew, the sink being clogged up had been reported to the Administrator by a 1st shift staff.
-"The plumbing issues had been going on for a while, it would get fixed and then start again."

Observation on 1/11/17 at 12:00pm revealed

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there was an uncovered plastic drain pipe protruding from the ground in the center rear of the facility that had water slowly overflowing and a large amount of wet tissue paper and standing water on the ground around the pipe.

Interview with the maintenance man on 1/11/17 at 3:05pm revealed:
-He worked at the facility on an irregular part time basis.
-A plumber was going to have to come out and "snake" the sewer drain because it was backed up.

Interview with the Administrator on 1/12/17 at 11:45am revealed:
-The plumbing had been repaired on 1/11/17 by a plumber; the problem came from residents putting incontinence briefs and wash clothes in the toilet.
-There were three or more gloves "pulled out of the sink" in janitor's closet on the women's hall; that was not the residents, it was staff.
-The maintenance man inspected everything in the 2nd floor apartment and the ceiling for water damage from the leak; the facility dining room ceiling tiles were going to be removed and replaced on 1/12/17.
-There was no evidence of mold.
-A fan had been put in the dining room to help everything dry.

The facility failed to assure all plumbing equipment was maintained in operating condition resulting in frequent backups, a significant leak in the dining room causing a ceiling tile to fall. The facility's failure to maintain the plumbing and septic system in in operating condition was detrimental to the residents' safety and welfare and constituted a Type B Violation.

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D 105	Continued From page 18 Review of the facility's Plan of Protection dated 1/12/17 revealed: -The plumbing system and the pipe that leaked have been repaired; the plumbing line was cleaned by the plumber. -The Administrator and the plumber will continuously monitor the pipes and plumbing lines to ensure the lines are working properly. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 2/26/17.	D 105		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record	D 176		

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reviews, the facility failed to ensure a safe operational environment within the adult care home as evidenced by violating resident rights, inadequate staffing, absent supervision of residents, failure to report resident abuse allegations to the Health Care Personnel Registry, a deteriorating, unsafe and unclean physical environment and unsafe medication administration.

The findings are:

Based on observations, interviews and record reviews, the facility failed to keep 3 of 5 sampled residents (#1, #2, and #8) from physical abuse by a staff member (Staff A) who physically assaulted Residents #1 and 2 and verbally abused Resident #8. [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type A1 Violation)]

Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to provide direct personal assistance and supervision needed by the residents by routinely staffing the facility with one person on each shift who was responsible for administering medications, cooking meals, performing housekeeping duties and supervising 18 residents, one of which had a history of ingesting potentially hazardous substances, such as toothpaste, hand sanitizer and "aftershave." [Refer to Tag 187 10A NCAC 13F .0604(d) Personal Care and Other Staffing (Type A2 Violation)]

Based on observations, interviews and record reviews, the facility failed to respond in any reasonable manor to Resident #4 ingesting harmful substances including toothpaste, mouthwash, hand sanitizer, and aftershave on

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two occasions within one month; and to provide intervention and supervision to prevent continued incidents and harm as evidenced by the resident having free access to a storage closet containing large bottles of mouthwash, aftershave and medications of former residents including Trazadone, Prednisone and Clozaril. [Refer to Tag 271 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A2 Violation)]

Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse for 3 residents (#1, #2 and #8) by a staff person (Staff A) to the Health Care Personnel Registry (HCPR). [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)]

Based on observations, interviews and record reviews, the facility failed to assure the adult care home was maintained in a clean, and free of hazards and obstructions as evidenced by the presence of numerous live bed bugs observed in two resident rooms with evidence of bed bugs in a two additional resident rooms; saturated and deteriorating ceilings in the dining room and hallways; dirt and debris on floors in the dining room, hallways, bathrooms and resident rooms; unclean bathrooms, showers and resident rooms and foul smelling standing water in a sink in the janitor's closet on the women's hall. [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]

Based on observations, interviews and record reviews, the facility failed to assure prompt repair and adequate maintenance for long standing plumbing and sewer problems in the facility causing a significant leak in the facility dining room that presented potential hazards to

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D 176	Continued From page 21 residents from large amounts of water in the ceiling and on the floor, damaged ceiling tiles falling to the floor and potential bacterial growth in standing water left in a sink for up to a week. [Refer to Tag 105 10A NCAC 13F .0311(a) Other Requirements (Type B Violation)] Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by the physician to 4 of 8 residents resulting in Resident #11 not receiving a blood thinning medication (Plavix) and a multivitamin (CetaVite) and not receiving a muscle relaxer (Flexeril) and pain medication (Hydrocodone with Ibuprofen) within an hour of the scheduled time; Resident #4 receiving a multivitamin without an order; Resident #7 not receiving a decongestant (Flonase) and a laxative (Miralax); Resident #5 having five unknown medications in her purse; and a Home Health Nurse being provided another residents expired antipsychotic injection (Fluphenazine) to administer to Resident #6. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)] The Administrator failed to maintain the total operations of the facility in accordance to the rules, regulations and laws specific to residents' rights resulting in three residents being physically and verbally abused by a staff; reporting and investigating allegations of abuse to the Health Care Personnel Registry resulting in risk of harm for 18 residents left in the care of the accused staff unsupervised; and staffing resulting in inadequate care and services including lack of supervision of a resident with a history of ingesting caustic substances. The systemic failure of the operations of the facility resulted in	D 176		

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D 176	Continued From page 22 serious harm and neglect of residents which constitutes a Type A1 Violation. Review of the facility's Plan of Protection dated 1/12/17 revealed: -The Administrator will ensure that the facility is properly managed and supervised at all times. -The Administrator will develop a new job description for the employees; and constantly supervise the employees to ensure that each employee is performing their job. -The Administrator will ensure the facility is clean at all times, residents are well taken care of and their needs are met. -The Administrator will ensure the facility is properly maintained and provide safety to residents and employees. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 2/11/17.	D 176		
D 187	10A NCAC 13F .0604 (d) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (d) Homes with capacity or census of 13-20 shall comply with the following staffing. When the home is staffing to census and the census falls below 13 residents, the staffing requirements for a home with 12 or fewer residents shall apply. (1) At all times there shall be an administrator or administrator-in-charge in the home or within 500 feet of the home with a means of two-way telecommunication. (2) When the administrator or administrator-in-charge is not on duty within the home, there shall be at least one staff member	D 187		

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D 187	Continued From page 23 on duty on the first, second and third shifts. (3) When the administrator or administrator-in-charge is on duty within the home, another staff member (i.e. co-administrator, administrator-in-charge or aide) shall be in the building or within 500 feet of the home with a means of two-way telecommunication at all times. (4) The job responsibility of the staff member on duty within the home is to provide the direct personal assistance and supervision needed by the residents. Any housekeeping duties performed by the staff member between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks. The staff member may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder care of residents or immediate response to resident calls, do not disrupt residents' normal lifestyles and sleeping patterns and do not take the staff member out of view of where the residents are. The staff member on duty to attend to the residents shall not be assigned food service duties. (5) In addition to the staff member(s) on duty to attend to the residents, there shall be staff available daily to perform housekeeping and food service duties. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to provide direct personal assistance and supervision needed by the residents by routinely staffing the facility with one person on each shift who was responsible for administering	D 187		

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medications, cooking meals, performing housekeeping duties and supervising 18 residents, one of which had a history of ingesting potentially hazardous substances, such as toothpaste, hand sanitizer and "aftershave."

The findings are:

Review of an untitled and undated document received from the facility on 1/11/17 revealed:
-Staff on duty for 1st shift on 1/11/17 and 1/12/17 included the Administrator, the Resident Care Coordinator (RCC), a Medication Aide (MA) and a cook.
-Staff on duty for 2nd and 3rd shifts on 1/11/17 and 1/12/17 was a Medication Aide.

Review of an "Adult Care Home Resident Census" form for January 2017 revealed there were 18 residents listed as present in the facility.

Confidential interview with a staff revealed:
-Staff was concerned there was not enough help in the kitchen and dining room to make sure the food was hot when served to residents.
-The food was put on plates and left to sit on the counter in the kitchen until staff was able to bring it to the residents.
-The facility really needed a dietary aide.

Confidential resident interview revealed:
-"It's so bad here [family member] was looking for a new place for me."
-"The staff are hateful because they don't have enough help."
-There was a male resident who "took two tubes of toothpaste from another resident's room and they didn't do anything about it."
-The Medication Aides (MAs) were responsible for cleaning the facility including resident rooms

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D 187	Continued From page 25 every day. Confidential interview with a family member revealed the facility could not keep staff; new people were "brought in all the time and they don't know what they're doing." Interview with a Medication Aide (MA) on 1/11/17 at 3:10pm revealed: -"It's hard to do all these jobs, I am just one person." -On 1/11/17 she had to "deal with the leak" by putting towels down and buckets under the leak in the dining room ceiling; administer medications to all the residents; cook breakfast; feed the residents "out there [living room and common areas]," and then sit down and help feed four residents. -She was the only staff person in the building on the morning of 1/11/17 until the Administrator had gotten to the facility; there was no cook for breakfast and the RCC came after the Administrator arrived. -There were four of 18 residents who needed assistance with bathing, toileting and eating; and one of those four residents was totally dependent on staff while a second of the four required frequent incontinence care. -MAs were responsible for administering medications, assisting residents with activities of daily living, serving residents for each meal, sitting with residents in the dining room for each meal; cleaning resident rooms, bathrooms and hallways; making residents' beds, sweeping and mopping; and sweeping outside of the facility. -There were two MAs on duty when the RCC was a MA; the RCC had become the RCC about three weeks ago. -There was no Personal Care Aide (PCA), Dietary Aide or Housekeeper.	D 187		

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-The RCC had to work 24 hours each day over the past weekend (1/7/17 and 1/8/17) because there was no staff.

Interview with a second MA on 1/11/17 at 4:05pm revealed:
-"It's hard to keep an eye on all of them."
-There was one resident with mental health issues who went in other residents rooms; stole toothpaste, mouthwash and aftershave; was hospitalized around Christmas 2016 for drinking something and had taken hand sanitizer off of the medication cart and drank it in the past.
-There was no time or opportunity to assist residents with personal care like bathing on 2nd shift because there was only one staff when the cook left.
-She did not think residents got the personal care assistance they needed on 1st shift either.
-There was only one staff person on duty for all shifts on the weekends.
-The 2nd shift MAs were responsible for cleaning the bathrooms and starting resident laundry if there was time.
-The 3rd shift staff was responsible for doing resident laundry and cleaning the bathrooms.

Interview with the Administrator on 1/12/17 at 11:45am revealed:
-There was no housekeeping staff, "just a PCA (Personal Care Aide) to do housekeeping."
-He did not have a response for who was the PCA on duty for 1/11/17.
-Sometimes there would be an MA and a PCA and sometimes there would be two MAs.
-On 1/11/17 for 1st shift, there was four staff on duty including himself, the RCC, the MA and the cook.

Observation on 1/11/17 at 12:00pm revealed

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D 187	Continued From page 27 there was a MA and a cook on duty in the facility. Observation on 1/11/17 at 4:05pm revealed there was a MA and a cook on duty in the facility. Observation on 1/12/17 at 7:29am revealed there was a MA, a MA in training and a cook on duty in the facility. Observation on 1/12/17 at 3:15pm revealed the Resident Care Coordinator, a MA in training and a cook were on duty in the facility. There was no housekeeping staff or dietary aides observed in the facility on 1/11/17 or 1/12/17. Interview with the Administrator on 1/12/17 at 6:12pm revealed he was not aware the RCC had been out of the facility since 1/11/17 at approximately noon; which left one MA and the cook until the cook left after dinner. The facility failed to assure adequate staffing to provide direct personal assistance and supervision needed by the residents. The facility routinely staffed one person on each shift who was responsible for administering medications, cooking meals, performing housekeeping duties and supervising 18 residents, one of which had a history of ingesting potentially hazardous substances, such as toothpaste, hand sanitizer and "aftershave." This noncompliance constituted a Type A2 violation for serious neglect. --- Review of the facility's Plan of Protection dated 1/12/17 revealed: -The Administrator and Resident Care Coordinator (RCC) will ensure the residents are	D 187		

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D 187	Continued From page 28 supervised at all times. -The Administrator will hire a part time Personal Care Aide (PCA) to assist the Medication Aide in the afternoon to ensure residents are being supervised properly. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 2/11/17.	D 187		
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: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to respond in any reasonable manor to Resident #4 ingesting harmful substances including toothpaste, mouthwash, hand sanitizer, and aftershave on two occasions within one month; and to provide intervention and supervision to prevent continued incidents and harm as evidenced by the resident having free access to a storage closet containing large bottles of mouthwash, aftershave and medications of former residents including Trazadone, Prednisone and Clozaril. The findings are:	D 271		

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Review of Resident #4's current FL-2 dated 12/27/16 revealed diagnoses included Schizophrenia, Mild - Moderate Intellectual Disability, Hypertension, History of Hyponatremia and History of Seizures.

Review of Resident #4's current care plan dated 3/28/16 revealed:
-There was no information under the section "Mental Health and Social History."
-The Primary Care Provider (PCP) signed and dated the form 4/8/16.

Interview with the Resident Care Coordinator (RCC) on 1/11/17 at 10:30am revealed there were no residents in the facility that wandered or needed increased supervision.

Interview with a Medication Aide (MA) on 1/11/17 at 4:05pm revealed:
-"It's hard to keep an eye on all of them."
-Resident #4 went in other residents rooms; stole toothpaste, mouthwash and aftershave; was hospitalized around Christmas 2016 for drinking something and had taken hand sanitizer off of the medication cart and drank it in the past.
-The MA was not certain of when the resident did these things except for the toothpaste which happened a few days ago.

Confidential resident interview revealed there was a male resident who "took two tubes of toothpaste from another resident's room and they didn't do anything about it."

Second interview with the MA on 1/12/17 at 7:35am revealed:
-Another resident reported to the MA that Resident #4 had taken and eaten a tube of

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toothpaste a few day ago; she could not remember the exact day.
-The MA went to the resident and asked him for the toothpaste and if he had eaten the toothpaste.
-The resident reported he had eaten the toothpaste and gave her approximately half a tube of toothpaste.
-There was no further action taken and there was no documentation of the toothpaste event.
-The MA was not on duty when Resident #4 drank aftershave and hand sanitizer; she thought she may have been there the day after and "by then there was ¼ bottle left of a personal size bottle of hand sanitizer" and she did not know how much aftershave.
-The resident "got sick to his stomach and did not want to go to the hospital" after drinking hand sanitizer and aftershave.
-The MA did not know if "they" called the doctor about the aftershave and hand sanitizer; "you would have to ask them in the office."
-In response to who was responsible for contacting the Primary Care Provider the MA said, "Put it this way, one weekend I tried to call the doctor's office for a residents blood sugar and never got a call back."

Interview with Resident #4 on 1/12/17 at 3:14pm revealed:
-"At different times I tried to do that [drink mouthwash, aftershave and hand sanitizer.]"
-He ate approximately half a tube of toothpaste and drank a whole small bottle of mouthwash (travel size) but was unable to say when.
-He was sent to the hospital a number of times in the past for the same thing and feared "getting institutionalized."
-He could not remember the staff who was on duty for these events and the last time "might have been two weeks ago."

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Second interview with Resident #4 on 1/12/17 at 3:40pm revealed:
-He went to the hospital in December 2016 because he drank hand sanitizer.
-He had eaten toothpaste and drank mouthwash at other times.
-He ate and drank those substances "to get high" and was bored at the facility.

Telephone interview with Resident #4's family member on 1/12/17 at 3:43pm revealed:
-He did not have contact with the facility often, "maybe every three months or so."
-Resident #4 had a long history of ingesting things like mouthwash, toothpaste and rubbing alcohol.
-The last incident he knew of was around Christmas 2016 when the resident was hospitalized for unknown reasons.
-The facility did not always contact him when there were incidents.

Observation on 1/12/17 at 11:10am revealed:
-Resident #4 was unsupervised in the storage closet in the hallway across from the dining room.
-He told the Department of Social Services (DSS) worker he was getting a trash bag.

Observation of the same closet on 1/12/17 at 4:26pm revealed:
-There was a storage closet in the hallway across from the dining room that was unlocked.
-The storage closet had two large bottles of mouthwash, four large cans of shaving cream, barrier spray, insulin syringes and two clear garbage bags full of former resident's medications including Trazadone (an antidepressant), Prednisone (a steroid) and Clozapine (an antipsychotic); all in immediate

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sight with unrestricted access. (Clozapine is an antipsychotic dispensed only under strict monitoring of blood counts due to risk of potentially fatal side effects.)

Interview with the RCC on 1/12/17 at 4:26pm revealed:
-The storage closet in the hallway across from the dining room had never been locked since she started working at the facility in April 2016.
-She did not know how long the former resident's medications had been stored in the closet.
-The Administrator knew the medications were stored in the closet and that the closet did not lock.

A third interview with Resident #4 on 1/12/17 at 5:18pm revealed:
-He went into the unlocked storage closet in the hallway across from the dining room by himself to "get toilet paper and sometimes trash bags for the garbage cans."
-Staff had never told him not to go in the closet and he "guessed" it was okay.

Interview with the Administrator on 1/12/17 at 5:45pm revealed:
-He was not aware medications were being stored in the storage closet in the hallway across from the dining room.
-Medications were not supposed to be stored in that closet.
-There was a key and the closet was supposed to be kept locked.

Review of an untitled and unsigned document dated 12/13/16 found in Resident #4's record revealed:
-"[Name of Resident #4] drank a whole bottle of aftershave lotion around 8:00pm [name of

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another resident] told me."
-"He went in the kitchen and stole a soda and had it (2 liter); when I got off the phone with you I found him in the kitchen again trying to steal something else."
-"He had went out on the porch and trying to hide with the soda; asked where he got it and he said I don't know, He's lying. Doesn't want to go to bed."

Review of Emergency Department (ED) discharge instructions for Resident #4 dated 7/30/16 revealed the resident was seen in the ED for ingesting poisoning.

Review of hospital discharge instructions for Resident #4 dated 12/27/16 revealed Resident #4 was admitted to the Behavioral Health Unit at the hospital on 12/23/16 for "eating toothpaste and drinking mouthwash at facility."

Interview with the RCC on 1/12/17 at 6:00pm revealed:
-Resident #4's behavior had been different starting sometime in December 2016; he was eating toothpaste, drinking green rubbing alcohol and hand sanitizer.
-The latest incident was two evenings ago (1/10/17) when the resident ate a tube of toothpaste.
-The RCC did not know if the resident had eaten the whole tube of toothpaste.
-Around Christmas time 2016 the resident ate toothpaste, drank mouthwash and was eating out of garbage cans.
-The resident also "had that look like he could kill, that's why we sent him out" at Christmas time.
-Resident #4 had been taking his medications and never had a problem with refusing; she did not know what happened.
-Staff were expected to send the resident to the

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Emergency Department (ED) "if they knew he did something like that (ingested large amounts of toothpaste, mouthwash, hand sanitizer, rubbing alcohol etc.)"
-The hand writing for the unsigned note in Resident #4's record dated 12/13/16 looked like either the 2nd or 3rd shift MA.
-In response to what was done about the resident drinking aftershave, the MA said, "I believe I and [name of Administrator] talked to him [resident]."
-The Primary Care Provider was not contacted for eating toothpaste 1/10/17 or for the aftershave 12/13/16.
-Resident #4 did not see a mental health provider, his 1st mental health appointment was on 1/13/17.

Review of hospital and ED discharge forms, "Nurse's Progress Notes" and PCP visit notes for Resident #4 revealed:
-There was no documentation Resident #4 went to the ED on 12/13/16 for drinking aftershave; or on or about 1/10/17 for eating toothpaste.
-There was no documentation that the Poison Control Center, PCP or a Mental Health Provider were contacted on 12/13/16 for Resident #4 drinking aftershave; or on or about 1/10/17 for Resident #4 eating toothpaste.
-There was no documentation of any intervention or increased monitoring and supervision of Resident #4.

Interview with the Administrator on 1/12/17 at 6:12pm revealed:
-The Administrator did not recognize the hand writing for the unsigned note dated 12/13/16 for Resident #4.
-He was not aware of any incident occurring on 12/13/16 with Resident #4.
-Staff informed the Administrator only one time of

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D 271	Continued From page 35 Resident #4 ingesting hazardous substances which he thought happened last week where the resident ate toothpaste. -The Administrator instructed staff to send Resident #4 to the Emergency Room. -Ingesting harmful substances was part of Resident #4's history; he had been hospitalized a week ago and three months before that. -Staff was expected to notify the PCP and send the resident to the ED if he ingested harmful substances. -Resident #4 had left the dinner meal early and went to another resident's room where he took the toothpaste. -The Administrator recognized the significant potential danger in having unsecured medications and an unlocked storage closet given Resident #4's history. -The medications were moved by the Administrator; he planned to increase supervision checks for Resident #4. The facility failed to provide supervision for Resident #4 who has a diagnosis of Schizophrenia and Moderate Intellectual and Developmental Disability and a history of ingesting poisonous substances. The facility's failure to supervise Resident #4 resulted in the resident ingesting a bottle of aftershave on 12/13/16 where no action was taken by the facility and the resident being hospitalized on 12/23/16 for ingesting mouthwash and toothpaste. The resident was observed on 1/11/16 unsupervised in an unlocked storage closet at the facility where there were numerous medications including Clozapine; and personal care products including mouthwash, shaving cream, lotion and barrier spray. The facility's failure to supervise Resident #4 to ensure his safety resulted in serious neglect, which constitutes an A2 Violation.	D 271		

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D 271	Continued From page 36 Review of the facility's Plan of Protection dated 1/12/17 revealed: -The Administrator and Resident Care Coordinator (RCC) will ensure the residents are supervised at all times to prevent residents from harming themselves. -The facility will initiate 30 minute checks for all residents to ensure residents are being monitored and supervised at all times. -The storage room and medications will be locked at all times. -Employees will remove mouthwash and toothpaste from all bathrooms. -If a resident ingests and household material, the physician will be notified immediately and the resident will be sent to the Emergency Department (ED) for observation. -The Administrator will hire a part time Personal Care Aide (PCA) to assist the Medication Aide in the afternoon to ensure residents are being supervised properly. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 2/11/17.	D 271		
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: TYPE A1 VIOLATION	D 338		

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Based on observations, interviews and record reviews, the facility failed to keep 3 of 5 sampled residents (#1, #2, and #8) from physical abuse by a staff member (Staff A) who physically assaulted Residents #1 and 2 and verbally abused Resident #8.

The findings are:

1. Review of Resident #1's FL-2 dated 7/15/16 revealed:
- Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease, metabolic encephalopathy, cerebral ischemia.
-The resident was non-ambulatory and intermittently disoriented.

Review of an FL-2 dated 2/10/16 revealed the resident had a history of hip fracture.

Review of Resident #1's care plan dated 2/10/16 revealed the resident required total assistance for all personal care and was bed/chair bound.

Interview with the facility's Resident care Coordinator (RCC) on 1/11/17 at 11:15am revealed:
-A former staff member who worked as a cook reported that she observed Staff A, a Medication Aide (MA) physically abusing Resident #1 approximately 1 week ago.
-The former staff reported she observed Staff A grabbing the resident and jerking her while the resident was in bed.
-The incident was reported to the Administrator by the former staff and RCC, but nothing was done; Staff A was not suspended and an incident report was not completed.

Interview with the former staff on 01/12/17 at

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9:50am revealed:
-She worked as a full time cook (7:00am -6:00pm) until last Friday (01/06/17).
-Resident #1 required assistance with feeding and often tried to grab the staff's hand when feeding her.
-The former staff observed Staff A slapping the resident's hands on multiple occasions when feeding her in the dining room.
-About a week ago (a few days before the former staff resigned), the former staff was walking down the Women's Hall and observed Resident #1 lying in bed, awake and facing the wall.
-Staff A grabbed the resident's arm and jerked the resident. She "flipped" the resident over with so much force, the resident almost fell on the floor, but Staff A caught the resident with Staff A's leg.
-Staff A then pushed the resident over on the bed and told the resident to go back to sleep.
-She did not know why Staff A was so mean to Resident #1 because the resident was small and was 90 years old.
-The incident was reported by Staff A to the RCC and the Administrator the next day, but the Administrator did not do anything; Staff A continued to work at the facility.
-Staff A was different after the RCC and the Administrator left at 5:00pm. She hollered at the residents, and was aggressive and threatened the residents.

Interview with Staff A on 01/12/17 at 11:40am revealed:
-Staff A was rehired in December 2016 as a MA and worked second shift (3:00pm - 11:00pm).
-The RCC and the Administrator usually were off duty at 5:00pm, and the cook was off duty at 6:00pm.
-After 6:00pm, she was the only staff on duty until 11:00pm.

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-She had to feed Resident #1 supper and put her to bed every evening.
-Resident #1 was agitated at times and would holler out during care.
-About a week ago, Staff A found a bruise on Resident #1's left arm, but did not know how the resident's arm sustained a bruise.
- The Administrator never talked to Staff A about being too rough or abusive with Resident #1.
-The Administrator only told Staff A to "be careful how you handle residents". Somebody reported Staff A was being rough and abusive to residents.
-The Administrator did not send report to Health Care Personnel Registry (HCPR) or suspend Staff A.
-Staff A did not remember jerking Resident #1 over in bed.

Observation made on 01/12/17 with the RCC at 5:15pm revealed:
-Resident #1 had 2 small dark bruises on her outer forearm about the size of pennies.
-The resident had a small scab on her left elbow.
-The RCC was not aware of the injuries.

Interview with the Administrator on 01/12/17 at 5:45pm revealed:
-He was not aware that Staff A had abused Resident #1.
-He had not suspended Staff A or sent a 24 hour report to HCPR.

Refer to interview with a former staff member (full-time cook) on 01/12/17 at 9:50am.

2. Review of Resident #2's FL-2 dated 12/15/16 revealed diagnoses included mental retardation, seizure disorder, diabetes mellitus, and anxiety.

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AUTUMN WIND ASSISTED LIVING	4302 NC 210 SMITHFIELD, NC 27577

(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 338	Continued From page 40 Interview with the facility's Resident Care Coordinator (RCC) on 01/11/17 at 11:15am revealed: -About a week ago, Resident #1 reported to her that Staff A "spanked" her on her buttocks. -The resident reported she was sitting on the chair in the living room after suppe,r and Staff A hit her on her buttocks, and told her to get up and go to bed. -The resident showed the RCC her buttocks, but there were no injury/bruising. -The RCC reported the incident to the Administrator the same day, but did not document the incident on an incident report. -Staff A was not suspended and continued to work her normal schedule. Interview with the 1st shift medication aide (MA) on 01/11/17 at 11:30am revealed: -On 01/03/17, Resident #2 reported, after supper, that she was sitting on a recliner asleep in the living room, and Staff A woke her and told her to get up and go to bed. -Staff A "spanked" the resident on her buttocks after she did not get up, and told her to get up and go to bed. -The resident did not say which day the incident occurred. -The MA reported the incident to the Administrator, but no incident report was completed and Staff A was not suspended. Interview with Resident #2 on 01/11/17 revealed: -She was in the living room sitting on the recliner and Staff A tried to get her to go to bed. -Staff A hit her hard on her left buttock and told her to go to bed. -The incident occurred about a week ago. -The resident told the RCC and the MA about the incident the next day.	D 338		

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-Staff A was "mean" to her and talked mean to her.

Interview with a former staff on 01/12/17 at 9:50am revealed:
-Resident #2 told her that she reported Staff A to the RCC and the Administrator, and accused Staff A of spanking her on her buttocks.
-Staff A admitted to the former staff she did hit Resident #1 on her buttocks, but did not get fired or suspended.

Interview with Staff A on 01/12/17 at 11:40am revealed:
-Resident #2 accused her of hitting her, but Resident #2 told lies.
-The Administrator told Staff A to be "careful how you handle the residents".
-The Administrator did not suspend Staff A, and she worked her regular schedule.

Interview with the Administrator on 01/12/17 at 5:45pm revealed:
-Last week, the RCC reported that Staff A spanked Resident #2.
-When the Administrator talked to Resident #2, she "gave me a different story".
-A 24 hour report was not sent to the North Carolina Healthcare Personnel Registry (HCPR).
-The Administrator talked to Staff A and other staff about treating residents with respect and talking to residents with respect.

Interview with a resident on 01/12/17 at 7:30pm revealed:
-Staff A hit Resident #2 on her bottom recently, but the resident did not observe the incident.
-Resident #2 told the resident about the incident.
-Staff A was mean to Resident #2 and made her cry repeatedly in the evening after all the other

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staff was gone. It did not make any sense because Resident #2 was a sweet girl.
-The resident did not report the incident to the RCC or the Administrator, but somebody needed to do something because Staff A should not treat the residents so bad.

Refer to interview with a former staff member (full-time cook) on 01/12/17 at 9:50am.

3. Review of Resident #8's FL-2 dated 11/04/16 revealed:
- Diagnoses included mental retardation, infantile autism, depression, glaucoma, hypothyroidism, and type 2 diabetes mellitus.
-The resident spoke very little.

Review of Resident #8's care plan dated 8/01/16 revealed the resident required total assistance for personal care and transferring but ate without assistance.

Interview with a former staff on 01/12/16 at 9:50am revealed:
-About a month ago, Resident #8 was in the dining room eating supper, and asked for an extra serving of food.
-The former employee gave the resident an extra serving but when Staff A walked in the dining room, she "snatched" the fork from the resident and hollered at her that she did not need anything else to eat.
-She did not report this incident to the RCC or the Administrator because she did not think the Administrator would do anything.

Interview with the Administrator on 01/12/17 at 5:45pm revealed:
-He was not aware Staff A had verbally abused

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D 338	Continued From page 43 Resident #8. -He had not sent a 24 hour report to HCPR. -He had not completed a 5 day investigation. Interview with a resident on 01/12/17 at 7:30pm revealed: -About 3-4 weeks ago, Resident #8 was in the dining room eating supper. -Staff A came in the dining room and took the resident's fork away from her and yelled that the resident did not need anything else to eat. She even took the resident's fork away from her. -The resident did not understand why Staff A was so mean and continued to work at the facility. -The resident did not report the incident to the Administrator because he would not do anything. Refer to interview with a former staff member (full-time cook) on 01/12/17 at 9:50am. _____ Interview with a former staff member (full-time cook) on 01/12/17 at 9:50am revealed: -When Staff A was working alone, after the RCC and the Administrator left, she was different. -Staff A hollered at the residents, was aggressive and repeatedly threatened the residents -The former staff member was a cook and worked from 7:00am to 6:00pm. -From 5:00pm to 6:00pm, Staff A work alone and the former staff observed Staff A's abusive behavior toward the residents repeatedly. -The former staff member resigned last Friday, because the Administrator did not suspend or fire Staff A after she was reported for resident abuse. _____	D 338		

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D 338	Continued From page 44 The facility failed to assure three residents were free from abuse. Resident #1 who had diagnoses of Alzheimer's dementia and required total care was grabbed by a staff member and forcefully flipped over in bed, almost falling from the bed onto the floor. The same staff hit Resident #5 on her buttocks and snatched away Resident #8's eating utensil and food after dietary staff gave the resident a second serving of food; the staff screamed at the resident that she did not need anything else to eat. The incidents were not investigated by facility management or reported as required to the N. C. Health Care Personnel Registry. The failure of the facility to protect Residents' #1, #5 and #8 from abuse and the failure to report and suspend the staff person accused of resident abuse places all residents in the facility at substantial high risk for physicial abuse. This constitutes a Type A1 violation. _____ Review of the facility's Plan of Protection dated 1/12/17 revealed: -The Administrator will conduct an in-service with all the employees regarding residents' rights and resident abuse. -The Administrator will have the Ombudsman conduct an in-service on residents' rights. -Staff A has been suspended pending investigation by the Health Care Personnel Registry (HCPR). -The Administrator will ensure that any allegation of resident abuse is fully investigated and reported to the HCPR. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY	D 338		

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D 338	Continued From page 45 11, 2017.	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, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by the physician to 4 of 8 residents resulting in Resident #11 not receiving a blood thinning medication (Plavix) and a multivitamin (CetaVite) and not receiving a muscle relaxer (Flexeril) and pain medication (Hydrocodone with Ibuprofen) within an hour of the scheduled time; Resident #4 receiving a multivitamin without an order; Resident #7 not receiving a decongestant (Flonase) and a laxative (Miralax); Resident #5 having five unknown medications in her purse; and a Home Health Nurse being provided another residents expired antipsychotic injection (Fluphenazine) to administer to Resident #6. The findings are: The Medication Pass error rate was 11% as	D 358		

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evidenced by five errors out of 46 opportunities on 1/12/17 between 7:20am and 11:06am where Resident #11 did not receive a blood thinning medication related to the medication not being available for five or more days and did not receive a multivitamin as ordered; Resident #4 had a second multivitamin added without verification of the order; Resident #7 did not receive an allergy preventive nasal spray and laxative; and Resident #11 received medications (Cyclobenzaprine and Hydrocodone with Ibuprofen) ordered for three times daily two hours after the scheduled time.

1. Review of Resident #11's current FL-2 dated 8/12/16 revealed:
-Diagnoses included Pneumonitis due to inhalation of food and vomit, Type II Diabetes Mellitus, Unspecified Obesity, Unspecified Dementia, Major Depressive Disorder, Restless Leg Syndrome and Insomnia.
-Medication orders included Plavix 75mg daily and CertaVite one tablet daily. (Plavix is a blood thinning medication used to prevent blood clots and CertaVite is multivitamin used to treat vitamin deficiency.)

a. Review of Resident #11's January 2017 Medication Administration Record (MAR) revealed:
-There was an entry for Plavix 75mg daily which staff documented as not administered from 1/7/17 through 1/10/17 and documented as administered on 1/11/17.
-There was an entry for CertaVite one tablet daily which staff documented as not administered 1/7/17 through 1/10/17 and documented as administered on 1/11/17.
-Staff A (Medication Aide) documented administering the Plavix and CertaVite on 1/11/17.

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D 358	Continued From page 47 Observations on 1/11/17 revealed: -Staff A was not present in the facility for 1st shift on 1/11/17. -Staff A started work on 2nd shift on 1/11/17. Observation of the Medication Pass on 1/12/17 at 10:04am revealed Resident #11 did not receive Plavix or CertaVite with her morning medications. Interview with the Medication Aide (MA) (Staff A) on 1/12/17 at 11:18am revealed: -She did not know the usual process for first shift medications and could not say how long Resident #11's Plavix had been out of stock. -She normally worked second shift and did not administer the Plavix and CertaVite. -Resident #11 received her medications from the Veteran's Administration (VA). -The MA usually notified the Resident Care Coordinator (RCC) when the resident "runs out" and the RCC called the VA. -"I mean, normally when [the medications] get low." -There was no specific number remaining or facility procedure she went by to reorder medications. Interview with Resident #11 on 1/12/17 at 11:10am revealed: -Staff had not told her she was out of Plavix and CertaVite. -Her family member ordered her medications. -Staff usually called the family member, and then the family member would order the medications. -"A lot of time they wait until they are all out to call him." Telephone interview with Resident #11's family member on 1/12/17 at 7:18pm revealed:	D 358		

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-Facility staff was supposed to call when the resident's medications were running low; they usually waited until the medication was all gone before they called.
-Staff had called the family member on 1/12/17 about two medications they were out of; he told the staff those were medications the facility got for the resident.
-The facility was responsible for getting the resident's Oxycodone, Plavix and CeraVite from their drug store because the VA did not cover those.
-The family member was not happy with the care Resident #11 was getting at the facility because the resident had reported not getting her blood sugar checked in the evenings, not getting her medications, and having a whole pack of her Oxycodone go missing.
-The family member had spoken to the Administrator two days ago (1/10/17) and reported his concerns about the resident's medications and blood sugar checks on the 2nd shift.

Interview with the Resident Care Coordinator (RCC) on 1/12/17 at 7:52pm revealed:
-Resident #11's Plavix was ordered from the new pharmacy on 1/12/17.
-She did not know how long the resident was out of Plavix; a note had been left on her desk on 1/12/17 and that's when she ordered it.

Interview with the Administrator on 1/12/17 at 11:45am revealed for the residents who received services from the Veteran's Administration (VA), staff called the VA and the VA would send the medication.

b. Review of an "Examination or Contact by Physician" form dated 10/17/16 for Resident #11

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revealed an order for Cyclobenzaprine 5mg three times daily. (Cyclobenzaprine is a muscle relaxer used to treat pain and stiffness.)

Review of Resident #11's January 2017 Medication Administration Record (MAR) revealed:
-There was an entry for Cyclobenzaprine 5mg three times daily scheduled for 8am, 2pm and 8pm.
-There was no documentation for the 1/12/17 8am administration of Cyclobenzaprine.
-The Resident Care Coordinator (RCC) documented administering the 2pm dose on 1/12/17 of Cyclobenzaprine.

Observation of the Medication Pass on 1/12/17 at 10:04am revealed Resident #11 received the 8am scheduled dose of Cyclobenzaprine at 10:04am.

c. Review of "Examination or Contact by Physician" forms, Medication Review Order forms, Prescription orders and the 8/12/16 FL-2 for Resident #11 revealed there was no order for Hydrocodone 7.5/Ibuprofen 200mg three times daily. (Hydrocodone with Ibuprofen is a narcotic and anti-inflammatory pain medication.)

Review of Resident #11's January 2017 Medication Administration Record (MAR) revealed:
-There was a hand written entry for Hydrocodone 7.5mg/Ibuprofen 200mg three times daily scheduled for 8am, 2pm and 8pm.
-There was no documentation for the 1/12/17 8am administration of Hydrocodone/Ibuprofen.
-The Resident Care Coordinator (RCC) documented administering the 2pm dose on 1/12/17 of Hydrocodone/Ibuprofen.

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D 358	Continued From page 50 Observation of the Medication Pass on 1/12/17 at 10:04am revealed Resident #11 received the 8am scheduled dose of Hydrocodone with Ibuprofen at 10:04am. Interview with the Medication Aide (MA) on 1/12/17 at 9:41am and 10:04am revealed the Hydrocodone with Ibuprofen was a new order; "the order was probably on [name of RCC's] desk somewhere." Interview with the RCC on 1/12/17 at 7:52pm revealed the Hydrocodone/Ibuprofen was a new order; it was "in the pile" on her desk. Interview with the Medication Aide (MA) on 1/12/17 at 9:41am and 10:04am revealed: -The morning medications were usually given at 8am. -She was "usually a little faster" but was "taking [her] time" on 1/12/17; she was "more used to the afternoon [medication] pass" and did not work 1st shift often. Refer to interview with the Administrator on 1/12/17 at 11:45am. 2. Review of Resident #4's current FL-2 dated 12/27/16 revealed: -Diagnoses included Schizophrenia, Mild-Moderate Intellectual Developmental Disability, Hypertension, History of Hyponatremia and History of Seizures. -Medication orders included a Multivitamin one tablet daily. (A multivitamin is used to treat vitamin deficiency.) Review of Resident #4's January 2017 Medication Administration Record (MAR) revealed there was an entry for Stress Formula	D 358		

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Multivitamin one tablet daily which was documented as administered 1/1/17 through 1/11/17 except 1/6/17 and 1/9/17.

Observation of the Medication Pass on 1/12/17 at 10:58am revealed:
-The Medication Aide (MA) removed bubble packs and a prescription bottle from the medication cart for Resident #4.
-The MA "popped" medications from the bubble backs including one which had a pharmacy label with Resident #4's name for Stress Formula Multivitamin one tablet daily.
-The MA then looked at the bottle which had a pharmacy label with Resident #4's name for Therapeutic Multivitamin one tablet daily.
-The MA then made an entry on Resident #4's Medication Administration Record for "TherapeuticM tabs take 1 by mouth daily" and placed a tablet in the medication cup.
-The MA then went to Resident #4 to administer the medications before surveyor intervened.
Interview with the MA on 1/12/17 at 11:00am revealed:
-She was not sure if there was an order for the second Multivitamin and was going to check.
-There was no order "but [Resident Care Coordinator] has a lot of paperwork on her desk."
-She was going to remove the pill from the medication cup and take the entry off of the resident's MAR.
-She was feeling stressed because of the medication pass observation.

Observation of medications on hand for Resident #4 on 1/12/17 at 7:46pm revealed:
-There was a bubble pack of Stress Formula Multivitamin with a pharmacy label which included Resident #4's name and instructions to take one tablet daily.

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-The pharmacy label indicated there were 31 tablets dispensed on 1/15/17 and 31 tablets remained.
-There was a prescription bottle of Therapeutic M Multivitamin with a pharmacy label which included Resident #4's name and instructions to take one tablet daily.
-The pharmacy label indicated there were 30 tablets dispensed 12/27/16 and the prescription bottle was approximately half full.

Refer to interview with the Administrator on 1/12/17 at 11:45am.

3. Review of Resident #7's current FL-2 dated 10/4/16 revealed:
-Diagnoses included Atypical Chest Pain, Hypertension, History of Cerebral Vascular Accident with Right Hemiparesis, Hyperlipidemia, History of Seizure Disorder and Major depression.
-Medication orders included Flonase Nasal spray one spray each nostril daily and Miralax one capful in 8 ounces of water twice daily. (Flonase is steroid decongestant used to relieve allergy symptoms and Miralax is a laxative used to treat constipation.)

a. Review of Resident #7's January 2017 Medication Administration Record (MAR) revealed:
-There was an entry for Flonase nasal spray one spray each nostril daily.
-There were staff initials documenting the Flonase was administered on 1/1/17, 1/3/17, 1/5/17, 1/7/17 and 1/8/18; the boxes for 1/2/17, 1/4/17, 1/6/17, 1/9/17, 1/10/17, 1/11/17 and 1/12/17 were blank.

Observation of the Medication Pass on 1/12/17 at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 53 9:02am revealed Resident #7 did not receive Flonase nasal Spray. Interview with the Medication Aide (MA) on 1/12/17 at 9:04am revealed: -All of Resident #7's morning medications had been administered, "That's everything for her." -In regards to the Flonase, the MA said, "I'm going to ask her if wants it in just a moment." Observation of the Medication Pass on 1/12/17 at 9:06am revealed Resident #7 declined the Flonase nasal spray. Observation of medications on hand on 1/12/17 at 9:06am for Resident #7 revealed: -There was a nearly full bottle of Flonase with a pharmacy label indicating it was dispensed on 11/7/16 for Resident #7. -There was a hand written "open date" of 11/9/16 on the label. b. Review of Resident #7's January 2017 Medication Administration Record (MAR) revealed: -There was an entry for Miralax one capful in 8 ounces of water twice daily. -There were 11 of 21 boxes that were left blank between 1/1/17 and 1/12/17 including 1/12/17 at 8am. Observation of the Medication Pass on 1/12/17 at 9:02am revealed Resident #7 did not receive Miralax. Interview with the Medication Aide (MA) on 1/12/17 at 9:04am revealed: -All of Resident #7's morning medications had been administered, "That's everything for her." -In regards to the Miralax, the MA said, "I'm going	D 358		

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D 358	Continued From page 54 to ask her if wants it in just a moment." Observation of the Medication Pass on 1/12/17 at 9:06am revealed Resident #7's Miralax was administered mixing one capful in a small "Dixie" bathroom size cup initially, then the MA said "we're going to need more water." Observation of medications on hand on 1/12/17 at 9:06am for Resident #7 revealed there was no Miralax on the medication cart for Resident #7. Observation on 1/12/17 at 3:32pm revealed: -There were two bottles of Miralax on the facility kitchen counter. -Both bottles had a pharmacy label with Resident #7's name. -One was dispensed from the [new pharmacy provider as of 1/1/17] which was nearly full and the other was dispensed on 11/7/16 which was approximately half full. Interview with the cook on 1/12/17 at 3:32pm revealed: -She did not know anything about Resident #7's Miralax, "the MA's handled that." -She did not know why the Miralax was stored on the kitchen counter. Observation on 1/12/17 at 3:32pm revealed there was no MA or Resident Care Coordinator (RCC) available to interview on 1/12/17 at 3:32pm and at 3:43pm the Miralax was no longer on the kitchen counter. Interview with a Personal Care Aide (PCA) on 1/12/17 at 3:32pm revealed: -There was no other MA to replaced Staff A when she was sent home by the Administrator. -She did not know where the RCC was.	D 358		

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D 358	Continued From page 55 Refer to interview with the Administrator on 1/12/17 at 11:45am. 4. Review of Resident #5's current FL-2 dated *** revealed: -Diagnoses included -Medication orders included Review of Resident #5's January 2017 Medication Administration Record (MAR) revealed: -There were entries for medications including Amlodipine, Abilify, Aspirin, Bumex, Ferrous Sulfate, Vitamin D3, Acetaminophen and Metoprolol scheduled to be administered at 8am. -All of the staff initials documented for 8am on 1/11/17 were circled with documentation the resident refused on the back of the MAR. -All of the boxes for 1/12/17 at 8am were blank. Refer to interview with the Administrator on 1/12/17 at 11:45am. 5. Review of Resident #6's current FL-2 dated *** revealed: -Diagnoses included -Medication orders included (Fluphenazine is an antipsychotic used to treat chronic psychosis.) Review of Resident #6's January Medication Administration Record (MAR) revealed: -There was an entry for Home Health to administer Fluphenazine 25mg intramuscularly (IM) every two weeks. -Staff had documented as administered on 1/1/17, 1/3/17, 1/5/17, 1/7/17, 1/8/17 and 1/12/17. Interview with the Home Health Nurse (HHN) on	D 358		

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D 358	Continued From page 56 1/12/17 at 8:35am revealed: -She was at the facility to administer Resident #6's monthly injection. -Staff usually obtained the medication from the pharmacy and kept it on the medication cart. -Staff handed the HHN another resident's medication from the medication refrigerator which was expired as of August 2016. -Resident #6's medication for injection was not in the facility. -Staff had been "marking" the entry on the resident's MAR; only the HHN was supposed to administer and document for the IM injection of Fluphenazine. Observation of the medication provided to the HHN on 1/12/17 at 8:35am revealed: -There was a pharmacy bottle with another resident's name indicating it had been dispensed 2/2/15. -Inside the pharmacy bottle was a bottle labeled Fluphenazine 125mg/5ml with an expiration date of 8/2016. Interview with the Medication Aide (MA) on 1/12/17 at 8:40am revealed: -She had two bottles in her hand and thought one was Resident #6's medication and did not know what happened. -She went through all of the medications in the medication refrigerator and there were a "whole bunch" that needed to be sent back to pharmacy because "they were all expired." -Usually the Resident Care Coordinator (RCC) checked the medication refrigerator and medication carts for medications that needed to be returned to the pharmacy. -She did not know how often this was done; this was her first time checking the refrigerated medications for expired medication.	D 358		

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D 358	Continued From page 57 Interview with the Administrator on 1/12/17 at 8:35am revealed: -The medication provided to the HHN for Resident #6 was discontinued. -The medication belonged to Resident #5 who received the medication at the mental health clinic. -The vial of Fluphenazine given to the HHN should have been returned to the pharmacy. Refer to interview with the Administrator on 1/12/17 at 11:45am. Interview with the Administrator on 1/12/17 at 11:45am revealed: -He expected MAs to administer medications correctly at the right time. -A nurse from the pharmacy trained each of the MAs prior to them administering medications at the facility. -He and the RCC monitored medications every week by checking the Medication Administration Records for residents. -When a resident was down to a ten count on medication he expected staff to order the medication from the pharmacy immediately. -Most medications should be available in the facility because the facility received "batch refills every 15th of the month" from the pharmacy. -There had been several times when the facility had requested medications they never received from the pharmacy and that was why they were switching pharmacy providers effective 1/1/17. -If there was a problem with getting a resident's medication the Administrator expected staff to contact the Primary Care Provider by calling or faxing. -Staff were expected to "write down that they've	D 358		

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D 358	Continued From page 58 contacted the doctor." The facility's failure to administer medications as ordered by the physician resulted in a Medication Pass error rate of 11% (5 errors out of 46 opportunities) including Resident #11 not receiving a blood thinning medication (Plavix); Resident #5 having five unknown medications in her purse; and a Home Health Nurse being provided another residents expired antipsychotic injection (Fluphenazine). This noncompliance was detrimental to the health and safety of the residents which constitutes a Type B Violation. Review of the facility's Plan of Protection dated 1/12/17 revealed: -The pharmacy nurse and/or pharmacy personnel will conduct an in-service for all the Medication Aides (MAs) on the process of medication administration. -The Administrator will meet with all of the MAs regarding timely administration of medications. -The facility will hire a Nurse Consultant to train and monitor the MAs for medication administration. -The Administrator and RCC will continue to educate and assist the MAs. -The Administrator will selectively monitor medication administration by the MAs to ensure the residents receive adequate and proper medication. -The facility has changed pharmacy providers (1/1/17) to ensure timely and accurate delivery of medications. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 2/26/17.	D 358		

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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 A2 VIOLATION Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse for 3 residents (#1, #2 and #8) by a staff person (Staff A) to the Health Care Personnel Registry (HCPR). The findings are: Interview with the Administrator on 01/12/17 at 5:45pm revealed: -Last week, the RCC reported Staff A spanked Resident #2. -When the Administrator talked to the resident, she "gave me a different story". A 24 hour report was not sent to the HCPR nor had he completed a 5 day investigation report. He was not aware Staff A had abused Resident #1. He had not sent a 24 hour report to HCPR nor had he completed a 5 day report. - He was not aware Staff A had verbally abused Resident #8. He had not sent a 24 hour report to HCPR nor had he completed a 5 day report. -Staff A had never been suspended and continued to work 2nd shift (3:00pm - 11:00pm) and worked 1st shift if needed. Refer to Tag D0338, 10A NCAC 13F. 0909	D 438		

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D 438	Continued From page 60 Resident Rights. (Type A1 Violation)]. The failure of the facility to accurately report and investigate a known allegation of abuse to three residents (#1, 5 and 8) by a staff member (Staff A) to the N. C. Health Care Personnel Registry resulted in an alleged perpetrator of abuse being allowed to continue to work around the abused residents, putting Residents' #1, 5, 8 and other residents at risk for further abuse, which constitutes a Type A2 Violation. Review of the facility's Plan of Protection dated 1/12/17 revealed: -The Administrator will forward a 24 hour and 5 day working report to the HCPR to investigate the reported resident abuse immediately. -The Administrator will immediately investigate any report of resident abuse and forward the 24 hour report to the HCPR for investigation. -Staff A will be suspended immediately pending the outcome of the investigation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED February 11, 2017	D 438		
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	D912		

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D912	Continued From page 61 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to management of the facility, housekeeping and furnishings, other requirements and medication administration. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure a safe operational environment within the adult care home as evidenced by violating resident rights, inadequate staffing, absent supervision of residents, failure to report resident abuse allegations to the Health Care Personnel Registry, a deteriorating, unsafe and unclean physical environment and unsafe medication administration. [Refer to Tag 176 10A NCAC 13F .0601(a) Management of Facilities (Type A1 Violation)] Based on observations, interviews and record reviews, the facility failed to assure the adult care home was maintained in a clean, and free of hazards and obstructions as evidenced by the presence of numerous live bed bugs observed in two resident rooms with evidence of bed bugs in a two additional resident rooms; saturated and deteriorating ceilings in the dining room and hallways; dirt and debris on floors in the dining room, hallways, bathrooms and resident rooms;	D912		

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D912	Continued From page 62 unclean bathrooms, showers and resident rooms and foul smelling standing water in a sink in the janitor's closet on the women's hall. [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)] Based on observations, interviews and record reviews, the facility failed to assure prompt repair and adequate maintenance for long standing plumbing and sewer problems in the facility causing a significant leak in the facility dining room that presented potential hazards to residents from large amounts of water in the ceiling and on the floor, damaged ceiling tiles falling to the floor and potential bacterial growth in standing water left in a sink for up to a week. [Refer to Tag 105 10A NCAC 13F .0311(a) Other Requirements (Type B Violation)] Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by the physician to 4 of 8 residents resulting in Resident #11 not receiving a blood thinning medication (Plavix) and a multivitamin (CetaVite) and not receiving a muscle relaxer (Flexeril) and pain medication (Hydrocodone with Ibuprofen) within an hour of the scheduled time; Resident #4 receiving a multivitamin without an order; Resident #7 not receiving a decongestant (Flonase) and a laxative (Miralax); Resident #5 having five unknown medications in her purse; and a Home Health Nurse being provided another residents expired antipsychotic injection (Fluphenazine) to administer to Resident #6. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]	D912		

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D914	Continued From page 63	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse, neglect, and exploitation related to violating residents' rights, inadequate personal care and other staffing, absent personal care and supervision and lack of health care personal registry reporting. The findings are: Based on observations, interviews and record reviews, the facility failed to keep 3 of 5 sampled residents (#1, #2, and #8) from physical abuse by a staff member (Staff A) who physically assaulted Residents #1 and 2 and verbally abused Resident #8. [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type A1 Violation)] Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to provide direct personal assistance and supervision needed by the residents by routinely staffing the facility with one person on each shift who was responsible for administering medications, cooking meals, performing housekeeping duties and supervising 18 residents, one of which had a history of ingesting potentially hazardous substances, such as toothpaste, hand sanitizer and "aftershave." [Refer to Tag 187 10A NCAC 13F .0604(d) Personal Care and Other Staffing (Type A2	D914		

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D914	Continued From page 64 Violation)] Based on observations, interviews and record reviews, the facility failed to respond in any reasonable manor to Resident #4 ingesting harmful substances including toothpaste, mouthwash, hand sanitizer, and aftershave on two occasions within one month; and to provide intervention and supervision to prevent continued incidents and harm as evidenced by the resident having free access to a storage closet containing large bottles of mouthwash, aftershave and medications of former residents including Trazadone, Prednisone and Clozaril. [Refer to Tag 271 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A2 Violation)] Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse for 3 residents (#1, #2 and #8) by a staff person (Staff A) to the Health Care Personnel Registry (HCPR). [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)]	D914		